

HEALTH PLAN DESKTOP		
Title: Delegated Member Call Center Oversight and Monitoring		Number: DMPHR07 Revision: A
Department: Medical Management	Sub-Department: Pharmacy	
Applies to Product Lines:		
<input type="checkbox"/> Medicaid	<input type="checkbox"/> USFHP	
<input type="checkbox"/> Children's Health Insurance Plan	<input type="checkbox"/> Commercial Insured	
<input type="checkbox"/> Health Insurance Exchange	<input type="checkbox"/> Non Insured Business	
<input checked="" type="checkbox"/> Medicare		
Origination/Effective Date: 01/03/2019	Reviewed Date(s):	Revision Date(s): 04/28/2020

DEFINITIONS AND ACRONYMS:

- **Appointment of Representative (AOR)** - A form (AOR Form-CMS 1696 or equivalent form) that may be used by a member to appoint a specific person as their representative to allow them to receive/give information or to start requests on the member's behalf.
- **Authorized Representative** - An individual either appointed by an enrollee or authorized under State or other applicable law to act on behalf of the enrollee in filing a grievance, requesting a coverage determination, or in dealing with any of the levels of the appeals process. Unless otherwise stated in part 423, subpart M of the Medicare Part D regulations, the representative has all of the rights and responsibilities of an enrollee in obtaining a coverage determination or in dealing with any of the levels of the appeals process, subject to the rules described in part 422, subpart M of the Medicare Part C regulations.
- **Centers for Medicare and Medicaid Services (CMS)**
- **Coverage Determination** - Any decision made by or on behalf of a Part D plan sponsor regarding payment or benefits to which an enrollee believes he or she is entitled. Types of coverage determinations:
 - Prior Authorization (PA) - Always Applies to All Members (Type 1 PA)
 - PA New Starts - Only-Applies to Members Not Currently Taking the Drug (Type 2 PA)
 - PA BvD - to determine if covered under Part D or Part B Medicare Benefit (Type 3 PA) - Administrative PA
 - PA Part DvExcluded – to determine if covered under Part D for the purposes of transition or otherwise.
 - Quantity Limit Exception (Type 1 is Maximum MDD, Type 2 is Quantity Over Time, morphine milligram equivalent (MME))
 - Step Therapy
 - Tiering Exception
 - Non-Formulary Exception
 - PA Exception
 - Step Therapy Exception
 - Direct Member Reimbursement (DMR)

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- **Enrollee/Member** - A Part D eligible individual who has elected a Part D plan offered by a Part D plan sponsor, also known as a beneficiary or member.
- **Formulary** – A formulary is a listing of medications covered under an enrolled member’s prescription drug benefit implemented in accordance with requirements set forth by the Centers for Medicare and Medicaid Services (CMS).
- **Grievance** – any complaint or dispute, other than a coverage determination or an LEP determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Part D plan sponsor, regardless of whether remedial action is requested. A grievance may also include a complaint that a Part D plan sponsor refused to expedite a coverage determination or redetermination. Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item.
- **Pharmacy Benefits Manager (PBM)** – Is most often a third-party administrator (TPA) of prescription drug programs. Responsibilities include processing and paying prescription drug claims and may include developing and maintaining the formulary, performing coverage determinations, MTM services, developing pharmacy networks/contracting with pharmacies, and negotiating discounts/rebates with drug manufacturers.
- **Redetermination** - The first level of the appeal process, which involves a Part D plan sponsor re-evaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.
- **Tier** - Typically, each Plan's formulary is organized into tiers, and each tier is associated with a set copay amount. Most formularies have between 3 and 6 tiers. The lower the tier, the lower the copay amount. For example, Tier 1 might include all of the Plan's preferred generic drugs, and each drug within this tier might have a copay of \$5–10 per prescription. Tier 2 might include the Plan's preferred brand drugs with a copay of \$40–\$50, while Tier 3 may be reserved for non-preferred brand drugs which are covered by the plan at a higher copay level - perhaps \$70–\$100. Tiers 4 and higher typically contain specialty drugs, which have the highest copays because they are generally quite expensive.
- **Utilization Management (UM)** – UM shall refer to any clinical, safety, or cost containment edits applied to formulary drugs including but not limited to Prior Authorization (PA), Step Therapy (ST), and Quantity Limits (QL).

PROCEDURE:

The following describes CHRISTUS’ oversight process of the Pharmacy Benefit Manager (PBM) delegated operation of member call center. This process is to ensure Medicare members receive accurate and factual information and are provided with their rights as a Medicare Part D enrollee on CHRISTUS’ behalf including but not limited to: eligibility, CHRISTUS’ formulary and benefit information; coverage determinations, exceptions and appeals processes; network pharmacies and providers; and grievance process.

- A. CHRISTUS receives the Medicare Call Log report by 8 a.m. daily via secure email from CHRISTUS’ PBM account manager for member calls that occurred the day prior. Call logs are titled “eSD Call Log YYYY-MM-DD”.
- B. CHRISTUS has assigned a pharmacy technician to review the call log report. A second CHRISTUS pharmacy staff member is trained as a back up when the primary technician is unavailable.

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- C. The CHRISTUS reviewer targets members calling customer service requesting coverage or reimbursement of a medication, appealing a previous coverage determination decision or expressing dissatisfaction about processes and services related to Medicare. The CHRISTUS reviewer specifically focuses on members who have a rejected pharmacy claim within 7 days of the call date or who have received a denial for a coverage determination request within the previous 60 days.
- D. The CHRISTUS reviewer documents all questions or issues identified during the review of the call log report on the call log tracking document and sends them timely to the PBM for further research or resolution.

Questions or issues may be triaged to different PBM teams and will have different turnaround timeframes as noted below.

- E. CHRISTUS sends any of the below listed issues to the PBM's Issue Resolution Team at IssueResolution@express-scripts.com and CHRISTUS Account Manager.
 - 1. Mail/retail benefit questions, prior authorizations, mail order home delivery questions, emergency fills, outreach to MD for coverage determinations or urgent issues.
 - 2. Response time is 2-4 hours based on level of urgency.
 - 3. CHRISTUS may also call the PBM's Issue Resolution team at 1-888-848-4452.
- F. Call summary requests are also sent to the PBM's Issue Resolution Team and the PBM will provide a response in accordance with the following timeline:
 - 1. Response time is 24 hours. Timeframe for call pulls, timeline of events or call summaries is 1 week.
 - 2. CHRISTUS may also call the PBM's Issue Resolution team at 888-848-4452.
- G. If the CHRISTUS reviewer cannot determine if the member needs a Coverage Determination from the information provided from the PBM, CHRISTUS will reach out to the member and prescribing physician to make a determination.
- H. If it is determined by the member that a Coverage Determination is needed, CHRISTUS will call the PBM's Client Helpdesk to initiate the coverage determination process as outlined below.
- I. If it is determined by the prescribing physician that a coverage determination or redetermination is needed, CHRISTUS will accept the coverage determination request verbally from the prescriber's office or warm transfer the prescriber's office to the PBM's coverage determination team at 1-800-935-6103. Coverage determinations are sent to the PBM's Coverage Determination team and redeterminations are sent to the CHRISTUS Appeals and Grievance department to initiate the process as outlined below.
 - 1. If the provider prefers to initiate the request via fax or e-script, CHRISTUS will provide the necessary information and phone numbers to the prescriber.
 - 2. If the prescriber requests a faxed prior authorization form, CHRISTUS will send completed MA PA form to prescriber's office via fax.
- J. Identified coverage determination requests are sent via email to the PBM's Coverage Determinations team via the account manager. For urgent requests, CHRISTUS will call the PBM's coverage determination team to initiate the request.
 - 1. Send information to the account team. The CHRISTUS reviewer includes all necessary information for the coverage determination including but not limited to member name, ID number, name of the

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- requested drug, type of request (standard versus expedited) and the date and time of the original member call.
2. Account team will engage the coverage determinations team.
 3. Resolution timeframe is dependent on the urgency of the coverage determination start time, which is based on the time of the original call from the member-to-member services.
- K. Identified requests for redeterminations and grievances are forwarded to the CHRISTUS Appeals and Grievance department via email to the appeals and grievance manager and the group appeals and grievance mailbox at Christus.hp.appealsandgrievances.org.
1. The CHRISTUS reviewer sends the necessary information to process the redetermination or grievance including but not limited to member name, ID number, name of requested drug or description of grievance, and the date and time of the original member call.
 2. CHRISTUS Appeals and Grievance department will process the redetermination or grievance in accordance with the required Medicare timeframes.
 3. The start time of the appeal or grievance is the time of the original call from the member to member services.
- L. All outreach and research performed by CHRISTUS and PBM is documented on the call log tracking document and stored on the CHRISTUS Pharmacy drive under the appropriate Call Log Medicare reports folder.

RELATED DOCUMENTS:

None

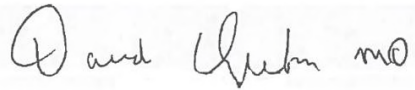
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REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	01/03/2019	Initial release.	Executive Leadership
A	04/28/2020	Annual review. No change to policy content. Made minor grammar corrections.	Executive Leadership