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TRANSCRIPT

Part D Audit

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My name is Matt Febbo. I am one of the lead auditors for PACE part D in our region, Philadelphia. Again, for the next 35 minutes I'm going to go over some basics of the Part D section of PACE audit. I can tell you that over the last two years or so, doing the Part D audit, most PACE organizations are doing a great job on this section, and I will say the pharmacists, this section is not clinically based, really. It's all about billing mostly. I'd rather you guys knock this out and spend 98 percent of your time doing patient care, but nonetheless, it's still a requirement, so we do have to go through the elements, okay?

And a lot of people--I have some questions here. I thought there was only going to be ten or 15 people, so I was going to just do it like more of a casual breakout session with just questions and answers, but since there's so many people I'll just make it more structured. I do have some questions here. One is how is a pharmacy providing service for PACE company Part D audit? And I just wanted to mention this. The pharmacy, the clinical end is really not that involved in this section at all, just a little tiny bit, and you'll see when I go through the elements.

There's a few elements in the other parts of the audit where IDT and stuff like that, where contract pharmacists and your staff pharmacists can (inaudible). Okay, so I'm going to have to go a little quicker than I thought. I got more behind here and I don't want to interrupt your break. I'm just going to go through the elements. I'm going to pick out a couple areas where we consistently see mistakes, and hopefully that will help, okay? Just real quick, before I go into the elements, in general with the Part D audit, most of it is desktops, so when you guys send your files in, organization is really real important. Most auditors, including myself, just want a disk now. We don't want this huge binder. Total waste of the environment. My office is filled with them because once you send them, by law I can't get rid of them for seven or ten years, they're just everywhere. Just send me a disk, please, it's fine.

When you send your disk for Part D, please, please, please be organized. It's very hard as an auditor doing a desktop audit. If the files aren't organized, it's really difficult, and remember, I have two audits a month so it's not like we have a lot of time to spend. Put your folders, have the 11 elements, you know, ER13--everything pertaining to ER13 should be in that folder, and just keep going down the line, okay. If you can title what's inside there, it makes it easier for me to find it. Risk assessment tool.pdf, stuff like that.

Most people do a great job. Some people have sent files everywhere, and it's really, really difficult, okay? One other point I'll make here is one of the first things that any auditor will do is go to your

previous audit, and for those who were here two years ago, I kept stressing this: if you got a not met or met with note on an element from a year or two ago, and you get it again, it looks really bad, okay? I think the message you guys probably get is CMS wants PACE organizations to succeed. We're kind of like a partner here. You guys are mostly nonprofit, and we don't want to nickel and dime you on the audit, but really, if you got a not met or met with note, there's no leniency the next time. If it's wrong again, it's just wrong. I'm not going to work with you, okay.

And then one final point: please reach out, throughout the course of the year. If you have any questions, don't wait until a week before the audit to say you don't understand the element. E-mail me, e-mail your account manager or somebody, and we will definitely get back to you on that, okay? Any real quick questions before we start?

Okay, so ER13 is a confirmation of enrollment for members in an employer union group, receiving an employer subsidy. Basically in a nutshell, CMS wants to make sure that the beneficiary you're about to roll doesn't have any other like RDS plan or employer group plan, and important thing here to know is if you disenroll somebody in an employer plan, it could affect their benefits package somehow. We have heard heart wrenching stories where Mrs. Smith gets disenrolled, she loses all these benefits and retirement monies, and unless that employer group wants to take them back legally, they don't have to. It could really be damaging. So it's not just kind of a nonsensical element, it's an important. So you want to make sure you're finding out that beneficiary has an RDS or employer group. If they do, you need to have some kind of mechanism to make sure that they know if you disenroll them from that, and they get in the PACE, there's a good chance they're not going to get back to that employer group. One area of this is the--I don't think I put it up here, but you can contact the beneficiary in person, to discuss this and document it, or you can do it in writing. If you send a letter to that participant saying, Mrs. Smith, you're an RDS, you really want to enroll, if you never hear back you have to send another letter in 30 days saying you're no longer considered being enrolled in this plan, and that's just so that they don't think they're (inaudible), okay. That's the one part that almost everyone gets wrong. You need to have that policy, and if you're going to send a letter, that letter needs--I'm clipping this right out of the element--it needs to come from the chapter manual, (inaudible) manual. It's got to be a standard letter.

If you don't know where that is, e-mail me. It's right in the manual. You can just--and put your letterhead on it, okay? Remember, anything you're sending off to beneficiaries almost always has to be a CMS standard notification. So that's one area I almost always see PACE plans, they don't get that part. This is a no-brainer. We'll spend 30 seconds on this. You can't use social security numbers on ID cards. Never seen this happen. It's common sense now, we don't do it. When you send your audit materials, you don't have to send me a card, just send me a PDF of ten front and ten back. You know, why ten? Just remember, we get reaudited, so other people look at our work, so everything I do goes in electronic file. So if I ask you for something that seems stupid, or why would you want ten, it's because that's the standard. So just send ten cards there.

Collecting of other health insurance, OHI, something happens extremely infrequently. A beneficiary may have some kind of other health insurance. Again, I think I've seen it three or four times in all the PACE audits. You need to coordinate with the COB contractor through the Ecker system, find out if they have any other health insurance, okay. What a lot of PACE organizations do is the Medicare secondary payer survey (inaudible). When they get to your plan, that MSP survey is the standard thing. You're basically asking them and their family members, is there any other health insurance, anything, any other benefit involved? Because remember, if there's another benefit of any sort, Medicare, as long as--almost always a secondary payer.

So make sure that you're getting this done, you have policies for it, you're documenting this, and you're submitting anything to the COB contractor. Some PACE organizations do this on a yearly basis. It would be real rare, but let's just say a spouse is in PACE and the other one is not, the spouse dies, that person may receive some other kind of benefit. Super rare, so if you do a yearly survey, a (inaudible) survey, you could catch something like that.

This is not really a troublesome element for PACE audits. I think my slide deck got a little--I'm missing some slides, but that's all right. We'll just keep going here. CP '06, '07, and '08. '06 and '07 are missing, I don't know how. This is definitely one area I want to spend a little extra time on, because a lot of the PACE organizations may only have 150 beneficiaries, (inaudible) beneficiaries. The amount of fraud and abuse that you would probably see in these small plans is small to nothing. Nonetheless, you need to have a robust program in place that deals with fraud, waste, and abuse, and compliance, okay?

Remember, CMS adopts these standards from huge plants. I might manage a claim with three million beneficiaries, with pharmacies involved, and the amount of abuse and fraud, as we all know, we read the paper, is huge. And so those standards bring down to your little PACE organization, you still need to have these things in place, okay. If you have a corporate umbrella, or a corporate compliance policy, that you have a larger organization like affiliated with a hospital, let's see--send me that. Send everything that you have. I'd rather have more than less. Again, '06, '07, '08--these three elements deal with compliance, and fraud, waste, and abuse. We need to see a risk assessment tool of some sorts that your compliance team is reviewing your plan yearly.

One of the questions is, is there any standard risk assessment tool? There is not. I know that NPA had to put one out that probably 95 percent of you guys use. It's a great risk assessment tool. Just make sure if you're doing it yearly, which is probably a good idea, compliance officer or someone is signing it (inaudible), you know, not just checking it down the line, that doesn't mean anything. You need to have someone sign off that they're doing it, okay.

So make sure also, with your risk assessment tool and your policy on compliance, again, a lot of people use MPA's policy which is a nice 40-page (inaudible). Make sure you're doing X, Y, and Z, not just saying you're doing it. It's very easy to say, okay, our compliance program's awesome. We've got three nets in a row, three years, they're not going to look at stuff. Well you know, if it says we're going to meet quarterly, we need to see the minutes for that meeting. If it says we're going to review these things, I want to see those things, okay. You can't just go down and check you're doing it. And I just say that because a few organizations unfortunately, they have done that, probably because they're stressed out on the clinical end (inaudible) you can't do that, okay.

So we want to see a lot of documents here. Remember, all your contractors, you are responsible for, so any kind of contract service really dealing with these, so your pharmacy contracts, we need to see fraud, waste, and abuse training, and if you contract with Walgreen's, those pharmacists and techs need to do the fraud, waste, and abuse training, usually on a yearly basis. You need to have that signed, that they took the training and attestation, and send that to me. I think you guys mostly get the point there. I see that being said. What else here? Clinical--this is probably the most--the only area we're going to see any kind of clinical--

We contract both internally within our system, within our health system, for a lot of day-to-day drug uses, but we also use multiple pharmacies for after hours drugs. Is simple attestation that (inaudible)

we don't need to provide that education. Okay, because I really wasn't clear on the new guidelines. One of our compliance officers was making a big deal out of it (inaudible).

She brings up a good point. Every auditor you get may want something different, and I apologize. The consistency is not always 100 percent. For me personally, if I have an attestation for that pharmacy, Rite Aid with all their techs and pharmacists, to me, they're legally attesting that they completed the training, I'm good with that. I don't need to see the training or an answer sheet, that's just over the top. But you need to have every single pharmacy you send that in probably on a yearly basis. So again, downstream contractors, you guys need to have oversight of them. That includes your driving. I don't really look into the driving so much but make sure that there's no drug diversion with your drivers. If you're in an area that's more maybe low income, the driver's not walking in the door and leaving narcotics out in that car. So stuff like that you might want to think about.

And lastly, occasionally I will be asked to go to a PACE organization and not do the desk review. I may ask a nurse or a tech giving pills out, you know, can you give me an example of fraud, waste, and abuse. They should know what an example is, and who they would go to. Most of you have like an 800 number that's a corporate number for compliance and maybe tech fraud. Would be either that, or Medicare, Safe Med, SafeRX number, and I've never seen any PACE organization have any evidence of fraud, waste, and abuse, which I'm scratching my head, but if you detect any kind of fraud or diversion, you need to report it, you need to have it on record, so when we review, we need to see what your follow-up action was on that.

So that's kind of it. Again, one last thing I was attempting to say is, this is the one clinical section. We want to see drug reports here, so if you have contract pharmacists or a PBM doing your like top 100 drugs dispensed, top narcotics by prescriber, I want to see some of those reports. The best plans will send me three or five or eight reports, that I know that someone's reviewing what your prescribers are doing, they're kind of keeping an eye out on what's going on. So those are the kind of reports you want to send. With these three elements, I would say you probably have 15 to 20 files at least coming over, and a lot of them overlap. Don't worry about sending more, okay? Any other--any questions about this topic, fraud, waste, and abuse or compliance?

You talked about a corporate compliance plan. Can you just differentiate it from the plan itself?

Absolutely. So Mitch is just asking, corporate compliance versus your internal compliance plan. I'm not an expert on compliance. I think Mitch is more in that area, but what I think he's saying is, if you're affiliated with a hospital and they have their own compliance program, we want to see a little bit of that, too. You don't have to send every minute from every meeting, but send me that policy. Send me who's the compliance officer in that organization, how does that trickle down to oversight for your organization, and then internally, you guys would probably have your own compliance officer. How do you guys connect? Does your compliance officer go to the meetings, those kinds of things.

So there's often oversight on two levels. If you don't have a corporate umbrella, if you're just a standalone PACE organization, wouldn't apply. This element here is a little more technical. I think most people in here contract with PBM. There's a couple people that do it alone, which you can do. It's a little more technical, but this section really, the name of it's a little misleading. We're just looking to make sure that your prescription drug event data, which is a drug claim, anytime you fill a drug (inaudible) PDD, it's being sent to the contractor and it's being accepted on a timely basis, and that's all this is. We would get a list of random HIC numbers. I think it's 30, and then we would get--usually a

PBM would send the file, and I'd match up and make sure got accepted (inaudible). That's what we're looking for here.

Again, since this is a little bit more technical, I usually want to talk to the PBM here and working that out. This is, again, claims processing, this element really is just the nuts and bolts of filing a claim electronically, how it gets processed. Data storage, backup systems, use of metaspan as a standard. Again, 99 percent of you probably use the PBM. You would contract that out, since it's not your technical expertise. I would normally deal with like PharmStar is a contractor, and there's no issues here, okay. I normally have no problems with any PACE organization (inaudible).

This is probably the biggest not met in any of the elements, and I don't know why, so if you guys want to shoot out any kind of answer, or just say it's dumb, whatever you want to say I want to hear it. But the policy for this is right on the Reed and Associates Web site. It has--if you go to Reed and Associate, and click on Policies and go to PACE, it tells you exactly what they need and expect--the form, the attestation's on there, there is a marks calendar that's on there; everything is laid out.

So what we're looking for in this section is this is in terms of payment to your PACE organization. I kind of take this real serious, because--I mean, I take everything serious, but you're talking about payment of a lot of money. I just want to make sure like your CFO's involved here in looking over this. You need policy to show that you're submitting any kind of changes of enrollment/disenrollment. You're checking the data when it becomes available within 45 days, and then lastly, you're submitting those monthly attestations to Reed, okay.

When you submit those attestations, the one thing--I'm not trying to be nit-picky, but the dates need to match up. A lot of times the dates are wrong, so all you have to do is go to the marks calendar and match the dates up. If you have any questions about that, let me know. The payments don't start on the first and end at the end of the month, they're usually like in the middle of the month.

So for instance, if we're typically looking at a six month audit period, you would have six attestations sent to me for the review, with your policy with those three pieces. The attestations need to be signed by usually a CFO and dated. Don't have him or her just do it at the end of the six months. Again, they should be looking at this as kind of part of your compliance and oversight. Make sure she or he is signing on like a monthly basis and reviewing these, and that's basically it. You don't have to show me evidence that you're submitting them to the contractor, because we actually get a report if you're not, but if you want to show like the FedEx slip of all the submissions, that's fine.

Other than that, if you have any questions, again you'll need the marks calendar, the blank form, and Reed's Web site on this.

(Off mike.)

What was the question?

Is their electronic signature going to be used for the Reed attestations? I never heard of that, no. I mean, to my knowledge, no.

(Off mike.)

Yeah, I could follow up on that. I could send it to Anne-Marie for everyone to--Tim will be here, okay. That's a good question. Tim is the HPMS expert, technical expert. Now remember, some of the requirements, a lot of the requirements that we take from the big plans, the MA, MAPDs, we use them for PACE and a lot of times you're exempt for these things. For instance, like the Eckers referral system, you don't have to use the digital, you can just send a flat file, and I think the point is, we don't want to burden small plans like PACE organizations with having to have these systems. Like for instance, another one of my slides missing is truth transfer, keeping track of truth. Does anyone do that themselves, or mostly you're using like PBM?

I'm sorry the slides are missing. I don't know what happened with that. So let me go over that. That's CBO3. This deals with keeping track of truth. With PACE, there really isn't truth. There's nothing usually out of pocket with PACE. (Inaudible) all inclusive, that's the part of the program. However, you need to keep count of--yes, you need to keep count, because if they leave your PACE plan, which they usually almost never do, and go to another plan, the receiving plan needs to know where they stand in terms of truth. There is an easy online calculator--well, I wouldn't say easy, but there's a way to calculate this that CMS provides in the chapter manual, under coordination of benefits.

You're welcome to use that, and I think most everyone is going to the electronic transfer policy now in PBM. This is the way to go. I can't tell you what to do or how to run your organization, but this is the easiest thing to do. If you use a PBM, they get the (inaudible) data and it's all done electronically, and they send it to the new plan electronically. It's all done. You don't have to give the participant a letter saying this is not a bill, this is your true balance.

So if you have a PBM and you're using that electronic system, this element, basically all we need to see is their policy on that, and the rest is not applicable. If you're not using a PBM, you're doing it yourself, we need to see an example of the letter, the truth letter you're using, which again has got to be standard, it's in the guidance, and you need to show me how you're calculating truth, how you're doing that.

Okay, I think I covered the ones that aren't even there. One last one to mention for two seconds here, and then I can do like five or ten minutes of questions and get you out on time. PP01, this is actually a nice element for you guys, because what this does is if you just have one or two little policy things wrong with an element but you're doing the right thing, you would get that--you would have, for me, as an auditor, I'll give you the ability--rather than doing my cap later, and this may be lazy of me or whatever, if you have a problem with your policy, I want to fix it right there. I want to talk with you and say, this is wrong, we need to fix it. You fix it there or we documented that you fixed it during the audit period, and you officially can't change something in an audit. So what we do is we put it down here as a not met, as a policy and procedure thing. That element that we fix, we just get it (inaudible) and I document all this. This is a lot easier than just not getting guidance and then later you have to talk to an account manager, how do we come up with a cap.

So normally, if I'm auditing you, your cap's done. If you had a not met and we've already fixed it, it's done, okay, and then I would expect next year it would be perfect, because we just discussed it. So again, that's what this element deals with, and it was put in so you wouldn't have multiple not mets for little policy things. Before I go, I have a few questions that people had submitted. I can go over them, but is there any general questions, you know, any comments for anybody?

I was clear about compliance but I just want to go back to it (inaudible). PACE organization has a compliance officer. (Off mike.) Along with that being said and done, that PACE organization is a part of a larger organization for compliance. That PACE organization has its policies as well as its officers (inaudible) but reports up to the (inaudible). Those means for the PACE organization takes place with the larger organization, and that activity is stipulated in the minutes, which come from that larger organization. Is that a problem, is that an issue?

That's not an issue at all. I mean, what we were pointing out is if you have two compliance levels, like Sentara has--they're part of a large hospital, I believe. When we were at Sentara, they had the board of directors of Sentara Health, which is this big hospital, Virginia, and then they showed me the minutes for the meetings, quarterly meetings, and then they had their own internal compliance minutes and meetings with the compliance officer and a quality improvement (inaudible).

So they sent me both, which was nice. That's kind of what I want to see if you have two levels of compliance. Does that make sense?

Yes, it does.

Okay, and then just to follow up, in terms of fraud, I will look in your fraud detection policy. If there's a toll-free number, I'm going to call it and say, you know, actually one number was wrong, which was an immediate not met. If your number that you're putting in your policy gets me nowhere (inaudible) that's not met. In fact, when we go in your facility, in your break room, we need to have some posters saying what fraud is. It's a serious issue in this country. Again, I'm not picking on PACE organizations. We don't think there's a lot of diversion probably not happening in PACE, but it's a serious issue outside of PACE, and we want to make sure that doesn't affect you guys. So a poster in a break room to say what fraud is or drug diversion, how to reach somebody. The number when I dial--most numbers go to the corporate level and then they want to document the fraud, and then it goes to Medicare or medic, but you can also use the Medicare direct number, too.

I had a question come up. I have a compliance background, previous life, and it was always taught to me that the person responsible for the (inaudible) should not be the compliance officer because it's a conflict. Is there a policy that specifically--that I can point this out to my CFO and my (inaudible) to say, I'm not comfortable if I'm responsible for the bottom line being the compliance officer (inaudible). I just think there's a conflict there and that's--what is your opinion, and is there indeed a policy that would address that?

I don't believe CMS wants to get into the situation to tell clients how to run their programs, nor do we want to see how you're doing it and your policy. I would say you should fall back on your policy. If you have a corporate umbrella, what's their policy say? We don't want to get in the business of saying--we could point it out if something is weak or lacking in this area, but I don't want to say--does that make sense?

Yeah, I understand that, I just--again, everything in my nature just says it's not a good thing.

You might want to talk to Mitch on the break, because I think he's more of a policy expert if I recall, in the New York office. That's a good question, but again, I think you really want to fall back on your policy--what does it say, and (inaudible).

Okay, just the last couple minutes, the questions I have, about four of them here: how does the pharmacy get involved in the PACE Part D section? Again, real quick, there's not a lot of clinical parts to this. The only thing we'd see like a pharmacy consultant would be submitting maybe drug utilization reports, that kind of stuff in the compliance area.

Is there a best practice for Part D auditing, and if so, I'm going to single out Doris Mosako, okay. Doris at Riverside, I just want to point her out. I did an audit for them, Part D, maybe six months ago or something. Courtney was the gal responsible. The easiest audit I've ever done, and it was like autopilot. I just clicked each file, everything was there, it was highlighted. It took me half the time. It was great. If everyone could talk to Courtney, how did they organize it? It was awesome. So I want to point out, if you want a best practice, and you guys talk to each other, talk to Riverside, and I think Doris said she'd be open to talking about that. But again, that's what we want to see in a perfect world, and so a lot of PACE organizations are doing a great job.

Is there a preferred risk assessment tool? Again, I don't believe there is. I think most of you guys here are using the MPA drive, for a successful tool, which is fine. It's very thorough, so make sure you're checking it and you're signing your name to it and you've done it.

One--someone wrote about over-the-counter medication costs, vitamins, minerals--why can't they be submitted to PD? I guess everyone, most people here know by law or statute, Part D does not cover over-the-counter medicines, so legally you would not submit them through PD which is a Part D section. They would fall under the medical section of your reimbursement, or usually Part D in the Medicare Advantage plan. So I'm sorry they're costly, but your contract says all-inclusive care, you need to bundle that in with your (inaudible).

Lastly, someone asked about ESRD meds such as (inaudible). So not that anyone wants to read it, but I do have the memo about this. It's a little complicated, but the guidance is several pages, but remember, drugs that are always dialysis or ESRD related are now being bundled in a Part D capitation, not Part D.

So if you're using a pharmacy for this, they should not be billing D. I don't know--it probably will get rejected when they submit that PDE, so if whoever (inaudible) is in the room and they have more specifics, you can have this copy of the memo. It went out February 17, 2011, and the title if you're looking through the HPMS is--you can look on ESRD clarification. It lays out exactly what drugs are typically almost always used for end stage renal disease. There are some grey areas, and if you have specific policy questions, let me know. We have a subject matter expert in Baltimore for that, too.

So in closing here, just want to say thanks a lot for doing a great job with your audit materials. I think 95, 98 percent are always all met, maybe some small minor things. Again, I'd rather you knock out Part D section, have it run smooth, and spend all your time on patient care. It is important, we got to get it right, but don't spend too much time on this. Get it done right the first time, and keep up on it.

If you have any questions, please e-mail your account managers in your region, and they can filter it up to anyone if they don't know the answer. And I'll be floating around here for the next hour and a half if you want to talk to me outside the break area, feel free.