Life & Health

Health Care Communiqué

Q3 2013

BEST PRACTICES AND COMMON FINDINGS ON 2012 PROGRAM AUDITS

PART D FORMULARY AND BENEFITS ADMINISTRATION

The following is an excerpt from an upcoming paper written by SBG.

Over the past year the Centers for Medicare & Medicaid Services (CMS) has issued memos to discuss Best Practices and Common Findings they witnessed during Program Audits. CMS issued its most recent memo on July 30, 2013. A finding is considered common when it occurs in at least four of the conducted audits.

During 2012, CMS audited the following areas:

- Part D formulary and benefits administration
- Part D coverage determinations
- Appeals and grievances
- Part C organizations determinations
- Part C access to care
- Part C and D compliance program effectiveness
- Part C and D agent and broker oversight
- Part C and D enrollment and disenrollment
- Part D late enrollment penalty (LEP)

(continued...)

BEST PRACTICES AND COMMON FINDINGS ON 2012 PROGRAM AUDITS *(Continued)*

CMS expects all Sponsors to carefully and routinely assess risks to their organization and monitor and audit their operations to ensure compliance with CMS requirements. CMS also expects that Plan Sponsors use this information as a guide for these areas.

CMS listed numerous best practices that eased access to medications for members. This was done by having, at point of sale, easy-to-understand system edits that give direction to the pharmacist on how to resolve a rejected claim:

- Making sure that beneficiary cases are being worked in a timely manner and they are notified quickly to allow them access to their medications;
- Following up with the beneficiaries to confirm that their issues were resolved satisfactorily;
- Quality assurance programs that verified that cases were being completed timely and accurately for the beneficiaries;
- Stay current with Prescription Drug Formulary Administration.

BEST PRACTICES:

Pharmacy messaging that shows clear communication between the Part D sponsor and the dispensing pharmacy to ensure beneficiaries have access to prescribed medications. Messaging must be clear at the point of sale to include step therapy messaging which allows efficient processing of the claim and detailed secondary messaging that give the pharmacist instructions for resolving rejected claims.

Maximum cost edits set greater than the usual and customary pricing for standard dosing regimens which result in beneficiaries receiving medications in a timelier manner.

COMMON FINDINGS:

Unapproved system edits: Edits set up that do not coincide with the approved formulary.

Part B versus Part D coverage determinations: Not having a system in place to make a determination at point of sale.

Part D transition fills: Still seeing rejections for:

- **Failure to provide transition medication** that was removed from the formulary from one contract year to the next;
- **Failure to provide a new beneficiary with a transition medication** with a CMS approved prior authorization requirement, quantity limit requirement and non-formulary medication;
- **Failure to extend transition timelines** for long term care beneficiaries.

ISSUANCE OF NEW INTEGRATED DENIAL NOTICE

On August 13, 2013, CMS issued a new Office of Management and Budget OMB-approved standardized notice of denial and appeal rights, referred to as the Integrated Denial Notice (IDN). The IDN combines and replaces the standardized Medicare Part C denial notices entitled "Notice of Denial of Payment" and "Notice of Denial of Medical Coverage." In addition, the IDN integrates Medicaid appeal rights information for Medicare health plan enrollees receiving full benefits under a State Medical Assistance (Medicaid) program.

Medicare health plans, Fully Integrated Dual Eligible (FIDE) and Medicare-Medicaid Plans (MMP's) will issue the IDN to inform enrollees of their appeal rights, as applicable, for payment or service denials, and for discontinuation or reduction of a previously authorized course of treatments. All plans should begin using the IDN as soon as possible, but no later than November 1, 2013.

The IDN and instructions are posted on the CMS website: http://www.cms.gov/

RESULTS OF THE 2013 PART C AND D REPORTING REQUIREMENTS DATA VALIDATION

The third annual Medicare Part C and D reporting requirements data validation was conducted between April 1, 2013 and June 30, 2013. The following are the results:

A total of 608 contracts underwent data validation. Validation of Part C reporting was conducted on 530 contracts and validation of Part D on 603 contracts.

Overall average (mean) score was 98.6%. The mean Part C score was 98.1% with a minimum of 73.6% and a maximum of 100%. The mean Part D score was 99.0% with a minimum of 84.2% and a maximum of 100%.

Only 27 contracts scored below 95%. Contracts scoring below 95% on the overall score and plan on being active in CY 2014 were required to submit remediation plans to CMS by August 30, 2013.

Out of 530 contracts, 32.8% scored 100% on Part C Reporting Section data validation.

Out of 603 contracts, 49.6% scored 100% on Part D Reporting Section data validation.

Since the inception of Data Validation Audits, which began in 2010, the results of these audits have incrementally improved year after year, demonstrating the Plan's commitment to an overall high level of performance.

MEDICARE PART D OVERUTILIZATION MONITORING SYSTEM

On July 5, 2013, CMS issued a memo titled "Medicare Part D Overutilization Monitoring System" which provides information about the new Medicare Part D Overutilization Monitoring System (OMS). The OMS will help CMS ensure that sponsors have established reasonable and appropriate drug utilization management programs to assist in preventing overutilization of prescribed medications.

Beneficiaries with potential opioid or Acetaminophen (APAP) overutilization issues identified through analyses of Prescription Drug Event (PDE) and beneficiaries referred by the Center for Program Integrity will be reported to sponsors on a quarterly basis starting on July 31, 2013. The first report will contain dates of service between January 1 and June 30, 2013. Sponsors will have 30 days to submit to CMS a status on the review of each of these cases.

Effective January 1, 2013 CMS expects sponsors to have the following in place:

- Appropriate controls at point of sale (POS), including safety edits and quantity limits;
- Improved retrospective drug utilization review (DUR) to identify at-risk beneficiaries;
- Case management with the beneficiaries prescribers;
- Data-sharing between Part D sponsors when a beneficiary, for whom a beneficiary-level claim edit has been implemented, move from one Part D plan to another.

Beneficiaries with potential overutilization issues will be identified initially using three types of outlier metrics:

1. **Opioid Outliers:** Beneficiaries with morphine equivalent dose greater than 120mg for at least 90 days and who used more than 3 pharmacies and 3 prescribers;
2. **APAP Outliers:** Beneficiaries who may be taking more than 4 g of APAP per day for more than 30 days;
3. **CPI Referral Outliers**: Beneficiaries referred by the Medicare Center for Program Integrity.

By July 16, 2013, sponsors need to confirm that they have access to the Acumen Patient Safety Analysis website so they can obtain this report. Acumen allows for up to five users for this website. The memo goes into detail on this process. Sponsors need to work with the PBM to identify how this process will be handled going forward.

MEDICARE TIMELINE

Sept. 10-13	Second CY 2014 Medicare Plan Finder (MPF) Preview and Out-of-Pocket Cost (OOPC) Preview in HPMS.
Sept. 13	2012 Attestations of Prescription Drug Event Data (PDE), Direct and Indirect Remunerations (DIR) Data, Monthly Plan-to-Plan (P2P) Reconciliation Payments and Attestation of Data Relating to the Detailed DIR Report must be completed in HPMS.
Sept. 16-30	CMS mails the 2014 Medicare & You handbook to Medicare beneficiaries.
Mid-Sept.	Individuals who no longer qualify for LIS automatically in 2014 will receive a letter explaining this loss and a SSA application for extra help to
Sept. 30	CY 2014 standardized, combined Annual Notice of Change (ANOC)/Evidence of Coverage (EOC) is due to current members of all MA plans, MA-PD plans, PDPs and cost-based plans offering Part D. MA and MA-PD plans must ensure current members receive the combined ANOC/EOC by September 30. Plans have the option to include Pharmacy/ Provider directories in this mailing. All plans offering Part D must mail their LIS riders and abridged or comprehensive formularies with the ANOC/EOC to ensure current member receipt by September 30.
Oct. 1	Deadline for Part D sponsors, cost-based, MA and MA-PD organizations to request a plan correction to the plan benefit package (PBP) via HPMS. Deadline for Part D sponsors, cost-based, MA and MA-PD organizations to request any SB hard copy change.
Oct. 1	Tentative date for 2014 plan and drug benefit data to be displayed on Medicare Plan Finder on Medicare.gov (not applicable to EGWPs).
Oct. 1	Organizations may begin marketing their CY 2014 plan benefits. Note: Once an organization begins marketing CY 2014 plans, the organization must cease marketing CY 2013 plans through mass media or direct mail marketing (except for age-in mailings). Organizations may still provide CY 2013 materials upon request, conduct one-on-one sales appointments and process enrollment applications.
Oct. 2	The final personalized beneficiary non-renewal notification letter must be received by PDPs, MA plan, MA-PD plans and cost-based plan enrollees. PDPs, MA plans, MA-PD plans and Medicare cost-based organizations may not market to beneficiaries of non-renewing plans until after October 2, 2013.
Oct. 8	Star Ratings go live on medicare.gov on or around October 8, 2013.
Early Oct.	Individuals who will continue to qualify automatically for LIS in 2014, but have a change in their co-payment will receive a letter, effective date
Early Oct.	Release of the online CY 2014 Notice of Intent to Apply for a New Contract or a Contract Expansion (MA, MA-PD, PDPs, and "800 series" EGWPs and Direct Contract EGWPs).
Oct. 15	2014 Annual Election Period begins. All organizations/sponsors must hold open enrollment.

Nov. 1	All plans must have been implemented using the new Integrated Denial Notice (IDN).
Nov. 9	Notices of Intent to Apply (NOIA) for CY 2015 due for MA, MA-PD, PDPs, and "800 series" EGWPs and Direct Contract EGWPs.
Late Nov.	Display measures data are posted in HPMS for plan preview.
Late Nov.	2014 Readiness Assessment due to CMS.
Dec. 7	End of the Annual Election Period.
Mid-Dec.	Display measures data on CMS.GOV updated.

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About our Authors

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About SBG

Solid Benefit Guidance, LLC (SBG) is one of the nation's leading consulting firms and thought leaders in the PBM industry. With more than 130 years of collective experience in this highly complex industry, SBG provides plan sponsors and health plans an unparalleled evaluation of their compliance, pharmacy costs, performance and trends. Some of the services we offer include:

- PBM Procurement & Vendor Oversight
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SBG experts serve as UL Quality, Compliance and Learning's Health Care Library Course authors, and also contribute articles to the Health Care Communiqué.