Part D Internal Auditing and Monitoring for PACE

It’s More Than Just a Fraud Waste and Abuse Policy

NPA Educational Session
Tuesday 10/25/16, 3:30-5:00PM
Speakers

• **Amanda Boyle**, BSW, Risk Adjustment Supervisor, Immanuel Pathways, Omaha, NE; Council Bluffs, IA; Des Moines, IA

• **Matt Zimmerman**, BA, Risk Adjustment Consultant, Capstone Performance Systems, St. Louis, MO

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Learning Objectives

• Understand the key Part D monitoring and auditing responsibilities of PACE organizations

• Identify where necessary Part D data is obtained, how it is used in monitoring and auditing activities, tie them to the HPMS reporting and attestation schedule using a Compliance Calendar.

• Learn how to use a Compliance Calendar Worksheet to identify the appropriate areas/persons within your organization to perform the auditing and monitoring processes.
Keys and References

- In this presentation GREEN TEXT indicates the source of data, documents or information.
- This icon indicates topics that are covered in the CMS “1/3 Financial Audits”

- A list of acronyms is included and attached to the back of your handout.
PACE and Part D

PACE plans provide 100% of the drugs covered under Medicare Part D for their participants with some exceptions.

- Veterans’ Administration (VA) coverage
- Workers’ Compensation coverage
- Federal Black Lung Benefits
- Other insurance such as railroad retirement, etc.
Part D medications are available only by prescription, dispensed for a medically-accepted condition, approved by the FDA, and used and sold in the USA.

PACE also covers these other types of medications, but they are not Part D:

- Part A – hospital and skilled nursing stay drugs
- Part B – (in general) injectable drugs, infused drugs, vaccinations, drugs that are not self-administered
- Over-the-Counter medications (OTCs)
- Drugs that may be excluded from Part D (enhanced drugs.)
Other important factors in effective Part D Management:

• **Medication Therapy Management (MTM)**—this is not a Part D requirement for PACE Organizations (one that POs are required to provide as part of the personalized care plan.) PACE is waived from the regulatory process of MTM.
  - A strong MTM process is best practice for PACE and will help reduce hospitalizations, prevent adverse drug events, improve outcomes, reduce costs, and **MAKE PART D MANAGEMENT EASIER!**

• **Formulary**—only a very few POs use a formulary. The goal of PACE is to provide personalized care, not create barriers to access or provide only select medications based on the drugs for which a PBM receives the greatest rebate.
  - Many POs use a **Preferred Medication List** to help their providers choose the most effective generic medications in several key therapeutic classes to use when starting a new treatment for a participant.
The PACE plan is fully responsible for providing all medically necessary medications while controlling costs; preventing, detecting, and correcting Fraud, Waste, and Abuse (FWA); and meeting all CMS compliance and reporting requirements.
“Part D only affects our plan’s Clinic Operations and the Finance Department.”

WRONG!

Part D involves nearly every aspect of PACE operations.
If not managed and monitored properly, Part D can negatively impact:

- Patient safety
- Hospital, ER, and SNF utilization
- Your annual bid and reconciliation
- CMS annual surveys
- CMS 1/3 financial audits
OK, so if we have our clinical team and our financial folks fully engaged; and we get our entire staff trained on FWA; and we create a bunch of P&Ps........

Then we’re GOOD! Right?
Nope, still WRONG!

FWA training, documentation, and employee engagement are the building blocks, the foundation...
1. FWA Training

- All PACE employees must complete CMS FWA training annually and training records must be maintained.
- You must document the training processes in a P&P.
- Your FDRs (First-tier, Downstream and Related entities) must provide annual attestations of their employees’ annual CMS FWA training.
- You will need the attestations and your training records for your own monitoring and auditing purposes and for your CMS site survey.
1. FWA Training (continued)

- Annual FWA training provides the foundation for an effective compliance plan.
- From the annual training there is an expectation that everyone involved is on the same page and at least thinking about areas within the company that could lead to potential to fraud, waste or abuse.
- The Internal Monitoring and Auditing procedures undertaken help ensure success in identifying potential fraud, waste or abuse.
2. Part D Monitoring and Auditing Responsibilities

- Whether the PACE plan performs the Part D activity themselves, or they contract with their pharmacy, a PBM, or TPA to perform these services, the plan is fully responsible for the monitoring, auditing, and reporting.

- **Monitoring** activities consist of regular reviews performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

- An **Audit** is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures.
3. Documentation – P&Ps

- Maintain detailed and specific P&Ps describing the process being monitored or audited. They should include:

  ✓ Schedule or frequency of monitoring or auditing
  ✓ Data sample size
  ✓ Findings recorded
  ✓ Reports generated
  ✓ Describe how findings/discrepancies are handled:

    • Is it fraud, waste, abuse, or error?
    • What is the root cause?
    • How will it be corrected/reported?
    • How will it be prevented?
3. Documentation – P&Ps (continued)

- You may want a separate P&P for your auditing processes.

- P&Ps should be reviewed and updated regularly to ensure that they accurately reflect your current processes.

- Your FWA P&P should reference your monitoring and auditing processes.
4. Participant Eligibility

Monitoring Process:
Monthly enrollments, disenrollments, deaths, and status changes

- Prior to Enrollment
  - Validate in MARx UI
  - Participant name, Part B eligibility, gender, DOB, State & County eligibility, HICN
  - VA, Worker’s Compensation, Employer Subsidy, etc.

- Post Enrollment
  - DTRR
  - MMR

- Compare your records with the Daily Transaction Reply Report (DTRR) and Monthly Membership Report (MMR), which are downloaded from GENTRAN mailbox.
4. Participant Eligibility (continued)

- All eligibility adjustments are required to be done in a timely manner by the CMS subcontractor, Reed & Associates
  - CATEGORY II – Any adjustment that is < 90 days old
    - Work directly with Reed & Associates for reconciliation
    - Send adjustments to Reed via the CMS portal
  - CATEGORY III – Any adjustment that are > 90 days old
    - Adjustments this old require special approval from CMS regional office and can cause unnecessary delays in approval/payment
4. Participant Eligibility (continued)

- Make necessary corrections and resubmit to Reed & Associates using the CMS portal to access the electronic retroactive processing transmission (eRPT) module.

- All adjustments found in eligibility or the DTRR can be made with Reed & Associates.

- Document all corrections before submitting to CMS.

- Some adjustments can be made directly in the MARx(UI) before the Plan Data Due deadline.
The Plan Communication Guide (or MARx Calendar) on the CMS website shows monthly due dates for plan data and report availability dates in the GENTRAN mailbox.

- **PLAN DATA DUE:**
  - Meet this date to ensure timely and accurate submission of enrollments and disenrollments

- **CERTIFICATION OF ENROLLMENT & PAYMENT:**
  - Date the Monthly Plan Payment attestation is due in HPMS

- **MONTHLY REPORTS AVAILABLE:**
  - Date monthly reports are available in the GENTRAN system
## Yearly Schedule of Events

**YEAR 2016 MARx MONTHLY CALENDAR**

### October 2016

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 7, 2016</td>
<td>Plan Data Due (8pm Eastern Time)</td>
</tr>
<tr>
<td>October 8, 2016</td>
<td>Certification of Enrollment for August 24, 2016 - Monthly Reports</td>
</tr>
<tr>
<td>October 10, 2016</td>
<td>Columbus Day</td>
</tr>
<tr>
<td>October 15, 2016</td>
<td>Annual Enrollment Period - BEGINS</td>
</tr>
<tr>
<td>October 24, 2016</td>
<td>Monthly Reports Available</td>
</tr>
</tbody>
</table>

### November 2016

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 1, 2016</td>
<td>November Payment Due to Plan</td>
</tr>
<tr>
<td>November 6, 2016</td>
<td>Certification of Enrollment for September 22, 2016 - Monthly Reports</td>
</tr>
<tr>
<td>November 11, 2016</td>
<td>Plan Data Due (8pm Eastern Time)</td>
</tr>
<tr>
<td>November 11, 2016</td>
<td>Veteran’s Day</td>
</tr>
<tr>
<td>November 22, 2016</td>
<td>Monthly Reports Available</td>
</tr>
<tr>
<td>November 24, 2016</td>
<td>Thanksgiving</td>
</tr>
</tbody>
</table>
This guide explains many due dates with CMS, but also provides detailed documentation on many CMS reports

- **Key Reports include**
  - MONMEMD - Monthly Payment from CMS
  - HCCMODD – Detail record of HCC(s) by Participant used for Risk Adjustment calculation and payment
  - MSPCOBMA – Detailed file used to review Coordination of Benefits
  - DTRR – Daily Transaction Reply report

- The PCUG also provides a key to interpret response from CMS.
  - Adjustment Reason Code
  - Transaction Reply Codes
Items to Monitor

• Transaction Codes:
  o Enrollment (61)
  o Disenrollment (51)

• Transaction Reply Codes:
  o A – Accepted (enrollment and disenrollment)
  o R – Rejected (analyze the rejection)
  o I – Informational (additional information about the beneficiary)
  o F – Failed (action did not occur)
6. Pharmacy Claims and Utilization Review

- Executive Summary or high-level monthly data – used in your bid worksheet AND to indicate areas for improvement

1. Total number of prescriptions for the month
2. Total drug cost per month (including dispensing fee)
3. Average cost per prescription
4. Average cost Per Member per Month (PMPM)
5. Average number of prescriptions PMPM

- This information comes from your pharmacy or PBM in monthly reports and/or on their reporting website.
6. Pharmacy Claims and Utilization Review (cont.)

- Executive Summary or high-level monthly data – (continued)

6. Percent of Brand name drugs utilized

7. Percent of Generic drugs utilized

8. Specialty drugs – total prescriptions, total cost, percent of all prescriptions, percent of total monthly costs

9. Top 25 most expensive drugs

10. Top 25 by utilization

- This information comes from your pharmacy or PBM in monthly reports and/or on their reporting website.
6. Pharmacy Claims and Utilization Review (cont.)

- Executive Summary or high-level monthly data – (continued)

  - Who uses it?
    - Leadership – quarterly reports
    - Finance - PMPM costs
    - Healthcare Services - CPN
    - Medical Dir. – poly-pharmacy, comparative data + trends, benchmarking*

  - How does it tie in to PACE goals and objectives?
    - Improving Patient Care
    - Lowering Costs
    - Quality Initiatives
    - Process Improvement
    - Streamlining Work Flow
Monthly drug utilization detail data – used to highlight areas for investigation/intervention, QAPI initiatives, reporting requirements

1. Narcotics utilization/over-utilization

2. Anti-infectives utilization or infection control

3. Participants with the highest drug costs

4. Participants with the highest number of prescriptions

This data comes from your pharmacy or PBM in monthly reports and/or on their reporting website.
6. Pharmacy Claims and Utilization Review (cont.)


6. Review Part A stay dates to ensure that Part D claims were not processed during the stay

7. Review paid claims to ensure correct contractual pricing for drug ingredient cost and dispensing fees

8. Look at provider prescribing patterns

- This data comes from your pharmacy or PBM in monthly reports and/or on their reporting website.
6. Pharmacy Claims and Utilization Review (cont.)

- Who uses monthly drug utilization data?*
  - **Clinic Staff**
    - Participant drug review (at least 2 times per year)
    - Preparation for clinic visits and IDT meetings
  - **CMO/Medical Director**
    - Generic utilization/reduce brand drug use where appropriate
    - Specialty drug use
    - High utilizers
    - High spend drug categories
    - Alternative therapy opportunities
    - Prescribing patterns
  - **Quality Department**
    - Process improvement effectiveness
    - Corrective action results
    - FWA review
  - **UR department**
    - Appropriate drugs per diagnosis
    - Part A stay dates do not have Part D claims
PDE submissions are due monthly.

Submissions must be monitored to ensure they are complete, on-time and correct.

- Paid claims data are supplied by your pharmacy or PBM.

Ensure that no Part B or Part A claims are included if you are doing your own submissions. If you use a TPA or PBM, ensure that they have processes in place to exclude Part B and Part A claims from the submissions.*
7. PDE Submission and Reporting (cont.)

- Check PDE responses from CMS to ensure that Part D claims for all eligible members are accepted PDE.
  - The responses are downloaded from your GENTRAN mailbox, or received from your TPA or PBM.
- Reported errors must be corrected and the PDE resubmitted.
- The end of June is the annual deadline for submission or resubmission of prior calendar year PDE data.
- Your annual PDE attestation must be submitted on the HPMS website.
  - If you use a TPA or PBM to submit your PDE, they must send you an annual attestation for your records.
7. PDE Submission and Reporting (cont.)

- Documenting, Monitoring and Auditing

All PDE data needs to be monitored and documented for compliance with Part D regulations

<table>
<thead>
<tr>
<th>PBP-001</th>
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<tbody>
<tr>
<td><strong>Originals</strong></td>
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<tr>
<td>30 days following DOS of claim received (Enter DOS)</td>
</tr>
<tr>
<td><strong>Adjustment and Deletions</strong></td>
</tr>
<tr>
<td>resubmitted within 45 days following date of discovery (Enter DOS)</td>
</tr>
</tbody>
</table>

| **Original Submission Claims**         |
| **Accepted Claims**                   |
| **Rejected Claims**                   |

<table>
<thead>
<tr>
<th>PBP-002</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Originals</strong></td>
</tr>
<tr>
<td>30 days following DOS of claim received (Enter DOS)</td>
</tr>
<tr>
<td><strong>Adjustment and Deletions</strong></td>
</tr>
<tr>
<td>resubmitted within 45 days following date of discovery (Enter DOS)</td>
</tr>
</tbody>
</table>

| **Original Submission Claims**         |
| **Accepted**                           |
| **Rejected**                           |
8. Coordination of Benefits (COB)

- Eligible participants may have some Part D costs covered by other insurance or program benefits. Check at enrollment and annually for Coordination of Benefits opportunities.
  - Veterans’ Administration (VA) coverage
  - State or Federal Workers’ Compensation coverage
  - Other insurance such as railroad retirement, etc.

- If a participant has other insurance, the PACE plan must ensure that all eligible claims are billed to that insurance.

- Any portions not covered may then be submitted as PDE
Coordination of benefits reviews can be summarized in 4 steps:

1. Ask new enrolling participants about any instances of other insurance and have potential participants sign a document to that effect.

2. After enrollment use the CMS Electronic Correspondence and Referral System (ECRS) to review accuracy and process any corrections.

3. Review all CMS COB reports, MARxCOB (daily) and MSPCOBMA (monthly.)

4. Survey effected participants annually for any changes in COB records and make necessary updates.
8. Coordination of Benefits (continued)

- Implementation of processes in PACE

- Internal challenges?
  - How are the MSPCOBMA files converted?
  - Who coordinates the benefits within the company?
  - Are there available resources?
  - How are the claims processed internally?
  - Can the EHR software flag diagnoses to coordinate the benefits, if using the adjudication module?
9. True Out-Of-Pocket (TrOOP)

TrOOP is defined by CMS as follows:

- The PO must facilitate the transfer of a participant’s gross covered drug spend (GCDS) and true out-of-pocket (TrOOP) balance to the appropriate party upon the participant’s enrollment in, or disenrollment from, the plan during the coverage year.
9. TrOOP and Explanation of Benefits (EOB)

EOB letters must be sent to the participant or new Medicare Advantage plan within 7 days after their disenrollment appears on the DTRR.

EOB letter includes:

- The Gross Covered Drug Spend (GCDS) or the amount the plan spent on the participant’s Part D drugs during the current year.

- The GCDS comes from the accepted PDE.

- TrOOP (True Out-Of-Pocket) amount calculated upon disenrollment using the PACE TrOOP Calculator.
10. TrOOP Calculator

The TrOOP Calculator can be found here: https://www.cms.gov/apps/troopcalculator/

<table>
<thead>
<tr>
<th>Plan Year</th>
<th>Current Year TGDC Transfer from Non-PACE</th>
<th>Current Year TrOOP Transfer from Non-PACE</th>
<th>Current Year Dual-Eligible TGDC</th>
<th>Total True Out-of-Pocket Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INSTRUCTIONS:**
Enter the Plan year and incoming (non-PACE) TGDC and TrOOP amounts in the first 4 columns in Row 4

Press CTRL-SHIFT-J

Beneficiary’s year-to-date total TrOOP will appear in the 5 column in Row 4

Clear boxes by highlighting and pressing the DELETE key
Notice of Benefit Information for Your New Medicare Prescription Drug (Part D) Plan

THIS IS NOT A BILL. Report this information to your new prescription drug plan and keep this notice for your records.

<Insert Participant Name> <Insert Participant Address> <Date> <Member ID Number: <Member ID>

<Insert City,State ZIP Code>

Dear PACE PLAN Participant,

The Centers for Medicare and Medicaid Services (CMS) requires that PACE PLAN send you a notification of the True-out-of-pocket (TrOOP) drug costs and Gross Drug Costs incurred while you were enrolled in our program.

This notice includes:

1. TrOOP and Gross Drug Costs balances from the PACE plan during <coverage year>.
2. Any adjustments to your out-of-pocket costs or total drug costs due to new claims, reversed claims, or any other adjustments.

Totals:

- Total PACE Covered Drug Costs from <date> to <date>: <insert GCDC amount $>
- Out-of-Pocket costs during PACE plan Enrollment: <Enter TrOOP amount $>

If you enroll with a new Medicare Part D plan, we recommend that you forward this information to that new plan.

Please contact PLAN ANALYST at (999) 123-4567 if you have questions regarding this letter.

Sincerely,

<Employee Name> <Employee Title> <Employee Phone>
12. TrOOP Compliance in 3 steps

1. At enrollment, request TrOOP letter from participant or former Medicare Advantage (MA) plan requesting TrOOP and GCDS totals for the year. Document all attempts to obtain prior plan TrOOP letter.

2. At disenrollment, send the TrOOP and GCDS must be reported within 7 days of notice on the DTRR.

3. TrOOP letters must be sent again if any of the information changes after disenrollment.

- Monitor and document all steps taken in the effort to demonstrate compliance with this important CMS Part D requirement.
13. TrOOP Monitoring

- **Maintain documentation of all TrOOP activity**

**TrOOP Letters Received Upon Enrollment**

<table>
<thead>
<tr>
<th>Month</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Monthly enrollments</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>UPON Enrollment # TrOOP letters requested by Enroll Month</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Prior Plan TrOOP letters received by Enroll Month</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>

**TrOOP letters Sent upon Disenrollment**

<table>
<thead>
<tr>
<th>Month</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Monthly Medicare disenrollments (non-Deaths)</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td># of TrOOP letters sent</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>
14. P2P Payments and Reporting

- P2P (Plan-to-Plan) reports are downloaded from the GENTRAN mailbox.

- P2P payments must be made 30 days from notification or you may receive a request from the other insurance plan or CMS.

- PACE plans generally do not receive P2P payments.

- An annual P2P attestation must be submitted on the HPMS website.
There are 4 types of Plan to Plan (P2P) reports

- 40 COV – Cumulative Year-to-Date P2P report
- 41 COV – Monthly report detailing all receivables from other plans.
- 42 COV – Cumulative Year to Date P2P Payable report
- 43 COV – Monthly report detailing P2P payables

Document and monitor all P2P transactions to demonstrate compliance.
P2P guidance can be found at CSSCOOperations.com

Plan To Plan Payments to Other Medicare Advantage Plans (P2P)

This log will demonstrate that all P2P payments are submitted timely.

All P2P payments must be made within 30 days of receipt of the monthly P2P Payable report.

PDE Submission Timeliness

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount of P2P payable</td>
<td>$ 23.14</td>
<td>$ -</td>
<td>$ 48.76</td>
<td>$ 32.16</td>
<td>$ 180.01</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 78.16</td>
<td>$ 5.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date P2P Payment(s) generated</td>
<td>2/2/2016</td>
<td>N/A</td>
<td>4/12/2016</td>
<td>5/16/2016</td>
<td>6/6/2016</td>
<td>N/A</td>
<td>N/A</td>
<td>9/12/2016</td>
<td>10/15/2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date P2P sent</td>
<td>2/2/2016</td>
<td>N/A</td>
<td>4/12/2016</td>
<td>5/16/2016</td>
<td>6/6/2016</td>
<td>N/A</td>
<td>N/A</td>
<td>9/12/2016</td>
<td>10/15/2016</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Overpunch Character Map
• The Invoice Report and Confirmation of Payment Report contain monetary fields formatted with over-punch characters, or Extended Binary Coded Decimal Interchange Code (EBCDIC). Because PDEs comply with the NCPDP format, PDEs must be submitted in EBCDIC. An example of over-punch, or EBCDIC is provided below.

• 00000000035A (In the example to the left the A converts to the number one (1) making the number 351. Because this is a monetary field and the decimal is implied the true monetary value is $3.51. The number is considered positive because the letter A falls under the “Signed Positive” column (see chart next slide).
P2P Conversion Key for Accurate Payment:

This column indicates the number that your symbol will convert to.

Notice the **POSITIVE** and **NEGATIVE** headers. If the letter or symbol falls in the POSITIVE column the entire number will be positive. If the letter or symbol falls in the NEGATIVE column the entire number will be negative.

<table>
<thead>
<tr>
<th>Unit</th>
<th>POSITIVE</th>
<th>NEGATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>{</td>
<td>}</td>
</tr>
<tr>
<td>1</td>
<td>A</td>
<td>J</td>
</tr>
<tr>
<td>2</td>
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<td>Q</td>
</tr>
<tr>
<td>9</td>
<td>I</td>
<td>R</td>
</tr>
</tbody>
</table>

The two columns house the symbols that will be converted to a numeric character. Example:

\[ H = 8 \quad Q = -8 \]
15. Manufacturer Rebates and DIR

- DIR stands for Direct and Indirect Remuneration. Rebates are “direct remuneration.”

- Rebates are offered by drug manufacturers based on your plan’s utilization of certain eligible brand name drugs.

- Rebates are usually collected by your plan’s PBM and paid to the plan quarterly (if your plan participates in manufacturer rebates.)
15. Manufacturer Rebates and DIR (continued)

- You will receive quarterly DIR reports from the PBM.
- Remember to reconcile the claim detail (participants’ scripts) to the DIR Detail Summary (drug NDCs.)
- Plans must report DIR annually on the HPMS website in June following the coverage year.
  - Summary DIR Report - DIR data at the contract plan benefit package (PBP) level
  - Detail DIR Report - DIR data at the 11-digit National Drug Code (NDC) level

- The annual DIR Summary and DIR detail reports are supplied by the PBM.
15. Manufacturer Rebates and DIR (continued)

- An annual DIR attestation must be submitted on the HPMS website.

- The total of all DIR collected by the plan during the year is subtracted from the plan’s Part D spend for the year when CMS performs the annual Payment Reconciliation.

- In an audit, PACE is expected to be able to tie each NDC on the annual Detailed Rebate Summary to the specific participant Rx’s filled for the NDC.

- This can be extremely difficult and rebates are subtracted from Part D drug spend. Therefore many plans have already chosen, or are choosing now, not to accept rebates in order to reduce their liability.
The following data and report files from your GENTRAN mailbox are uploaded to PDAC monthly.

- PDE response files
- RAPS
- HCCMODDD (formerly MOR)
- PTDMODDD
- MONMENMD (formerly MMR)
- MAO-004 (encounter data file)
16. PACE Data Analysis Center (PDAC)

How does this tie in to what we do?*

• NPA
  o Benchmarking
  o Analysis
  o Trends
  o Emerging issues
  o Plan participation

• Actuary
  o Bid development
17. Acumen Reports and Responses

➤ CMS subcontracts with Acumen to perform patient safety data monitoring
  • Acetaminophen and narcotics over-utilization
  • Short cycle fills and possible duplicate prescriptions.

➤ Reviews PDE errors

➤ You will receive quarterly “Immediately Actionable” notifications from Acumen.
17. Acumen Reports and Responses (cont.)

- The information you need to respond to the reports comes from your e-prescribing system and clinical notes in the participant’s medical record.

- Responses are made on the Patient Safety Analysis Website.

- At least one user from each contract must have access to Summary and Confidential Beneficiary Reports to view and respond to beneficiary-level overutilization issues.
Handling Acumen emails, support system, monitoring processes

- Acumen sends out e-mail notification to all “Authorized PDE Website Users” addressing data quality issues in accepted PDEs

- Reports:
  - PDE Analysis_ PDE Issues Report
  - PDE Analysis Process_Reconciliation
  - PDE Analysis_PDE Response Form

- If using a PBM or TPA, reports are sent for further investigation on PDE reported issues. Once data is identified, PDE reports are resubmitted and a PDE response form can be uploaded to the Acumen website prior to the deadline.

- Check periodically to make sure all tickets have been resolved through Acumen.
18. Compliance Calendar

- When it comes to Health Plan Management there are numerous requirements, monitoring goals, CMS processes and regulations.

- Developing a master Compliance Calendar detailing all processes and deadlines is one way to manage the required compliance activities.
18. Compliance Calendar (continued)

The general fields of the compliance calendar are:

- **Category** – easy way to sort by type of compliance activity (PTD, MD, CMS...)
- **Compliance Item** – What is the task or item that needs attention?
- **Frequency** – How often is this reviewed: monthly, annually, weekly?
- **Compliance Description** – a short sentence about what the activity is. Enough information that anyone will understand the task.
18. Compliance Calendar (continued)

Compliance calendar fields (continued):

- **Who?** – person responsible for compliance item or process
- **Month** – date when compliance item or process is due

This report can be sorted by any given month for a full picture of any items that need to be addressed and when they are due.
## Sample from Calendar

<table>
<thead>
<tr>
<th>Category</th>
<th>COMPLIANCE ITEM / PROCESS</th>
<th>FREQUENCY</th>
<th>SHORT DESCRIPTION</th>
<th>WHO?</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS</td>
<td>CMS- Annual Fiscal Soundness Reporting - FY 2016</td>
<td>A</td>
<td>(could be quarterly depending on CMS advice) Fiscal</td>
<td>CMS</td>
<td></td>
</tr>
<tr>
<td>CMS</td>
<td>CMS - Annual Fiscal Soundness Reporting - FY 2017</td>
<td>A</td>
<td>(could be quarterly depending on CMS advice) Fiscal</td>
<td>CMS</td>
<td></td>
</tr>
<tr>
<td>CMS</td>
<td>CMS - 60 day notice/review Medicare Eligibility</td>
<td>M</td>
<td>for 60 day letter to PPT</td>
<td>CMS</td>
<td></td>
</tr>
<tr>
<td>CMS</td>
<td>CMS - ANNUAL RATE ANNOUNCEMENT</td>
<td>A</td>
<td>for all MEDICARE PPTS for</td>
<td>CMS</td>
<td></td>
</tr>
<tr>
<td>CMS</td>
<td>CMS - BATCH FILE RETURN REVIEW (ALL ACCEPTED?)</td>
<td>M</td>
<td>and disenrollment process. Just define any issues when</td>
<td>CMS</td>
<td></td>
</tr>
<tr>
<td>CMS</td>
<td>CMS - CERTIFICATION OF MONTHLY ENROLLMENT AND PAYMENT DATA (ATTESTATION)</td>
<td>M</td>
<td>Spreadsheet reconciliation of Payment/Participants &amp; Attestation (Use Schedule</td>
<td>CMS</td>
<td></td>
</tr>
<tr>
<td>CMS</td>
<td>CMS - COB certification letters</td>
<td>A</td>
<td>participants, To validate the</td>
<td>CMS</td>
<td></td>
</tr>
<tr>
<td>CMS</td>
<td>CMS - Daily Transaction reply report review</td>
<td>D</td>
<td>on Daily TRR (if adjustments are needed should end up on the</td>
<td>CMS</td>
<td></td>
</tr>
<tr>
<td>CMS</td>
<td>CMS - ECRS review_COB review</td>
<td>M</td>
<td>MSP participants to see if COB</td>
<td>CMS</td>
<td></td>
</tr>
<tr>
<td>CMS</td>
<td>CMS - ENROLLMENT/DISENROLLMENT FILE SUBMISSION (ALL ACCEPTED?)</td>
<td>M</td>
<td>Enrollments/Disenrollments to</td>
<td>CMS</td>
<td></td>
</tr>
<tr>
<td>CMS</td>
<td>CMS - MARx UI (enroll/disenroll)</td>
<td>M</td>
<td>Enrollments/Disenrollments to</td>
<td>CMS</td>
<td></td>
</tr>
</tbody>
</table>
Using a Calendar to monitor key compliance tasks puts all of the required activity in one place for everyone to review.

<table>
<thead>
<tr>
<th>Category</th>
<th>COMPLIANCE ITEM / PROCESS</th>
<th>FREQUENCY</th>
<th>SHORT DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS</td>
<td>HPMS - CONTACT ADMINISTRATION</td>
<td>M</td>
<td>In HPMS System - verify all CMS requested contact information is accurate &amp; up to date</td>
</tr>
<tr>
<td>CMS</td>
<td>HPMS - MEMO REVIEW/DISTRIBUTION</td>
<td>W</td>
<td>Review all new HPMS memos for implication/distribution</td>
</tr>
<tr>
<td>ENCT</td>
<td>ENCOUNTERT - Monthly Submission of CMS encounter data</td>
<td>M</td>
<td>Monthly submission of CMS Encounter data</td>
</tr>
<tr>
<td>IAM</td>
<td>AUDIT - Claims payment batch</td>
<td>M</td>
<td>Monthly audit to ensure claims are being paid to contract (sample IP, OP &amp; Phys)</td>
</tr>
<tr>
<td>IAM</td>
<td>AUDIT - ENROLLMENT FILE REVIEW update spreadsheet</td>
<td>M</td>
<td>Audit to ensure all enrollments/disenrollments were accepted and on a TRR or Batch Comp. Summary.</td>
</tr>
<tr>
<td>IAM</td>
<td>AUDIT - FDR (First Tier Downstream related entities) (split up into separate reports)</td>
<td>M</td>
<td>Audit - 3rd party vendors for accuracy and completeness and eligibility</td>
</tr>
<tr>
<td>IAM</td>
<td>AUDIT - MMR (followup with Reed/CMS processed?)</td>
<td>M</td>
<td>Verify all items outstanding are followed up with Reed/CMS regional office, EDV</td>
</tr>
<tr>
<td>IAM</td>
<td>AUDIT - P2P update spreadsheet</td>
<td>M</td>
<td>Audit, updated with latest monthly advise including who and when P2P payment was issued, keep accumulated CY spreadsheet for annual P2P recon process with CMS</td>
</tr>
<tr>
<td>IAM</td>
<td>AUDIT - PDE FILES PREPERATION/GENERATION/REVIEW</td>
<td>M</td>
<td>Internal audit preparation/administration to ensure Part D/PDE compliance</td>
</tr>
<tr>
<td>IAM</td>
<td>AUDIT - RAPS FILE LEVEL REVIEW</td>
<td>M</td>
<td>Internal audit preparation/administration to ensure Risk Adjustment compliance</td>
</tr>
<tr>
<td>IAM</td>
<td>AUDIT - TrOOP update spreadsheet</td>
<td>M</td>
<td>Audit, updated with latest monthly advise including who and when TrOOP letter was issued, keep accumulated CY spreadsheet</td>
</tr>
</tbody>
</table>

**Due/Status**: 10/2016
Regardless of what format you use, development of a compliance process to ensure timely and accurate response to required CMS processes is a great compliance tool.

This can be personalized to the job or created as a whole.

Completing the Risk Assessment for FWA will assist you in developing your worksheet.
QUESTIONS
Dec. 1, 2016, 3:00PM eastern time

NPA Health Plan Management Call – Representatives from CMS and Relay Health will be on the call to discuss Coordination of Benefits (COB) and Medicare as Secondary Payer (MSP.) Visit http://www.npaonline.org/ to get dial in information.

The NPA will soon make available the CMS 2017 Readiness Check List, with areas relevant to PACE highlighted for your review. Ensuring that your plan meets the readiness requirements will contribute to your success with the 1/3 Financial Audits.
References

CMS Internet-Only Manuals
PACE
PART D

CMS Plan Communications User Guide

NPA Member Resources for 1/3 Financial Audit (you must first log in to the NPA website)
http://www.npaonline.org/member-resources/payment/resources-13-financial-audit#sthash.6W34sFLf.dpuf (Home > Member Resources > Payment > 1/3 Financial Audit Resources)

2016 Compliance Calendar

Patient Safety Analysis Website

TrOOP Calculator
https://www.cms.gov/apps/troopcalculator/
Contact Information

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