A PUBLICATION OF THE HEALTH CARE COMPLIANCE ASSOCIATION

COMPLIANCE TODAY

MAGAZINE

JANUARY 2019

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SENIOR VICE PRESIDENT &
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NORTHWELL HEALTH

SEEING ENFORCEMENT ISSUES FROM ALL SIDES
(P12)

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VOLUME 21, ISSUE 1

Articles

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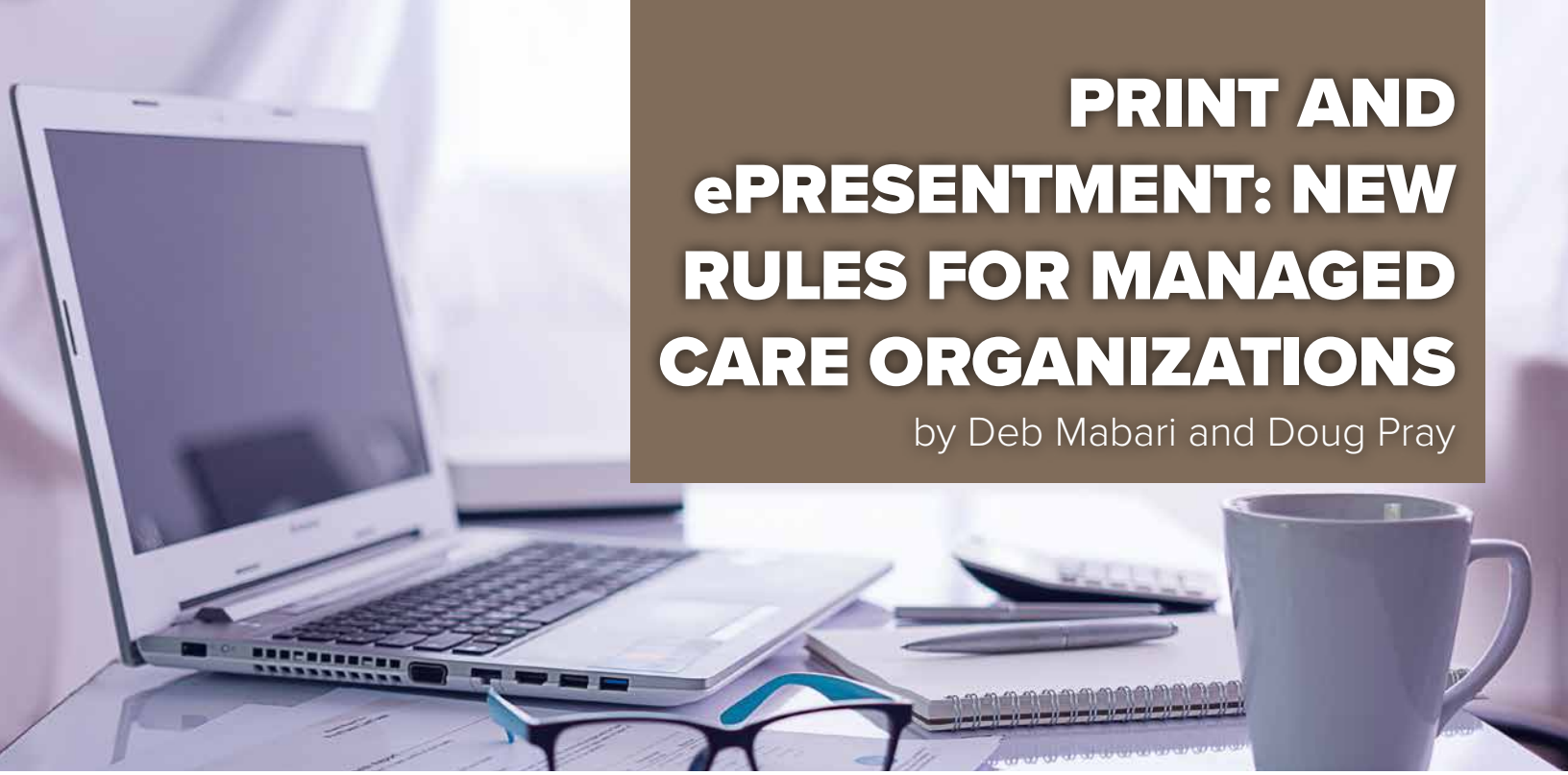
Compliance Today (CT) (ISSN 1523-8466) is published by the Health Care Compliance Association (HCCA), 6500 Barrie Road, Suite 250, Minneapolis, MN 55435. Subscription rate is $295 a year for nonmembers. Periodicals postage-paid at Minneapolis, MN 55435. Postmaster: Send address changes to *Compliance Today*, 6500 Barrie Road, Suite 250, Minneapolis, MN 55435.



PRINT AND ePRESENTMENT: NEW RULES FOR MANAGED CARE ORGANIZATIONS

by Deb Mabari and Doug Pray

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In October 2017, Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma announced an initiative called Patients over Paperwork.[1] The initiative focused on streamlining regulation to reduce unnecessary burdens on health plans and providers, as well as increasing efficiencies and improving the member experience. In April 2018, the CMS Final Rule for Contract Year (CY) 2019[2] incorporated policy changes driven by the Patients over Paperwork initiative that allows Medicare Advantage and Part D plan sponsors to provide specific types of plan information, such as the Evidence of Coverage (EOC) electronically instead of in hard copy.

Under the final rule, the Annual Notice of Change (ANOC) and the EOC documents are now two independent documents with different delivery requirements and flexibilities. This may seem like a simple change, but it requires serious thought and planning by health plans. It is imperative that health plans pay attention to these changes.

Benefits for health plans

Beginning with CY 2019, ANOCs and EOCs no longer need to be combined in the mailing due to members by September 30 each year. Health plans now have until October 15 to provide EOCs electronically. The ANOC must continue to be delivered by September 30 each year, which is 15 days prior to the Annual Election Period (AEP), and must be received by enrollees ahead of the EOC, allowing enrollees to "focus on materials that drive decision-making during AEP" as CMS suggested in the final rule.

CMS estimates this new rule has the potential to save health plans $54.7 million a year from 2019 through 2023.[3] These savings will come from eliminating or significantly reducing expenses related to printing, fulfillment, and mailing costs (e.g., paper, prepress and printing, bindery, lettershop, USPS postage, logistics carriers) for the EOCs.

Beyond the monetary savings, health plans now have more time to produce the EOCs. In addition to having two more weeks until these documents are due to members, health plans that provide EOCs electronically also free up part of the timeline previously

dedicated to prepress, printing, and mailing of the EOC books.

Health plans must use the extra time wisely

CMS has explicitly stated that the extra time for EOC creation "will also provide an additional two weeks for MA [Medicare Advantage] organizations and Part D plan sponsors to prepare, review, and ensure the accuracy of the EOC, provider directory, pharmacy directory, and formulary documents."[4] Health plans need to use the time wisely and get these documents right the first time, or be prepared for fines and sanctions from CMS.

Some health plans may quickly realize that the extra time to create these documents is a mixed blessing. They must allow additional time for document review from all participating departments, including Marketing, Product, and Compliance. Review of required documents must include all stakeholders and departments in an in-depth review of content pertaining to members' plan benefit information, co-pays by drug tier, and phone numbers and TTY, just to name a few.

Health plans need to take an enterprise-wide approach in their review process. Other departments, including, but not limited to, Operations, Pharmacy, Provider Network, Call Center, Health Services, Long-Term Care (LTC), and Claims, must be brought into the review process to ensure 100% accurate documents. This exercise should be like the one that happens annually during a health plan's annual budgeting process.

Create a single "Source of Truth"

Every health plan will have its own process for reviewing and comparing materials annually to ensure accuracy. One of the best ways to start the review process is to analyze and compare current CMS Model Documents[5] to the prior year's documents. A full understanding of the changes in all plan types from year over year is essential. This review can be done by mapping the plan benefit package (PBP) report to variable data fields and addressing the variability in the templated documents.

Although there are several products on the market that can help health plans do this mapping, it is essential that you work with a firm that has a broad-spectrum, hands-on understanding of the nuances of these reports across many plan calendar years. This is not a process that can just be managed by writing a query. The data produced at the end of this process becomes an invaluable input into creating the EOCs (and various other documents) and should be considered a health plan's annual "Source of Truth." This output will contain all the updated plan benefit information for the new year. If this mapping from the PBP report is not done correctly, all plan benefit and ancillary information could (will) be wrong, creating erroneous materials.

When changes are required during the materials creation process, changes to the single, centralized Source of Truth can be made and disseminated throughout the organization immediately. This is a critical step in the creation process. It keeps all departments and team members updated to any changes, which is essential to the goal of 100% accuracy. Effective communication is key.

Allow ample time for all departments to review

During the review process, allowing ample time for your subject-matter experts (SMEs) to review the data in the Source of Truth, templates, and final version documents is imperative. Many changes can occur during this process, and maintaining version control is *key*. It may sound simple, but it's not.

Your Pharmacy department may want to change language it does not like in a single version of an EOC, but it may not be a viable option to do so. This version was likely created using the most recent Model Documents provided by CMS, and CMS-compliant documents mean model language cannot be changed. The decision to move from model to non-model language should be made only by the Compliance department, because it could significantly impact the submission and review/approval process by CMS's Regional Office (RO).

Opt-in or opt-out

As noted, once the documents are created, approved, and submitted as final, CMS permits the electronic delivery of many materials (for this article, we will refer to any electronic delivery as ePresentment). CMS defines two distinct processes for ePresentment in Section 100.2.1 and 100.2.2 of the Medicare Communications and Marketing Guidelines (MCMG).[6]

The first is through a Notification of Availability or notice that tells the enrollee how to access designated materials on plan website(s) and gives the date that the materials will be available (or states that the materials are currently available). At minimum, health plans must also provide a phone number by which the member can opt-out of electronic delivery and request a hard copy version of the document. Updates to the CY 2019 MCMG on September 5, 2018, also state that if the member

requests a hard copy/printed version of a document, that "Plans/Part D sponsors may inquire to the member whether the request for a hard copy is a one-time request or is a request to receive the document in hard copy permanently."

The second option for ePresentment of materials requires prior consent from the member, or opt-in. With prior consent, health plans can provide any required materials through a member portal, email, or CD/DVD.

The use of member portals, email, and other delivery methods…requires the health plan to obtain consent from the enrollee to receive the materials…

The first process for ePresentment detailed above requires only prescribed notification of access and availability. The use of member portals, email, and other delivery methods for presenting materials to members requires the health plan to obtain consent from the enrollee to receive the materials, with specificity as to the media type or mechanism for ePresentment. In addition, a member must also have continued access to a mechanism for opting out or withdrawing the opt-in consent and reverting to hard copy receipt of materials upon request.

When a member opts in to ePresentment via email or a member portal, health plans must ensure that the member's contact information is current and can track electronic delivery of the materials with a time/date stamp recorded for each access point. If the transmission fails, due to an expired email address, connectivity issues, or other reasons, health plans must have a mechanism in place for automatic opt-out conversion of the member status, and a hard copy must be printed and mailed.

ICT Refresh and Revised 508 Standards

In 1998, the Workforce Investment Act[7] introduced amendments to the Rehabilitation Act of 1973. Included in these amendments was a new Section 508,[8] which required all federal agencies to ensure that their electronic and information technology was accessible to people with disabilities. Critical to our discussion of present-day standards was the requirement that "individuals with disabilities, who are members of the public seeking information or services from a Federal department or agency, have access to and use of information and data that is comparable to that provided to the public who are not individuals with disabilities."[9]

In December 2000, the U.S. Access Board introduced a set of accessibility standards, definitions, and guidelines that federal agencies would reference to comply functionally and technically with Section 508.[10] This set of standards and guidelines was the reference point for federally contracted healthcare and health insurance providers until January 18, 2017, when the Information and Communication Technology (ICT) Refresh[11] was published as part of the final rule that jointly updated requirements for information and communication technology.

The ICT Refresh, formally known as the ICT Standards and Guidelines, revised and updated the original Section 508 standards and codified them through the incorporation of the World Wide Web Consortium (W3C) Web Content Accessibility Guidelines (WCAG),[12] a globally recognized standard for web content and ICT. For a comparison table of the "old" 508 standards to the WCAG 2.0 A and AA standards, visit *https://bit.ly/1ToCnj1*.

With the incorporation of WCAG 2.0 AA standards set into Section 508 via the ICT Refresh, website, document, and media developers now have a specific set of success criteria for making web content accessible to a wide range of people with disabilities, including blindness, visual impairment, color blindness, deafness and hearing loss, and learning and cognitive limitation.[13] Critically, the success criteria that are part of the WCAG 2.0 standard set are testable. Auditing of websites and web-based materials can now be done objectively using software specifically designed for that purpose.

This background information is important from a compliance perspective because since January 18, 2018, every health plan website and all digital content must meet the testable WCAG 2.0 AA standards. CMS is now allowing more member-facing documents to be electronically presented, which presents website and content managers with a new and significant challenge—how to make sure that electronically presented PDF documents meet or exceed the WCAG 2.0 AA success criteria. Keep in mind that although the ICT Refresh currently incorporates WCAG 2.0 AA into the final rule, W3C has now updated the WCAG 2.0 standard with WCAG 2.1, which contains an additional 17 new

criteria, so this requirement is likely to get more stringent over time.

Creating and testing accessibility for ANOC, EOC, Formulary, Directory, Summary of Benefits, and other PDF documents available on health plan or provider sites is paramount before publishing these documents. Organizations that use downstream vendors for remediation of PDF documents should always ask for definitive and detailed reports showing that a PDF passes all WCAG 2.0 AA checkpoints before publishing. Federal auditors now have several specific software tools that can be used to check website and content accessibility.[14] Securing the services of a reputable authority to remediate Plan PDF documents should be a top priority.

Questions for health plans to consider

Armed with the information and perspectives shared above, the following questions may be helpful for determining whether your health plan is prepared to comply with the new print and ePresentment rules:

- Does the EOC Request Notice that is sent with the ANOC mailing contain a specific, variable URL (web link) for each electronically presented document within a PBP, or does the notice simply direct members to the Plan Documents section of the website, and have the member select their specific EOC document based on the health plan's name? How does a health plan ensure that a member accesses and references the correct PDF document?
- Do health plans need to create or update their member portal infrastructure? Plans should make it as easy as possible for members to find their specific documents.
- If a member opts out of receiving their electronic document(s), how do health plans document that members have opted out?
- How do health plans tie the opt-out notice to each member's record so that a call center representative can easily find the document when a member calls, thereby enabling a more positive customer service experience?
- How will health plans ensure that their website and the electronic documents, including EOCs, are compliant with Section 508 and the WCAG 2.0AA standard?
- How are printed copies of EOCs and other ePresentment documents made available to members who request them?
- Have Customer Service and Marketing managers developed efficient and scalable processes to compile and verify member request data?
- Do health plans print a limited number of copies to pull from the shelves, or will they use on-demand printing and fulfillment to meet the three-day rule for fulfillment of requested hard copy materials?

Conclusion

Health plan fulfillment is a changing landscape in the face of new electronic presentment and accessibility rules. Health plans must be vigilant and diligent about keeping abreast of these changing rules and guidance as we transition more and more to digital and online fulfillment practices. CT

Endnotes

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14. GSA Section 508.gov, Accessibility Testing for Electronic Documents. https://www.section508.gov/test/documents.

- Take the time. Prepare and have a plan.
- Create a centralized, plan benefit package-based "Source of Truth."
- Review, review, review—use your subject-matter experts wisely.
- Adhere to all CMS mandates and guidelines.
- Be mindful, and make sure that you have the proper policies and procedures in place to ensure accuracy.