Panel Discussion for Medicare Part D

Rejected Claim Analysis

Attendees

- Rob Shelley, President PSRx
- Tom Holden VP, Business Development (Dallas)
Situational Analysis

• CMS assesses how plans monitor Part D rejected claims
  – 2013 Part D Transition Monitoring Program
    • Errors with Refill too soon
    • Failure to ID new versus continuing member
    • Inter-plan transitions
    • Formulary Errors
    • Historical Claims not Loaded
    • Enrollment Coding Errors
    • PA errors
  – High Priority on Performance Audits
    • Rejection monitoring resulting from Formulary consistently included as an example of part of CMS Monitoring Work Plan
    • Consideration of the CMS 2013 Program Audit Process and Protocols
    HPMS Memo (dated January 25, 2013) and associated attachments related to Formulary Administration
Rejection Oversight

Reject Reporting - Experience

- X% of rejects are solved by a claim being processed for the Reject claim in 24 hours.
- X% are Rejects that require secondary attention
- X% are Rejects that need to be worked and require time and resources
CMS Requirements / CMS Reject Audits

- Auditable process to address Rejects
- Key CMS program elements that need to be part of your processes
- What they are looking for:
  - Protected Classes versus Standard Rejects

Rejection Oversight

- Tracking
- Provider Follow-Up
- Monitoring
- Segmenting Rejections by Type
- Transition Protected Class Prioritized
- Claims Status Verified Paid?
- PBM System Claim Analysis
- Actionable Rejects Identified
Rejected Claim
Key Filtering Criteria

Rejected Claims
• Review claims data from the plan, using the plan’s formulary, benefit design and utilization management criteria
• Six protected classes (Antidepressants, Antipsychotics, Anticonvulsants, Antiretroviral (AIDS Treatment), Immunosuppressant and Anticancer
• In addition to summary reports, TRICAST reviews relevant claims in each rejection category. The primary rejection criteria are referenced under:
  ✓ Rejection Code 70, Drug Not Covered
  ✓ Rejection Code 76, Prior Authorization Required
  ✓ Rejection Code 75, Plan Limitations Exceeded
• Plan design and eligibility adherence
• Transition members considered

How Plans Do it:
20k Life MA-PD
How do Plans Manage the process?

80,000 Life Plan

• To Be added

How do Plans Do it?

250,000 Life Plan

• To Be added
Working with Your PBM

• Not willing to “do it for you”
  — Expensive
  — Liability
  — Labor intensive
• Coordinating data feed >24 hours
• Assisting the Plan with provider follow up
  — Process Improvement
  — Education of outlier pharmacy providers
• Claim system access for status checks

Answers /Best Practices

• Automation
• Pharmacy Outreach
• Process Management

Program is manageable if you have the right tools.
### Automation Tools: Priority – Reject by Transition

#### Claim Reject Analysis
Claims Filled Between 05/01/2013 and 05/31/2013
Using Drug List: Protected Class [10068]
(Standard Rejection Rpt) May 2013

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<th>Class Description</th>
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<td>Paid Rejects Same Day</td>
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### Automation Tools: Priority – Reject by Code Protected Classes

#### Claim Reject Analysis
Claims Filled Between 05/01/2013 and 05/31/2013
Using Drug List: Protected Class [10068]
(Standard Rejection Rpt) May 2013

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Work Flow and Tracking

• Home Grown Systems
  – SharePoint
  – Spreadsheets
  – Member Tracking tools
• Third party applications available – Customizing likely
• Documentation Critical

• UHG Adds
Thank You
Roles and Responsibilities – Compliance Perspective

Health Plan Responsibilities

- Accountable to CMS
- Accountable to members
Health Plan Compliance Role

- Support business with structure and processes designed to achieve compliance outcome
- Business owners responsible for compliance
- Be the expert in role clarity

Health Plan Compliance Role with PBM

- Needs to be customized
  - One size does not fit all
- Depends on the characteristics of the partnership of PBM and the Plan
Health Plan Compliance

• Assess PBM and PBM Compliance Program
  • Business performance monitoring?
  • Reports, metrics – push or pull?
  • How do they handle problems?
    • Transparency
    • Remediation

Health Plan Compliance

• Quality program hard wired?
• Readiness planning hard wired?
• How do they handle regulatory changes?
  • Share interpretation and implementation plans?
  • Validation?
Health Plan Compliance

• Share internal compliance audits?
• Compliance Program Monitoring?
• Understand CMS expectations that each individual member counts?

Health Plan Compliance

• Look for gaps
• Recognize – Strong in one area, but not another
• Understand handoffs between organizations
• Find ways to articulate/demonstrate what you want
• Help business lead PBM
• Risk based monitoring – may overlap/conflict
  • Inherent
  • Specific to partnership
Health Plan Compliance

How?
• Communication and documentation
  • Formal Executive Oversight Committee
  • Less formal work groups/forums
  • Monitoring, validation plans
  • Transparency
  • Know when/how to escalate
  • Forum to clarify new regulations and implementation plans

• Relationship – Partnership
  • Tension – Accountability
  • Flexible but firm
  • Acknowledge frustrations
Compliance Assessments & Reporting

Alison Green

Compliance Oversight – Assessments & Reporting Overview

Compliance Assessments and reporting are conducted throughout the year, including, but not limited to the following:

◊ Annual Risk Assessment conducted & updated quarterly;
◊ Quarterly Key Compliance Indicators assessment and updates;
◊ Quarterly Compliance Scorecard reviewed in Compliance Oversight Committee; and
◊ Monthly reporting on key CMS activity:
  ▪ CMS Notices,
  ▪ CMS Self Reports,
  ▪ CMS Inquiries,
  ▪ CMS Identified Issues,
  ▪ Escalated CTMs.
## Compliance Oversight – Risk Assessment

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<td>YOE (Complete, Timely, and Resolution of Rejects)</td>
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<td>Member Materials (Pharmacy / PBM Only)</td>
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<td>Regulatory Response (CARR, Implementation &amp; Audit Report)</td>
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<td>CMS Reporting - Part D</td>
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*Information presented in table does not represent actual assessment.*

## Compliance Oversight – Key Compliance Indicators

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Compliance Oversight – Compliance Scorecard

**UHC Government Programs Compliance - Medicare Compliance Scorecard**

**Quarterly Performance - Q2 2013**

**Compliance Program Lead:**

**Business Lead:**

<table>
<thead>
<tr>
<th>STRUCTURE / PROCESS (25)</th>
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**TOTAL:**

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*Information presented in table does not represent actual assessment.

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Compliance Oversight – CMS Notice Reporting

**CMS Notices by # of Contracts Impacted**

*Information presented in graphs does not represent actual data.

Monthly/Quarterly reporting on CMS Notices to outline # of contracts being impacted, where the issue occurred and in a FDR is impacted.

**Notice of Non Compliance By Operational Area**

- Pharmacy
- Sales
- Operations
- Materials
- Clinical
- Finance

**Number of Unique Issues from CMS Notices By Area of Error**

- Plan Error
- FDR Error

*Information presented in graphs does not represent actual data.*
Compliance Oversight – CMS Notice Reporting

Report to business & compliance leadership the impact of CMS notices on Star Ratings and Past Performance Methodology – specific to the Compliance Letters category.

*Information presented in graphs does not represent actual data.

Compliance Oversight – CMS Self Reporting

Monthly reporting to Business & Compliance leadership indicating status of self reports to CMS.

*Information presented in graphs does not represent actual data.
Compliance Oversight – CMS Self Reporting – TAT Goals

Compliance Goals Average TAT

- CMS Notice Response Goal
  - Respond to CMS Notices within 30 calendar days of receipt.
  - Current average is 20 calendar days.

- Compliance Notification to CMS Self Report Submission
  - Submit self report to CMS within 15 calendar days of issue notification.
  - Current average is 6 calendar days.

- Business Discovery to Compliance Notification
  - Business notify Compliance within 2 calendar days of issue identification.
  - Current average is 2 calendar days.

*Information presented in graphs does not represent actual data.

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Compliance Oversight – CMS Inquiries, Identified Issues & Escalated CTMs

CMS Inquiries, Identified Issues & Escalated CTMs

Number of Issues per Category

- CMS Inquiries & Escalated CTMs include member level issues, as well as policy questions.

- CMS Identified Issues include assessment of plan data (i.e. PDEs) across contracts for notable issues requiring action.

*Information presented in graphs does not represent actual data.
Compliance Oversight –
Summary

◊ Developed reporting post CMS Program audit to help provide leadership a snap shot of compliance and CMS activity for pharmacy operations at the Plan as well as delegated to the PBM.

◊ Began development of reporting late 2013 to outline compliance letter impact to STAR Ratings & Past Performance Methodology.

◊ Continually changing – there is always enough data to mine!

◊ 2013 was year of developing reporting; 2014 will be year of refining data and enhancing reporting.