HEALTHCARE PAYER News
Brought to you by the publisher of *Healthcare Finance News* and *Healthcare IT News*

RECEIVE NEWS BY EMAIL Enter email Sign up!

Reading between the lines in the 2016 MA Call Letter

June, 02 2015

By Deb Mabari, Cody Consulting

Don't let errors that could have easily been avoided be the reason that CMS comes knocking on your door.

By now, it is safe to assume that health plans across the nation have thoroughly read and examined the Center for Medicare & Medicaid Services' Final Medicare Advantage Rate Announcement and Call Letter for 2016. I think we all heard a collective sigh of relief with the announcement that reimbursements would increase, rather than decrease, in the coming year.

However, while this is great news for MA plans, it will likely come with strings attached. With increased payments, plans should expect increased regulatory oversight, as CMS will be on a sharper lookout for compliance violations – and not just in those areas outlined in the call letter, such as maintaining real-time updates for formularies and provider directories.

This is a logical assumption, considering that CMS spends billions of dollars each year on managed care. In fact Medicare, Medicaid, Children's Health Insurance Program (CHIP) and the Accountable Care Act (ACA) accounted for 24% of the total federal government's budget in 2014. The total spend for all four health care areas was a staggering $836 billion. Approximately two-thirds of this – $511 billion – was spent on Medicare alone.

The federal government clearly has a fiduciary duty to ensure that plans administering these health services are free of fraud and abuse.

Pitfalls of noncompliance

The recent sanctions filed against Aetna exemplify a cautionary tale of the impact that non-compliance can have on a health plan. During the 2015 Annual Enrollment Period (AEP) year, Aetna reported that a total of 6,887 non-network retail pharmacies were erroneously identify as "retail in-network" on its website and through its call center customer service representatives.

As a result, CMS received 3,767 complaints from members who had trouble filling their prescriptions at pharmacies that were clearly listed in their membership materials as "in-network." These complaints accounted for 33 percent of all complaints received by CMS last year, and resulted in a $1 million fine to Aetna. In addition, CMS granted Aetna beneficiaries a special enrollment period to disenroll from Aetna's plan and re-enroll in another Part D plan.

For smaller health plans, these sanctions could be potentially life-threatening to the operation. There is a real concern that once a health plan has been flagged for non-compliance in one area, it could lead to expanded CMS oversight in other areas. Thus leading to the finding other violations and issuing additional fines.

The reality is that if a health plan has multiple erratas during AEP and extensive complaints that lead to multiple CTMs (Complaints Tracking Module), CMS will take notice. It is this "notice" that could potentially put a plan "under the CMS microscope." A situation no health plan would want to find themselves.

Increasing compliance, reducing risk

So what does that mean for health plans that need to prepare for this increased oversight? It's very important, especially now, that member materials like pre-enrollment kits, annual notification of change (ANOC), evidence of coverage (EOC), summary of benefits and post-enrollment kits—in addition to formularies and provider directories – are accurate, trackable and traceable.

The last thing health plans need is erratas for their ANOCs and EOCs. You may be out of luck when you have CMS knocking on your door ready to look through all areas of your operation because your ANOCs and EOCs were not compliant.

To better manage this process and reduce the risk of non-compliance, health plans should identify the appropriate resources to help them manage creation and distribution of these materials.

Tools are available to help manage all aspects of development, tracking and distribution of ANOCs and EOCs, and many successful plans integrate these software solutions into their materials creation process. A powerful tool will include modules that manage scheduling, compliance, document creation, as well as overall project management.

During the 2015 AEP materials creation season, health plans that used a software tool to help manage this process had an easier time coordinating the many moving parts involved. In addition, they likely reduced their risk of document errors, costly errata mailings, and late project completion—not to mention hefty fines from CMS.

So while CMS may not have stated that they are increasing compliance in these areas, it's safe to assume that they will not overlook non-ompliance simply because they are more focused on the accuracy of provider and pharmacy directories. Increased focus in these areas will only open the door for further examination and increase the risk of oversight in all areas of a health plans operation.

Deb Mabari is the founder and CEO of Cody Consulting.