Who is Geisinger?

- Integrated health system
  - Clinical side
    - 12 hospital campuses
    - 1,600 employed physicians
    - 30,000+ employees
  - Health Plan
    - All lines of business
    - 580,000+ members
    - 110 hospitals
    - 30,000+ primary care and specialist providers

Agenda

- Regulations
  - Understanding the Centers for Medicare and Medicaid Services (CMS) expectations
- Assessment
  - Determining the risk for your company
- Actions
  - Improving processes to increase accuracy
- Monitoring
  - Establishing routing activities to measure compliance
Regulatory expectations

- 2016 CMS fall conference included a session dedicated to review results and outline expectations
- Complaints and congressional inquiries led to pilot audit
- Focus on accuracy
  - Marketing to prospective members
  - Informed decision making
  - Ability to contact providers
  - Network availability standards

CMS audits

- 2016 round one audit
  - February through August
  - 54 parent organizations
  - 108 providers per organization
- Provider focus
  - Primary care providers
  - Oncologists
  - Ophthalmologists
  - Cardiologists

CMS review elements

- Provider name
- National Provider Identification (NPI)
- Provider specialty
- Practice name
- Phone number
- Street address
- Does the provider work at the location?
- Is the plan accepted at location?
- Is the provider accepting/not accepting new patients?
Review process – phase 1

Phase 1
- Up to three calls made to providers
- Results shared with sponsor
- Sponsor must respond within 2 weeks (concur/non-concur/both)
- CMS review, additional calls as needed to make final determinations
- Plan sponsor has 30 days to make all required corrections

Review process – phase 2

Overall results: 45.1% inaccurate
- CMS validates corrections
- Online directories
  - Health services delivery tables

Audit results – ‘weighted deficiency score’ based on severity

<table>
<thead>
<tr>
<th>Audit Result</th>
<th>Weighted Deficiency Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider name needs updated</td>
<td>0 points</td>
</tr>
<tr>
<td>Specialty needs updated</td>
<td>1 point</td>
</tr>
<tr>
<td>Provider is accepting new patients</td>
<td>1 point</td>
</tr>
<tr>
<td>Suite number in address needs updated</td>
<td>1 point</td>
</tr>
<tr>
<td>Address needs updated</td>
<td>2 points</td>
</tr>
<tr>
<td>Provider is not accepting new patients</td>
<td>3 points</td>
</tr>
<tr>
<td>Phone number needs updated</td>
<td>3 points</td>
</tr>
<tr>
<td>Provider should not be listed in the directory at this location</td>
<td>3 points</td>
</tr>
</tbody>
</table>
How is the weighted deficiency score calculated?

- Maximum deficiency score example
  - Provider locations x 3
  - 120 provider locations x 3 = Maximum deficiency score of 360

- Weighted final deficiency score example
  - Sum of location deficiency scores/maximum deficiency score
  - 45 / 360 = Final deficiency score of 12.5%

Phase one audit results

<table>
<thead>
<tr>
<th>Parent organizations</th>
<th>Deficiency score range</th>
<th>Compliance action</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>1.77% to 4.63%</td>
<td>No action taken</td>
</tr>
<tr>
<td>31</td>
<td>19.66% to 39.48%</td>
<td>Notice of non-compliance</td>
</tr>
<tr>
<td>18</td>
<td>41.27% to 58.79%</td>
<td>Warning letter</td>
</tr>
<tr>
<td>3</td>
<td>65.08% to 70.75%</td>
<td>Warning letter with business plan requested</td>
</tr>
</tbody>
</table>

Regulatory expectations

**State level**
- Pennsylvania (Notice 2015-07 46 Pa.B. 5744)
  - Pennsylvania law prohibits unfair or deceptive acts or practices by insurers, including publishing or circulating an advertisement, announcement, or statement which is untrue, deceptive, or misleading. If a person receives health care services from a provider listed in the insurer’s provider directory as in-network, and the insurer then attempts to settle that claim as if the provider were out-of-network, her department will consider this to be an unfair claim settlement practice.

- New Jersey (§11:24C-4.6 Standards for accuracy of provider directory information)
  - Carriers shall confirm the participation of any provider who has not submitted a claim for a period of 12 months or otherwise communicated with the carrier in a manner evidencing the provider's intention to continue to participate in the carrier's network and for whom no change in provider status has been reported by CAQH.
Assessment

- How often is your online directory updated?
- Is there a process in place to make updates?
- Do you have any providers listed at more than six locations?
- Have you received any member complaints?
- How many providers have not filed a claim within the last 12 months?
- Call providers randomly
  - Compare information to what is online and verify that it is being reviewed by CMS

Actions for improvement – start now!

Direct provider outreach

- Provider outreach
  - Vendor services (call centers or those offering full range of solutions)
  - Health plan alliance-type organizations
  - Call blitz: contact all network providers
- Challenges
  - Accuracy of third party information
  - Time-consuming
  - Inconsistent information depending on who you speak to at providers office
Creating tools and processes

- Create tools and develop processes to update information
  - Instruct front-line phone contact center to verify provider information upon receiving calls
  - Give providers the ability to update info via a web portal
  - Require confirmation of information at each logon
- Challenges
  - Dependent on providers initiating contact

Direct mail

- Hard copy direct mail reminders
  - Include in provider communications
- Challenges
  - Static communication
  - Does not require provider action

Provider orientation

- Update and/or highlight new provider orientation
  - Presentations and hard copy materials
  - Stress importance of updated/correct directories
- Challenges
  - Time between orientation and any changes
    - Amount of information distributed at orientation
    - Dependent on provider action
Utilizing claim information

- Develop reporting to identify providers with zero claims activity over the past 12 months
- Contact providers to verify network status
- Remove providers who do not respond

Challenges
- Time consuming to develop reports and send letters via mail
- Costly (especially if sending via certified mail for no first response)

Correcting addresses

- Develop process to contact providers with incorrect address (returned mail, incorrect fax number, etc.)
  - Notify employee(s) responsible for accuracy of returned mail or fax
  - Utilize alternative information such as e-mail and phone

Challenges
- Timeliness
- Manual process
- Limited alternative information

Updating contractual language

- Update contractual language
  - Include provision to hold provider financially responsible for any compliance actions taken by regulators, including monetary reimbursement

Challenges
- Provider acceptance
- Legal costs associated with contract changes and enforcement
Verifying contact information

• Verify contact information whenever a provider calls with a prior authorization request
  – Modify call scripts to gather information at the beginning of every call
• Challenges
  – Additional time on phone for staff
  – Provider discontent

Audit readiness for immediate improvement

Focus on updating areas highlighted by CMS

• Cardiology
• Oncology
• Ophthalmologists
• Primary care

Perform call blitz activities

Monitoring

• Communication
  – Compliance and audit staff call providers weekly to verify information
  – Develop process to notify provider network team of changes
  – Improve communication channels
• Tracking and reporting
  – Implement tracking system to identify providers that have not been contacted
  – Report results via metrics
  – Mimic CMS scoring
References/Resources

- November 13, 2015 CMS Memo “Provider Directory Requirements – Update”
- May 26, 2016 CMS Memo “Continued Monitoring of Medicare-Medicaid Provider and Pharmacy Directories”
- September 8, 2016 HPMS E-mail “Follow Up to the MMP Provider and Pharmacy Directory Technical Assistance Webinar”
- January 13, 2017 HPMS E-mail “Release of CMS’s Online Provider Directory Report and Supporting Data”
- January 17, 2017 CMS Memo “Provider Directory Policy Updates”

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Questions?