Medication Therapy Management (MTM) Panel

Emily Greenspon, Division of Analysis, Policy and Strategy, MOEG, CMS
Theodore S. Regalia, Director of Pharmacy, Ministry Health Plan
Crystal C. Chang, Director of Clinical Pharmacy Services, SCAN Health Plan
Kempton Presley, Business Information Solutions & Client Performance, (Representing SCAN Health Plan)

Stacey Plizga: Welcome back, everyone, and thank you for being on time. If you are joining for the first time from the webcast today, we have a full afternoon planned for you that includes polling and session evaluations. If you are on the webcast and you are using – we suggest you use an Ethernet connection instead of WiFi, and also, we suggest using Google Chrome instead of Internet Explorer. It may increase your streaming speed, and prevent delays.

We are also featuring polling during our event today, thus if you have not reviewed the polling instructions, please go to the CTEO website and look at the participant instructions, and the instructions will be there, on how to join polling. Also note that if you have questions for the presenters, that you can submit your questions at any time, following the Ask CMS Live Survey Monkey link that is posted on the website.

All right. Our next session includes an MTM panel, that will share what they have learned from the Pilot Audit experiences, including any operational or oversight changes or enhancements they recommend. Here to introduce our panel and facilitate the discussion from the Division of Analysis, Policy, and Strategy, I'd like to introduce Emily Greenspon.

Emily Greenspon: Thank you for the introduction. Good afternoon, everyone. I would now like to introduce the speakers of the MTM panel, who will share about their organization's experience and lessons learned from the 2016 MTM Program Pilot Audit. So please welcome, from Ministry Health Plan, Theodore Regalia, Director of Pharmacy with Ministry Health. And from SCAN Health Plan, we have Crystal Chang, Manager of Clinical Pharmacy Services with SCAN Health. As well as Kempton Presley, Vice President of Business Information Solutions and Client Performance with PharmMD, representing SCAN Health. Now, one further note is to please hold questions until the end. Thank you.

Theodore Regalia: Good afternoon. My name is Ted Regalia, and I'm the Pharmacy Director at Ministry Health, also known as Network Health Plan. And we're an MAPD plan in Wisconsin, go Badgers! And we have several different plans that we serve, including a special needs plan. Altogether, we have about 60,000 lives. So I have a short slide deck to keep me on track, and let's get started with a polling question.

The images aren't very large, but which of these cats is my cat, Bob? No one's going with the cute little kitten, huh? Well, the majority of you have it correct. That is Bob in the second picture. Yes, that is a pharmacy jacket. It's hard to see with the small picture, and yes, it took lots of catnip to get him in a pharmacy jacket and pose for a picture, but Bob managed quite well. So I was kind of curious on the different models that are being used for MTM, if this slide will advance. There we go.

So there's four different models I have listed here. Do you fully delegate the MTM function to your PBM or a vendor? Do you directly contract with the vendor? Do you do it in-house with your own staff, or do you do some kind of hybrid model of the aforementioned? So it looks like the majority of you are using a direct contract with an MTM vendor. This will come in pertinent towards a later part of my presentation.

So, we underwent an MTM pilot audit in the summer of 2016, and it was based on 2015 data, and at that time, we had completely delegated the MTM function to our PBM. So, in July of 2016, about three weeks before the actual audit, we submitted the universes, and there were four universes that we submitted, and that covered the enrollment into the MTM program, the disenrollment, the actual CMR, and the TMR and how it related to the CMR.

So this audit was performed remotely. We had screen sharing, telephonic, and it took place over the course of three days, at least the field audit portion did. And so we asked our PBM to be present during the entire audit session, and have their subject matter experts, or SMEs, available. And I want to emphasize how important this is, since the majority of you were using a vendor. You're going to need to have your vendor and their subject matter experts available during the MTM audits, because they're going to need to navigate through the screens, the platform software, and they're going to need to be able to assist in answering questions. So that's a very important takeaway.

So the other thing that we didn't plan on was assistance from our enrollment department, and our customer service, or call center department. I wish I would have anticipated that, but I didn't, and so that would be another takeaway, is that other areas within your organization may need to be part of this MTM, especially when it comes to enrollment.

So during the audit, we were asked to provide two impact analyses, and one was to gather more additional information to assess our targeting method for CMR qualification. There were some concerns about under-qualifying. And the second impact analysis was additional information to assess the frequency of not offering the CMR within 60 days of qualification or enrollment in the program.

So once the MTM pilot audit was completed, we had one observation, which resulted in one cap, and the finding was, the sponsor failed to offer comprehensive medication review to newly-targeted beneficiaries within 60 days of qualification or enrollment. So when we tried to understand what or why, we found two root causes: One of them was we had an inadequate process to update our PBM with the change in patient address or phone number. And the second cause was when our PBM was unable to reach out to our members, we weren't assisting them with additional information we may have, like a secondary number. So those were the two root causes, and we employed caps, and I think we're succeeding quite well, as a result.

So another takeaway would be, is if you're using a vendor, make sure you have a process in place to be notified of the inability to reach a member by them, so that you as a plan or sponsor can follow up, and assist in obtaining or getting the information to perform the CMR.

So now, let's go over some of the content from the audit, and I titled this Discussions. It's really not for me to give you answers. These are some of the focus areas that came up by the auditors. And please note, this was a pilot audit, and so there were a lot of questions from the CMS auditors, as they were trying to better understand some of the different MTM models or processes that are out there. And some of the questions were very surprising, but interesting nonetheless. And I'd also like to note, I'd only been with Ministry for about a month when this happened. Perhaps that contributed to the surprise.

So for the first bullet point, I listed the 90 day prescription. So we have a very large number of our maintenance or chronic medications filled as a 90 day supply, rather than a 30 day supply. So when you have a 90 day supply, does that count as one or three targeted hits, as you count your

Part D Rx claims? And we were counting it as one, and in our look-back period. And we believe that by using that methodology, we underqualified our members. So there was a lot of discussion in trying to assess the impact of a 90 day versus counting as one or three fills.

The other bullet point had to do with the long-term care. And for long-term care, that can be assisted living or skilled nursing facility. And in our case, our assisted living members actually are on more meds, and in Wisconsin, chart review, routine chart review is not required for assisted living, only for SNF. And does the member manage their own meds if they're in assisted living facility? Should you perform the MTM CMR at the facility? Do you work with the floor nurse at a skilled nursing facility? Which we found very helpful, by the way. Should you ask the member if they appear cognitively impaired, can you work the PCP? Talk to the member or the caregiver? So you can actually still perform the MTM CMR with the physician.

And as far as the SNF goes, we were very close to contracting directly with Omnicare. Last year, we saw a rapid increase in the number of CMRs needed to get a four-star, and so, in our panic, we were pretty close to contracting directly with Omnicare, which they would have done the MTM for us, in the long-term care facility. We didn't have to, but we were pretty close.

The next bullet point has to do with the assessment of chronic disease, and this generated a lot of discussion. So if you're on a drug like spironolactone, does that qualify you for heart failure? It's not something you would use for a swollen ankle, necessarily. So is that, by definition, chronic? Do you need two dispensing, or is one dispensing enough to define chronic? Another example would be a basal insulin. And with a basal insulin, it usually denotes some kind of chronic condition, such as diabetes, and does a single dispensing qualify you automatically? So as

we look at how to best administer an MTM program, some of these questions are very interesting.

So one of the takeaways I wanted to share was, look at your MTM program, and look who is qualifying, or more importantly, who is not qualifying. And have your pharmacist or clinician say “Geez, why isn’t this person qualifying? They really should be.” And rather than just focusing on the numbers that were submitted to Medicare, look at how you can improve the value, to try to qualify those who really should qualify, and that will improve your program.

Time might be tight, so I’ll come back to this slide if necessary. So I’d like to move on to what surprises I encountered. What surprised me? And again, please note, I’d only been in the position for the month. And the first bullet point, I was surprised our 120-day lookback period was possibly inadequate. And the reason I say that was, the 90-day dispensing percentages that we had, we were not qualifying enough of our members, in my opinion. And keep in mind, this was a rolling 120 day. This isn’t just first quarter calendar year. This was a rolling 120 day. So we ended up expanding that, and I’ll talk about that later.

The next bullet point, I was very surprised that the auditors were requesting the actual recorded calls that took place. And they wanted to see the letters that were returned. They wanted them scanned in for digital archiving. And I’m not saying that that’s going to be required, but this is what they were asking for.

The third bullet point, I was surprised how few referrals were coming back to us for a follow up. It’s not one and done. There is oftentimes need for some clinical review or follow up, and perhaps that has more to do with my situation, but it was something that was important.

And the fourth one, we didn't have much oversight in place. We would track the number of CMRs and TMRs, but we really didn't do much auditing, and we didn't critically assess the value. It was more of an administrative task, rather than an opportunity for value.

So, what did we do about it? Well, we changed our lookback period to 150 days, and we believe this will increase the number of CMR qualifications by 40%. That's an estimate. It's too soon to tell, but we believe it will increase about 40%, and it will get us in line with what I understand to be the national averages.

We also worked with our PBM to get a biweekly report, letting us know of the inability to reach out to our members for the MTM program. So this report will let us know if there was an incorrect address or phone number, so that we can follow up on our end. We also created several internal audits, to oversee the MTM program more closely, make sure that it is bringing quality and value to our members. And the biggest change we made is, we decided to go with a hybrid model, where our pharmacist will actually perform the CMRs in-house, in addition to what our PBM is doing. And this was kind of cool, because we were able to take our medical data, ER visits, hospitalizations. We were able to take our quality data, and we, for five-star, and we were able to work and identify the members who were probably the most needy, the risk stratification. And so bringing that in-house has been quite a success so far. It may be a little too early to tell, but we're enjoying the success so far.

We also made a big point of working with our members directly on the pharmaco-economic component. Can you afford this? Talk about alternatives that they could discuss with their doctor, or we could discuss. So we've taken an opportunity there. We do record all of our calls, so if we're audited again, and they ask us, we'll have our recorded calls. And the opportunity to perform the MTM program in a skilled nursing facility, or

in the primary care physician's office has been interesting, as well. It's too early to tell, but we find that there's going to be a lot of value with coordination of care in the skilled nursing facility. The floor manager nurse really enjoys, she learns just as much – he or she, learns just as much from this process.

I think that's it. You're up, Crystal.

Crystal Chang: Okay, thanks, Ted. So, hi, everyone. My name is Crystal Chang. I'm the Director of Clinical Pharmacy Services at SCAN Health Plan.

Kempton Presley: Hi, I'm Kempton Presley. I'm Vice President of Business Information Solutions and Client Performance with PharmMD.

Crystal Chang: And today, we're happy to share with you our pilot audit experience for MTM, and much of what we, what Ted has said, we actually share a lot of the same themes, which hopefully you'll find as we go through our presentation.

So before we dive in, a little bit about SCAN Health Plan. We're a Medicare Advantage prescription drug plan, with also special needs plans, as well. Those being institutional, dual-eligible, and chronic care for cardiovascular disease and diabetes. We have a total of 186,000 Medicare members, 15% of which are in special needs plans. Our market presence is in California, and we operate a delegated provider network model, with over 60 affiliations with medical groups. We've been around for 40 years, and in keeping our mission of keeping seniors healthy and independent. And for 2017, we're a four-star plan.

Kempton Presley: PharmMD has been around for roughly a decade, and we've been providing medical – medication therapy management services through

technologies, as well as clinical activities, and we do that for SCAN in partnership.

Crystal Chang: So to give you a sense of how we operate our MTM program, SCAN sends to PharmMD raw data files, and that includes our Rx claims, medical claims, and counter data. Everything that we have, we send over to PharmMD. We give them our MTM criteria. They use that data, apply it towards our criteria to identify our members every quarter.

Kempton Presley: And we work with SCAN very closely, to ensure that our targeting is aligned with their expectations, based on the clinical efficacy standpoint, as well as understanding the volume. From there, we do kind of a multi-modal approach, where we work to issue, offer information through telephonic means, as well as through the mail. Following that, we'll set up appointments through comprehensive medication reviews that are telephonic, and our internal pharmacists use our clinical decision support system, as well as our documentation system to capture all of the different elements of that review.

Crystal Chang: And we have a mechanism built in place with PharmMD, to where, if they find any potential members requiring case management, we have a way for them to refer those members to SCAN case management. And every month, PharmMD provides to us oversight reports, to ensure we meet quality and compliance requirements on a year-round basis. So before we get started with sharing our pilot experience, a few polling questions. Unfortunately, it's not as fun as Ted's. It's straight to business.
So first question is, what data sources are used to identify chronic conditions for potential MTM-eligible members? What data sources do you use?

Kempton Presley: Option A is medical claims only. Option B, Rx-inferred diagnoses only. C, combination medical and pharmacy claims. D, HCC risk scores. Or E, some other means of identification?

Crystal Chang: So either only one person is voting, okay, there we go. So far, it looks like the majority is both medical and Rx claims.

Kempton Presley: And what we have found is that can happen across the gamut. The majority of the plans that we work with have, go with one or the other. Medical, or the pharmacy lens directly. But we've found that in our discussions with CMS, that there are definite benefits to both sides that can be argued either way.

Crystal Chang: Okay, next question. What is the percentage of member-requested opt-outs in your MTM program? And this would be just those opt-outs that the member has requested to, where the reason is member requested, and not death or disenrollment.

Kempton Presley: Option A, 0% to 1%. B, 2% to 5%. C, 6% to 10%. D, 11% to 15%. E, greater than 15%. And then F, not sure.

Crystal Chang: And it looks like a majority are not sure, but also second majority being greater than 15%, so that's interesting to know. Next slide? Okay. Final question. How do you engage LTC members in your MTM program?

Kempton Presley: A, contract with LTC facilities/pharmacies. B, leverage CMS's LTC institutionalized reports. C, use internal eligibility files. D, all of the above. And E, none of the above. A lot of suspense here.

Crystal Chang: Looks like the majority are all of the above or none of the above. I think it has to be one or the other. So I think from, based off of the movement of the poll question, this probably is a challenge for most MTM programs,

figuring out what is the best way to engage the LTC members. Okay. So thank you for submitting your answers.

This is a general timeline of our audit experience. So it started when CMS sent, released the MTM audit protocol back in March. And three months after that, SCAN got the audit engagement letter, and we found out that we were the first plan sponsor to be audited by CMS for the MTM pilot, so that was fun. It was truly a learning experience for both SCAN and CMS, as a result, being first-timers for this.

After the audit engagement letter, we had 15 business days to submit our audit universe, and following that, we had 15 business days to prepare before CMS gave us our sample case selections. After the – after we got our sample case selections, we had two business days to provide all the documentation needed to support the sample cases, and then we were into the live audit. After the live audit, we had our exit conference, in which CMS shared with us preliminary findings, and we immediately began to plan for potential remediation efforts for the next four months, until the findings were semi-solidified, and the draft audit report release in November.

Once it was released, we solidified our remediation plan, and CMS released the final audit report the following month, in December. By the end of January, we submitted a corrective action plan, and began to execute our remediation efforts. And the validation occurs about 150 calendar days after that, and right now, we are actually in the middle of our validation audit. It's scheduled for May/June. And just something to note, because we were a pilot audit, we are not subject to actually submitting the corrective action plans, or going through with a validation audit, but we did – SCAN did proceed with doing so, as if it were, you know, as if it counted.

So that gives you a general sense of the audit timeline, and what we'll do is go over the key stages of each of the audit experience, share with you what challenges we felt were the top challenges, and how we met those challenges, or tips on how you can meet it.

So the first key stage was the audit universe, and the biggest challenge being that we had a very short turnaround time, to provide the audit universe with new data elements that were not coded or necessarily captured, as a requirement in previous years. So one way that helped us was having frequent and open lines of communication with CMS and PharmMD. So we worked with CMS on clarifying definitions that were new for us, behind the new data elements, then worked with PharmMD to capture that information, and then communicated back to CMS whether those elements made sense to us or was possible or impossible to retrieve.

Once we clarified with CMS the meanings behind the data elements, we relied on PharmMD to provide all of the data necessary to pull for the audit universe. And in order for PharmMD to do this, successfully do this, their entire organization was all hands on deck, to support us through the audit, and that went from the executive team down to the clinical leadership and data analytics team.

And finally, without having a year-round audit readiness approach, neither PharmMD nor SCAN could have supplied this information in the time needed. And I mentioned that the audit protocol was released back in March, so as soon as that was released, we didn't yet know if we were going to – when we were going to be audited, but we did begin working with PharmMD on working on that audit universe that would be new for us.

So diving into kind of the solutions of how we met the challenges. I mentioned that communication was key. So SCAN met with PharmMD on a daily basis, in this preparation of the audit universe. And as a result, any clarifying issues that were identified, we had the opportunity to identify it timely, and communicate that back to CMS, and CMS was very receptive and responsive to us, and provided prompt answers, that allowed us to work with PharmMD and make adjustments as needed.

Kempton Presley: And so from our standpoint, as SCAN's partner, we had to use very much a hub and spoke type of approach, where the information about the audit was disseminated throughout our organization. A core audit team was assembled, consisting of multidisciplinary perspectives. That core audit team was very much on call throughout the preparation of the audit, and during the live audit itself. But we had to have various parts of the organization, both from a clinical, data, fulfillment, call center, and software IT standpoint, to be ready, as different types of information was needed, in terms of primary source verification, as well as the different clues that support the entire program experience.

Crystal Chang: So while it was a challenge, providing new data elements quickly for the audit universe, it definitely helped that we had a very close working relationship with PharmMD, and we had a tight oversight process all throughout the year. And so this is kind of what that oversight process looks like. Throughout the year, the SCAN team responsible for overseeing MTM includes a clinical pharmacist, programs coordinator, data warehouse specialist, and programmer analyst. This team meets with PharmMD every other week, to perform quality and compliance oversight.

PharmMD in turn, they send to us a daily feed of CMR letters generated, call recordings on a quarterly basis, and monthly reporting. This monthly report mirrors that of the annual report that we submit to CMS each year,

and this allows for PharmMD to be ready to provide this report as accurate as possible, because they're having to pull this report every month, as it is. It also provides us the information we need, to ensure we're hitting all the CMS requirements. For example, that the letters are being sent within 14 days, the offer rate, things like that.

The CMR PDFs, those PDFs allow us to validate that CMR's reports are actually accurate. So if we see a CMR counted on the report, we have a letter to back it up. And the call recordings that we receive every quarter, we listen to those to ensure that the calls are of quality, and match with what we report.

So that next stage is preparing for the audit. Once we've submitted the audit universe, now we're in this limbo phase of waiting for CMS to give us the sample case selections. So we were in this limbo phase for 17 business days. We did our best to prepare for the audit in this time. Until they provided us with the sample case selections, and then we had two business days to provide all the documentation needed, to support the 50 sample cases that were selected, until the live audit.

So some challenges in the phase of preparing for the live audit. First, we knew that we needed to be able to seamlessly navigate through the documents and live systems, and in order to do this well, in time for the audit, we had to practice. And without the actual sample cases, we picked our own random sample cases from the audit universe we selected to practice, and prepare the case. So taking the right – the appropriate screen shots, pulling the right letters, and then designating someone on the team to navigate through the systems, to be able to move through our MTM eligibility platform, our Rx claims adjudication system, our eligibility platform. To be able to move through those systems with ease, so that on the day of the audit, they were very familiar with moving through different

systems, and knowing which samples to go through. We also enlisted the help of our compliance department, to practice with mock audit sessions.

When we were pulling data for supporting the case samples, we found that there was a heavy reliance on producing data to support what we pulled. And so, one example was, we needed to pull medical claims and Rx claims data to show that we appropriately identified members into the MTM program. And so, have a data analyst ready to be able to do that for you. And then keep in mind that expertise from people outside of your department may be needed to help you, and I mentioned, we worked with compliance on performing the mock audit sessions. We also enlisted the help of IT for some data support and access to certain data.

And finally, we had a short turnaround to provide the documents needed for the sample selection. I mentioned we had two business days to prepare all the documents for 50 sample cases. We actually originally were only given one business day to do that, and we worked with PharmMD, we had open lines of communication with both PharmMD and CMS to – for PharmMD to advise us that, hey, we need more time than that, we have certain things archived, that's going to require time to retrieve. And we relayed that back to CMS, and they were receptive to our feedback, and they gave us an extra business day, so that was helpful. We also used non-business days to prepare as well.

Kempton Presley: Yeah, but with so many samples, it still required everybody to be engaged and going in the same direction. That's why, when you find out about that notification, getting executive endorsement of what's about to happen, so that every department is engaged and ready to go, is critical. Because you never know what piece of the sample may require a different element of insight.

Crystal Chang: So now we're in the stage of the live audit. Once we were done preparing, and we have the sample cases, and we've prepared the sample case, now it's time for the live webinar. It was conducted over Webinar, and we allocated four days to complete it, but we were fortunate enough to complete it in three days.

And so here are some of the challenges during the live audit, and what we did to meet those challenges. During the live audit, there may be a potential reliance on other departments that you may not have anticipated. So very much, like what Ted had mentioned, we had to call upon the assistance of our risk adjustment team to pull encounter data. We didn't think that we would need to pull encounter data, but you never know how the audit is going to go, what questions are going to come up. So it's helpful, as an organization, to have all departments have the expectation to be ready, to support any audit with short notice.

Also, to ensure that we provided accurate responses to CMS, we had to effectively coordinate with PharmMD, our partner in this, on our response. PharmMD is not based where we are based, so we knew we would not be in the same room with PharmMD, and to ensure that we could coordinate, we had a separate line with PharmMD, so that we could discuss our answers, before we gave CMS our response. And CMS was very good about allowing us time, sufficient time, to investigate each case, before we gave our final answer.

And finally, it's a challenge in itself to simply produce all of the deliverables in real time, to walk through each of the cases. And some of the things that we did was basically having PharmMD, having the all hands on deck approach. Like Ted mentioned, sometimes CMS will request to hear a call, or see a particular letter, and so as much as you can prepare for the audit, there is going to be a level of providing

materials that you can't necessarily prepare up front, and so having an all hands on deck is important.

Kempton Presley: Yeah, and just from our perspective, we had the equivalent of a war room set up, with a direct channel to SCAN, as Crystal mentioned. And we had, at any given time, we may have the data analyst running queries to try to understand details about a question that was asked. We may have our clinician reviewing policy. We may have our account executive working with the call center to start queueing up calls that were in archives. And we constantly sought to get information, either, whether we were going to provide the direct answer, or whether we were going to try to work with SCAN to manage expectations about the timeliness of turnarounds. So can't emphasize enough the criticality of everybody being in lockstep during that time.

Crystal Chang: And then finally, in the moment, as we're going through each of the cases, having that designated person to go through each of the case samples and knowing, and having the familiarity in moving through the different systems helped. So this diagram shows you, just visually, how our teams worked together on the SCAN side, and on the PharmMD side, each of us had a point person that was a lead responder to CMS.

And these two point people, they worked together to coordinate what to do. There was a team that supported that point person, so if anything, if any other department needed to be outreached to, then that team would do it, so the lead responder wouldn't be tasked to kind of do ten things at once. And so this diagram depicts two teams, with the lead responder and their kind of supporting casts, in real time discussion on one line, and then in a coordinated fashion, providing a single response that was the most accurate response we could provide to CMS.

Okay, so this is the last poll question. What areas do you foresee to be the biggest challenge in time of an audit?

Kempton Presley: A, clinical team bandwidth. B, access to primary source data. C, data analytics. D, visibility/coordination with other departments. E, other. And then F, I'm perfect, please audit me. I would just go ahead and let everybody know that we didn't choose F. What we would have chosen would be B and C.

What we found throughout the entire process is the whole concept of a universe, and going beyond the qualified population from an MTM perspective. Not only were you trying to understand and isolate whether the people you identified were the right people, but you had to look at everybody that you didn't identify, and understand why they may or may not have been at risk. So to us, in working with SCAN, so much of this experience was about opening up the channels of data and information, and our systems.

Because we had such, we thought we had been so smart in hard-coding a lot of our workflows to correspond exactly with the elements required in the HPMS file. Well, when you're going to different derivatives of those elements, and you're looking in the dreaded detail, you've got to move away from that rigidity, so that you can show primary source verification for what went on in the offer attempt. Why did the TMR DTP have this particular situation? Getting into that level of detail required a level of data access and segmentation that was good for us as a company, good for our partnership, but it was new.

Crystal Chang: And I would like to speak to the person that says I'm perfect, please audit me. I'm interested in your program. Okay, and so here are our lessons learned. I think you know, being part of the pilot audit, it was a great opportunity to step back and evaluate our MTM program with a

microscopic lens. And I think a couple of our lessons learned actually mirror that of what Ted had learned as well, through his experience. The first one being leveraging Rx Inferred Diagnosis. For SCAN, we actually used ICD codes to identify our chronic conditions, and while we felt that that was a gold standard, the result of the audit would show that there might be missing potential opportunities of identifying eligible members. And so, we are actually moving from using medical claims to only using Rx inferred diagnoses. But I guess, it sounds like there are limitations to both methods. There's no perfect method, I think.

And then the second one being that, developing a feedback loop with PharmMD to obtain updated member contact information. So what we found was that while PharmMD was doing the outreach, we weren't getting the – there was not necessarily a process to know who was – which members we did not have the correct contact information for. So as a result of the audit, we developed this feedback loop. They now send to us members in which they can't contact, and we have developed a more robust approach to get that member contact information.

And then having gone through the audit, it was also clear to us that our well-established working relationship with PharmMD definitely facilitated easy audit coordination and preparation. Not only was it important for us to have a strong relationship with PharmMD, but it's also important for all departments in the company to be available and ready, should their assistance be needed.

Kempton Presley: And for us, as I mentioned, it was going beyond the mirror lens of the MTM-qualified population, and all of the different activities that are reported annually for MTM programs, and actually going to the depths of what types risk exist in the population beyond the MTM qualification cohort? What different ways that engagement can be measured and monitored? The ways that you can track opt-outs beyond just the fact that

someone wants to be out of the program, or that there's death and disenrollment. So there is a lot of different things that pushed us to work with SCAN to build a more comprehensive picture of the populations impacted by MTM.

Crystal Chang: So that concludes our audit experience. We hope you found it helpful.

Kempton Presley: Thank you.

Emily Greenspon: Well, thank you for the insightful information regarding the MTM pilot audit experience. Now, I was jotting down a few notes, and I have a few questions to ask the speakers from both organizations to answer, prior to opening up to the floor for questions.

And so, for the first one that I have, is, so prior to receiving the engagement letter, how did you prepare for the MTM audit? And from the pilot experience, would there be anything that you would do differently?

Kempton Presley: I would say that when we initially got the information about the pilot audit, we looked through all the fields, together with SCAN, and realized that there were certain elements that we just weren't going to be able to provide, because they didn't align with the way our program worked. What was relieving was the fact that, when we shared that information with CMS, along with our justification for not providing them, we felt like they worked well with us to figure out other ways to be able to report certain pieces of information. So my suggestion is don't give up, if you see elements that look like they're currently insurmountable or uncapturable with your current systems.

Emily Greenspon: And what about from Ministry?

Theodore Regalia: I'd like to opt out. In all fairness, I wasn't present during the entire process, so I truly am going to opt out.

Emily Greenspon: Okay, all right. So was there anything that you identified from the audit experience that you can recommend to your colleagues about administering the MTM program?

Theodore Regalia: Well, beyond what we kind of said during the presentation, a lot of our content was towards that, but in addition, just a reminder that, plan to be adherent and compliant with MTM from the get go, don't wait until you're notified of an audit. And make sure your process is all sound, and you have checks in place for audit, ensuring the compliance as well as quality of the program.

Crystal Chang: Yeah, and I think to follow up with what Ted said, pulling the audit universe in advance. So there's different levels of trying to prepare for the audit universe. I would just try to pull the audit universe as if you were being audited. Because until you are actually going through the process of trying to retrieve the data, certain questions may not come up until you do that. And so, working on preparing the audit universe. Another thing is, every step of the way, of the MTM process, to be able to capture it somewhere. Because in an audit, CMS will request to hear different phone calls, see different letters. And unless you are recording those calls, or storing those letters, it's really hard to produce the evidence behind it.

Kempton Presley: And I'd say, dovetailing off of that, looking from the outside to in, there are a lot of plans that have silos in their departments, and we've found that the SCAN pharmacy department is integrated throughout other parts of the organization in such a way that, when needed, the risk teams and the other medical teams were able to come together and understand the intent of the MTM program, so there was a shared response and shared

perspective on the ultimate goals there. And that seemed very helpful during the process.

Emily Greenspon: Okay, thank you. My next question is, what have you identified as the most effective approaches to offer and administer MTM services to beneficiaries in the long term care setting? Now, Crystal and Kempton, I know you had a polling question with respect to this topic, but can you share from SCAN and how you handle this?

Kempton Presley: Is that the polling question where none of the above and all of the above were the two answer?

Emily Greenspon: Yeah.

Kempton Presley: I think it was.

Crystal Chang: So, I think, conceptually, reaching out to members in LTC is a challenge, and there are different ways to contact these members. I would say that, as we looked at our LTC offer rate, and CMR completion rate, and it actually is pretty high, we're reaching out to most of our members. But I will say that the process of doing so is not automated. So for us to get those rates, we utilize the LTC institutionalized reports, and PharmMD has to do a manual workaround outside of their systems, to do a hard push for these members.

Kempton Presley: Yes, so our performance has been good in terms of parity, where these members are receiving the same level of access as non-LTC members. But as Crystal mentioned, with the good performance and with parity, there's also – can be efficiency challenges, based on data and the workarounds that you have to do to engage people in the facilities, and their proxies.

Emily Greenspon: Okay, thank you for the additional information, and it looks like we are just about out of time for this session. And so, is there an opportunity to open it up to the floor for questions, or will those have to wait to the end?

Stacey Plizga: Actually, we do have some time that we could take some questions from the floor.

Emily Greenspon: Okay.

Stacey Plizga: If there are any questions. No? Okay. Well, I guess we don't have any from the floor. So with that, then I would like to thank Crystal and Ted and Kempton, and Emily of course, for sharing lessons learned from the pilot audit experience. Thank you.

Okay, if you would like to evaluate session 3, go ahead and select A and click on the link that is sent to you. Here to provide us with an overview of the results of MOAG's 2016 program audits, including common conditions seen during 2016 audits, and the enforcement actions taken as a result of the non-compliance discoveries, from the Division of Analysis, Policy, and Strategy, help me welcome Greg McDonald.