



TRANSCRIPT

An Overview of PACE Part D Elements Matthew D. Febbo, R.Ph., CMS Region CMS Philadelphia Region III

Good afternoon, everyone. Now that everyone has some cookies and coffee, hopefully you'll be pepped up for this. I only have thirty minutes, so I'm going to go fairly quickly. I'm going to go over the PACE Part D elements. I realize at your technical advisory visit, they really don't give you much information on Part D elements. There's some confusion out there, so I want to go over just a general overview of each element. I'm going to go over some areas where I see plans having deficiencies and getting into trouble. Hopefully, it'll clear it up for your audit.

At the end, I'm going to go over some successful audit tips for you -- just general tips. And then I'm not going to answer questions because I only have thirty minutes; but I will be at reception, and you can talk to me in between. I'll be here tomorrow too. Okay?

Okay, ER 13, a lot of this is technical. So for the folks who don't really deal with Part D, just bear with me here; but ER 13, this is one element; a lot of the PACE organizations seem to be missing one particular part. There's three parts to this. This is for enrollment when you go to enroll a beneficiary, and they're already in an employer union group or have an RDS (Retirement Drug Subsidy). Very uncommon, but you still need to have a policy and procedure that deals with these folks. If you get a TRR rejection upon enrollment, within ten days you need to contact that beneficiary to make sure that they do intend to enroll in your plan. As you know, if you enroll them in a PACE plan, it will disenroll them from the RDS or employer group, which for some folks would be disastrous. So you need to make sure that that's what they intend to do.

The second part of this, you can contact the beneficiary. It must be within ten days of receiving that rejection. You could do it by phone or with a model letter. You do need to retain a copy that you contacted the beneficiary.

The third part is the part where I'm not really seeing in the policy and procedure, so I guess it's not clear. But when you attempt to contact that beneficiary, if they do intend to enroll in your plan -- which they probably do -- you need to resubmit that enrollment to CMS with the appropriate flag indicating that they do intend to enroll and be disenrolled from the RDS or employer plan.

Other part to this is if that beneficiary never contacts you --you don't hear anything from them -- after thirty days, you need to send them a letter saying that they are no longer going to be enrolled in the plan. Okay? That's important. So three parts to this element.

PRO2, use Social Security numbers on ID cards or HIG numbers. I have never seen this. This is very easy, self-explanatory. You can't use that on ID cards, okay? Or, you know, during your

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audit we're going to look at a sample of maybe thirty cards or ten or whatever, and we're going to document that.

CBO on collecting and updating enrollees on their health insurance -- again, really uncommon for a beneficiary. Most of these folks are dual eligibles, and they're not going to have an additional benefit of some sort. But some may have like a Veteran's benefit or some kind of -- another employer benefit. So when you enroll these folks in your plan, you need to make sure that you are finding out if they have any OHI that needs to be communicated to the coordination of benefits contractor. Very simple. I think most plans are using Medicare, secondary pay, or survey for this. It is a good idea. I've seen plans do this on a yearly basis just because three or four years have gone by. They may have received some sort of benefit. You do need to contact the coordination of benefits contractor to let them know. So if you want to do it on their anniversary or just do everyone once a year with a survey, either way. I think that's a good practice.

CBO3 -- TrOOP status at disenrollment. This element really has been tailored to PACE. You know, there's only one little piece this element versus other plans. It's kind of watered down and tailored to PACE. Again, most PACE beneficiaries or participants are dual eligibles. They will never have TrOOP. So really all you have to do -- there was a TrOOP addendum that came out. It was an HPMS memo. It's in the Chapters. It deals specifically with TrOOP and PACE. If you need a copy, let me know; I can send you the link. But really all you're going to do with these folks is if they disenroll from your plan, you can send them with an EOB of their gross drugs expenditure from your plan, which is really a tally of all the PDE (Prescription Drug Event) data. Most of you probably utilize a PBM. The PBM can do this for you, or you can do it. And you can give them EOB. They can take that to the new plan. If your PBM wants to do it electronically and submit that to the new plan, that's fine too. How many PACE organizations utilize a PBM? Okay, a good majority do, I believe.

All right. Okay, CP06. I'm going to spend a little extra time here. I'm sorry. I talk fast, so I have plenty of time. CP06, 07, and 08 kind of seem to be bundled together for audit purposes. However, out of the three, this is the one element I see a lot of plans are getting a "not met" or "met with note" It seems as though most PACE plans have the same policy; it's identical. I think it was acquired from NPA. I don't know, but I assume it's a lot of lawyer speak. It's bullet proof. It's beautiful. It's very extensive. It's thick. But I'm not sure the plans are following everything that they're attesting to doing in there.

The internal monitoring and auditing is a way of your plan to monitor yourselves -- to be prepared for audits, and to be prepared to meet all of the federal and state standards. It doesn't just deal with fraud, waste and abuse. Okay? Just remember that. So just to give you -- if you want to jot some stuff down -- again, I can talk to you about this afterwards. What they're looking for here is to ensure compliance of all applicable federal and state standards. That's huge. I mean that can deal with your drivers, your cooks, your nursing, their licensures, all the pharmacy standards -- State Board of Pharmacy standards. You want to have oversight of all your subcontractors and their downstream entities. You want to have auditing tools in place, a monitoring work plan, internal auditing. Okay? This doesn't mean that every month you have to

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have an internal audit. But I think once a year your compliance officer should be looking internally at your plan and making sure that everything is up-to-date, okay? That you have all these records compiled, and you're checking.

Most PACE plans are doing all this; but when it comes audit time, it's scattered everywhere. They have one binder of the driver records, one binder – I think it's important for auditing purposes that the compliance officer have some kind of spreadsheet or checklist; so that way when we're auditing, we can quickly find these things. Okay? So, again, a more robust internal monitoring program is definitely advised.

07 deals with corrective actions for offenses detected. I personally haven't seen any fraud, waste or abuse or offenses detected from any PACE plan; so I assume everyone's perfect on that. But if you do come across something, you need to have a corrective action plan in place and a policy and procedure for that.

In CP08 -- the last part -- fraud, waste and abuse is kind of a hot topic right now in Medicare. Again, this element is stuck with the Part D auditing. That doesn't mean that fraud, waste and abuse doesn't extend to your entire plan, your entire program. A lot of the PBMs will be doing the fraud, waste and abuse for Part D claims for you, which is fine. They're your subcontractor, your contractor. And they'll have their own policies, their reports; and all that is great. Just make sure also internally your employees know what fraud, waste and abuse is; they can cite an example. Who do they contact if they detect fraud, waste and abuse at your organization? Do you have the current medic information? Is it last contract medic? You know, this is important stuff. There should be some kind of refresher course for fraud, waste and abuse for your employees. It doesn't have to be super extensive -- you know, a once-a-year training slipped in with all their other trainings. Okay?

CL02 and CL03 -- these two elements are very technical. Again, the PBMs really deal with claims processing. I don't want to bore you with details. Just because a PBM -- just as a reminder -- is doing this for you doesn't mean you shouldn't have oversight of the PBM. You know, you should understand what they're doing for you, and you should make sure that their policy and procedures are updated and everything like that. So far I've seen the PBMs do an excellent job for the plans. I've had no issues at all. If you want more specific information on these two technical elements, again please see me. I can go over step by step if you're having trouble, if you're doing it on your own.

PA01 -- this element is important; and I see a lot of small errors that sometimes add up to a "not met" here. It's important because it deals with payment. It's certification of monthly enrollment and payment data relating to the CMS payment. Of course this is not as important as your clinical program. The clinical side is the most important thing, patient care. But again this is one element where minor dates, signatures, all that --there's no room for leniency here. This needs to be done right.

There's three parts to PA01. I'll go over it real quickly with you guys. The first part is on a monthly basis, you need to make sure that your plan is submitting enrollment, disenrollment and changed transactions to CMS, okay? Again, this shouldn't be a ton of changes in your plan.



Your participant population seems to be generally stable; however, this needs to be done as a requirement.

Within 45 days of the MMR (Monthly Marks Reports) being available, you're going to use your Marks calendar which is downloadable right in the Chapter. You need to have this handy. There are certain dates that need to match up. Within 45 days of the data being available, you need to reconcile any discrepancies to CMS. Real important. So if you see a discrepancy, you have a participant who's actually in your plan and it says that they were disenrolled, erroneous date of death, anything like that -- that needs to be reconciled within 45 days.

Third part of this element is you need to attest that you're doing this. Again, super important. That's why you're attesting to it. Within 45 days you need to use the Attestation Form. Make sure you're using the current Attestation Form; it has changed a few years ago. And again, there's several signatures that are required -- vice president of finance. That signature needs to be done within 45 days. If that person's reviewing that attestation three, four, five months later -- the auditor has to assume that they didn't really get it done within 45 days, okay? So for auditing purposes, normally there would be six attestations -- one for each month. Again, make sure you go over the dates. Make sure it matches the Marks calendar and everything looks good.

Okay, policies and procedure element -- This is kind of like a catchall element for all your policies and procedures. If we find a couple little things wrong with your policies and procedures that you can change during the audit period, we can give you like a "met with note" here -- again minor things, not things that would make your whole element a "not met." Rather than getting several "not mets" for these little minor things, we can put it into this element, okay? So it's better to get a one "met with note" versus several. But I will talk in audit tips about your policies and procedures.

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Okay. I want to go over real quick "Tips for a Successful Part D Audit." One thing would be to please be organized. I personally, if I'm auditing, don't need a physical copy of your policies and procedures. Some auditors may request it. Disc is fine. But please be organized -- meaning, you know, make sure everything is in order and there's not missing reports, and the binder's a mess and not tabbed -- I can't follow anything. I can say that Centra -- if I can pick on them in a positive way -- in Virginia was extremely organized. Anything that was missing usually was my fault. I couldn't find it because the manual was so big. But everything was labeled and tabbed. Their policies and procedures looked great. They had review dates on there. They're numbered. They're lettered. A table of contents that was really, really nice; and to me that showed that they were on top of things.

Communication is real important. If you're a new plan or if you have any kind of question at all, please communicate to your account manager. If you're in my region, you can e-mail me directly; it's fine. I definitely will get back to you. If I don't know the answer, I'll find out who does. I prefer e-mail; that way I can send you back attachments or policy or clips of policy. So again, please communicate. Don't wait until the week before your audit to say you don't

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understand this element; you're going to get a "not met," okay? Tell us up front, "I'm having trouble understanding this policy or guidance; can you let us know?" Okay?

Couple of more things here, and we're going to get done early on this one. Resolve old issues or caps. This seems obvious; but for some reason, the first thing an auditor should ever do is go back and look at the last audit. If you had an issue in your element the prior audit, the assumption is that should be fixed; right? It's not – we can't always assume that. And personally I've learned this mistake the hard way in a JCAHO audit. I did not go back to the previous audit; and we were doing everything wrong, and it was under my watch for that particular part, and it was embarrassing. So just make sure you go into HPMS. You're reviewing the old audit. I'm probably going to go right to that element and make sure you fixed it, okay? And if you didn't, there's no leniency. There's no reason for – it's not a "not met" or a "met with note." It should be a "not met," okay? So please review your old issues.

Part D interviews generally take maybe thirty-five, forty-five minutes. A lot of these are desktop audits, so we'll just do it over the phone – work around your schedule. I can say that really we're just going to go down each of your policies and each element and ask a general question. Tell me a little about this policy. Explain it. What's your procedure here? You know, just please have the experts for that policy there so we can have it all done in thirty-five, forty minutes. Please know your own policy. It's kind of embarrassing if you ask a question about your own policy that's in front of me and the person doesn't understand it. That just says that you don't understand the guidance, okay?

Two more things – read HPMS memos. This makes sense. I'm sure you have a compliance officer who's in charge of getting all these memos and reviewing them. A lot of them don't pertain to PACE; but the ones that do that say "all plans and PACE" or "all plans," read over them. Some are extensive; most are one or two pages. But make sure that if there's a policy change or something new has come out – a new procedure -- that you're implementing it. That's important.

And last, again, get help. If you ask questions, please get help early. E-mail is the best way. If you still don't understand, you can call me if you're in my region. Ask your account manager, "We don't understand this element," "We don't understand this policy." Try to get help early.

And that's it, guys. We're done here early. Sorry to speak too fast [Applause]

Okay, wonderful. On the count of three, let's all click --