Managing the MCO-Provider Relationship: It’s More than Just PHI

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Managed Care Compliance Conference
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Overview
1. Provider & Contracting Teams as Compliance
2. Legal Changes – Stark, False Claims Act
3. Cyber Security & IT Challenges in the Provider-Payer Relationship
4. Pharmacy
5. Provider Perspectives – Patient Engagement
6. Value-Based Purchasing Models
7. Medicaid and CHIP Final Rule: Mega-Reg
8. Political Changes

Provider & Payer Relations
- Providers and Payers traditionally have limited themselves to provide and pay transactions.
- The relationship may at times be mistrustful and potentially contentious.
- To improve care, a shift towards collaboration is necessary.
- Legislative changes, such as the Medicaid “MegaReg” promote this engagement approach.
Where Compliance Fits In

- Payers often focus on selling insurance, thinking this will maximize profits, and checking the compliance boxes for the business
- Fragmented Payer Operations can lead to more communication and compliance challenges
- Providers focus on care, seeing payers as intervening in patient care.
- Compliance adds quality, fewer errors, and lower costs
- Communicate organizational objectives to staff & how compliance plays a role
  - Improve organizational standards of integrity in reporting inappropriate conduct, fraudulent activities, and abusive patterns.
- Payers and Providers have similar interests and shared goals

Provider Relations Achieving Compliance Goals

Provider Records:
- Increase accuracy
- Engagement with the portal

Provider records and directory accuracy

Engage providers to retain them in network for adequacy

Quality withhold measures achieved by engaging providers – incentives

Contracting as an Ally

- Ensure contracting incentives don’t appear to be kick-backs or violate federal statutes
- Incentivize compliance with Control Interest Statement Forms
- Opportunity to interface and establish relationship.
- Engage with provider to show them information
  - Required compliance training
  - Identify resources
  - Educate on fraud and abuse consequences.
- Beginning, not the end of the relationship
False Claims Act

• 31 U.S.C. §§ 3729–3733 requires actual knowledge, reckless disregard, or deliberate ignorance in communications with government.


  **New Standard for Implied Certification**

  (1) The implied false certification theory - liability under the FCA when a defendant submitting a claim makes specific representations about the goods or services, but fails to disclose non-compliance with material statutory, regulatory, or contractual requirements that make those representations misleading; and

  (2) Liability under the FCA for failing to disclose violations of legal requirements does not turn upon whether those requirements were expressly designated as conditions of payment.

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False Claims Act Continued

• *United States ex rel. D’Agostino v. Ev3, Inc.*, 2016 BL 429304, 1st Cir., No. 16-1126, 12/23/16
  - Case dismissed on basis of Universal Case.

• Large Dollar 2016 FCA Cases
  - Pfizer $413 Million
  - Novartis $390 Million
  - Olympus $267 Million
  - Tenet $244 Million

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Stark Law

"If a physician (or an immediate family member of such physician) has a financial relationship with an entity... then the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made" under Medicare and to some extent Medicaid.

-Social Security Act § 1877; 42 U.S.C. § 1395nn

"Financial relationship" is defined as any direct or indirect (a) ownership or investment interest or (b) compensation arrangement by or between a physician (or an immediate family member of the physician) in the entity providing the designated health service (DHS).
Stark Law Changes January 1st, 2017 Compliance

- Physician Owned Hospitals:
  - An indirect ownership or investment interest in a hospital exists if:
    1. between the owner or investor and the hospital there exists an unbroken chain of any number of persons or entities having ownership or investment interests; and
    2. the hospital has actual knowledge of, or acts in reckless disregard or deliberate ignorance of, the fact that the owner or investor has some ownership or investment interest (via intermediary) in the hospital.
- Unit-based compensation in arrangements for the rental of office space or equipment
  - Results in no change to the law as it is currently implemented
  - Per-use of click fees.

Cybersecurity is not HIPAA


- “HHS’s guidance does not address how covered entities should tailor their implementations of key security controls identified by the National Institute of Standards and Technology to their specific needs.”
- HHS does not fully verify regulations implemented
- HHS has agreed and will take action to update its guidance for protecting electronic health information to address key security elements, improve technical assistance provided to covered entities, follow up on corrective actions, and establish metrics for gauging the effectiveness of its audit program.

OMB Guidance
- NIST SP 800-53 SC-5: Denial of Service Protection: requires management of excess capacity to counter flooding attacks
- NIST SP 800-53 AT-2: Security Awareness Training: requires training of employees to spot phishing scams

DOD Context
- NIST SP 800-171 required implementation by December 31, 2017: Guidelines regarding cybersecurity measures for defense contractors — flowdowns to critical support subcontractors.

Cyber Security & Mobile Health

- FDA issued final guidance on Postmarket Management of Cybersecurity in Medical Devices December 27th.
  - “Medical device cybersecurity is a shared responsibility among stakeholders including health care facilities, patients, providers, and manufacturers of medical devices…”

- Since covered entities retain individual responsibility, this has created a “tragedy of the HIPAA commons”
  - Larger Entities – Payers, Integrated Health Systems will need to take the lead
Simple Tools to Mitigate IT Risk

- Secure Send Portal (including making available commercial products for provider & contractor's use)
- Fax Number Audit
- Educate Providers on best practices – training of smaller practitioner offices
- Hotline disclosure
- Workstation Access
- Mobile Devices
- HEDIS "Chart Chase" USB Scanning for viruses
- Data Backups

Technological Tools

- Engage with health systems to work with their IT departments regarding guidelines. Engage providers in the development of guidelines.
- Ongoing Segment Reviews or soft internal audit reviews of your departments
  - Often you don’t have to go too far to discover gaps/compliance risks
  - Provider Relations in MCOs can then also review their relationships with providers under a similar external schema.
  - Providers can review the trail of communications with MCOs.

Pharmacy - MCO

- 340(b) Compliance – MCOs save money by having providers in the system
  - Costs are high, as are complexities, and incentives are low
  - Assistance construed as kickbacks, but saves money.
  - How to define value, act as purchaser, and create compliant incentives
- Any Willing provider States
  - Carefully craft quality standards – requires a strong relationship
- Automated voice and text reminders on phone – increased medication adherence and check-ups
  - TCPA implications for both pharmacies and managed care.
Provider Perspectives

The MCO and provider relationship is much like a therapist and patient.

- Trust
- Need for shared goals
- Clear communication
- Desire to look for the best fit

Providers Often Don’t See Value Created

- Large providers are increasingly frustrated with the myriad of MCOs in states with several MCOs.
- Administrative burdens seen as onerous and duplicative
  - Compliance forms, trainings, and more for multiple MCOs.
  - Uniform training and certification managed at State level alleviates burden.
- Medicaid Mental Health Reimbursement Rates are significantly below those of certain commercial plans
- Private Practitioners overwhelmingly eschew Medicaid patients
- MCOs need to create value for providers in narrow networks

Provider Perspectives
Policies – what you have and what you do

- Clearly document processes
- Inventory your policies, ensure they are compliant with operational efforts
- Clearly articulate your organization’s compliance policies with payers (and vice-a-versa) so the parties understand the systems, operational issues, and challenges each faces.
- Ensure processes are documented; helps compliance departments better understand organizational deficiencies and documents process

Meaningful Consumer Engagement Requires Collaboration

- Apps alone aren’t enough
  - CRM applications
  - Analytics
- Payers and providers can use similar strategies for consumer engagement
  - Payer - Historically a B2B strategy
- Compliance Challenges
  - Early identification of security risks
  - Train care providers/coordinators

Lower Cost and Improved Outcomes

Quality Provider Networks: Plans choose a selected network, which allows plans to recruit the most efficient and effective providers, and exclude high cost and low quality providers.

Financial Incentives Aligned with Clinical Best Practices: Pre-negotiated rates and services promotes efficient, effective care delivery. Incentive bonuses can be achieved if quality targets are met for MA plans. Global capitation care models with risk-adjusted annual PMPM rates encourage better outcomes at lower cost.
Compliance Tools and Techniques

- Active Care Management - Prevention
  - Data Analytics
  - Connected Devices
  - Disease Management
  - Discharge follow-ups.
- Collaborative tools can reduce costs, improve outcomes, and share information with providers of care.
- MCOs that demonstrate value to large provider organizations are likely to retain them in their networks.
- The sharing of data between organizations fraught with HIPAA risks can tremendously improve outcomes.
- Invest in the infrastructure to develop the technical solutions.

Aligning Resources

- Population health services organization (PHSO) - Lead on care coordination: common care plan and data analytics to refine care.
  - Multiple care team members can join the existing team.
  - Advisory Board developed model which is a team-based care coordination
  - Shared control & dollars.
  - Provider – Payer Partnerships where PHSO housed in provider organization.
- Engage care coordination teams from the MCO and health system to align messaging and create efficiencies.
  - Data Challenges + Legal Risks.
- Staff from MCO has been stationed at hospital to check on admissions
  - Medication compliance & Quality Withholds

Medical Waste and Inefficiencies Ongoing

An estimated $300 billion is wasted annually on unneeded and redundant medical tests, with another $150 billion lost to administrative waste.

It costs over $250 billion each year to process over 30 billion healthcare transactions, half of those being fake.
Value Based Payment Models

- State Contracts are increasingly requiring a significant shift towards value-based payments
- The Center for Medicare & Medicaid Innovation has encouraged this through demonstration projects
- Commercial Payers have demonstrated innovative payment strategies

Value for Providers, Payers, and Consumers in an Integrated payer/provider systems

Provider
- Improve Quality
- Reduce Costs
- Increase Revenue

Payer
- Ability to manage costs and proactively manage patients
- Sell insurance
- Deliver Improved Outcomes
- Care Coordination
- Care Management

Better Value
- Improved Disease Prevention
- Lower Costs
- More responsive to new payment models
- Improved Outcomes
- Manage System Costs
- Aligned Care Management and Care Coordination
- Eliminated Redundancies
- Enhanced Post-Discharge Coordination

Compliance in Value-Based Contracting
Meg-Reg

Aligns rules with those of other programs, modernizing how states purchase managed care for beneficiaries, and improves the consumer experience.

States must create network adequacy standards

National Medical Loss Ratio of 85%

Access to Care for Mental Health

QRS System similar to MA and CHIP Plans

Payment linked to delivered services or quality

Compliance Terms: 42 CFR parts 430 to 481

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Mega-Reg Compliance Highlights

**Plans who have a provider engagement strategy will be equipped to effectively comply:**

- Quality Rating System
  - Align with providers, engage key stakeholders (payers, providers, patients)
  - Coming in 2018
  
- July 1st, 2018: States Post on a Website
  - Accreditation status of managed care plans (Absence of Such)
  - State managed care quality strategy + Annual external quality review report

- States will have to develop a website that includes at a minimum:
  - The enrollee handbook, the provider directory, network adequacy standards, plan accreditation status, quality ratings for managed care plans, managed care quality strategies, and EQR technical reports.

- Directories 438.10(h) will include:
  - Provider names, addresses, telephone, cultural competency, ADA, specialty, accepting new enrollees.
  - Updated 30 days after receiving updated information – machine readable.
  - Formulary

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TRUMPCARE – A Better Way Changes

- ...MegaReg Modification Administratively without legislation
  - Tom Price may “pause” or eliminate parts of the MegaReg

- Block Grants
  - Payer – Provider Alignment

- Increase in wellness incentive programs – A Better Way
  - HHS nominee Tom Price also proposes this in his 2017 Balanced Budget Proposal
  - Payers and providers will work together on patient outcomes

- Waste, Fraud, Abuse, and Incentivizing Good Behavior
  - States will demand more from MCOs
    - MCOs in-turn asking more from providers
Implications of Political Changes

- Attorney General Nominee: Jeff Sessions
- Advocates for health care fraud task forces
- Faster DOJ investigations
- Higher qui tam settlements
- Managed Care Medicaid expansion continues
- Uncertainty for plans on exchanges
- Managed Medicaid may serve a larger role in some States.
- State Flexibility & Autonomy
- Patient Flexibility – Opportunities for Integrated Systems
  - Providers will hold power as consumers have choice

Questions and Contact

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Appendix
State Managed Care – VBP Contracts

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<thead>
<tr>
<th>State</th>
<th>Contract</th>
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<tbody>
<tr>
<td>New York</td>
<td>§438.608 (b) The annual report of overpayments as required in §438.608(d)(3)</td>
</tr>
<tr>
<td>South Carolina</td>
<td>§438.207(b) availability and accessibility of services, including the adequacy of the provider network as set forth in §438.206.</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>§438.602 (a) Documentation described in §438.207(b) on which the State bases its certification that the MCO, PIHP, PAHP, PCCM, or PCCM entity has complied with the State’s requirements for availability and accessibility of services, as set forth in §438.206.</td>
</tr>
<tr>
<td>Tennessee</td>
<td>§438.602 (d) §438.604. (5) The State must screen and enroll, and periodically revalidate, all network providers of MCOs, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E of this chapter. This requirement extends to PCCMs and PCCM entities to the extent the primary care case manager is not otherwise enrolled with the State to provide services to FFS beneficiaries. This provision does not require the network provider to render services to FFS beneficiaries.</td>
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July 1, 2017 MegaReg Implementation Measures

$438.207(b) Availability and accessibility of services, including the adequacy of the provider network

§438.021 (a) Ownership and control information. The State must review the ownership and control disclosures submitted by the MCO, PIHP, PAHP, PCCM or PCCM entity, and any subcontractors as required in §438.02(1).

§438.022 (b) Federal database checks. Consistent with the requirements at §455.436 of this chapter, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest.

§438.023 (b) Monitoring contractor compliance. Consistent with §438.02(4), the State must monitor the MCO’s, PIHP’s, PAHP’s, PCCM’s or PCCM entity’s compliance…

§438.04 (b) Information on ownership and control described in §438.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors as governed by §438.230.

§438.04 (c) The annual report of overpayment recoveries as required in §438.04(1)(1)

§438.06 (a) Administrative and management arrangements or procedures to detect and prevent fraud, waste

July 1, 2018 MegaReg Implementation Measures

$438.207(b) Availability and accessibility of services, including the adequacy of the provider network

§438.062 (b) Screening and enrollment requirements. The State, through its contracts with a MCO, PIHP, PAHP, PCCM, or PCCM entity must ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of part 455, subparts B and E of this chapter. This provision does not require the network provider to render services to FFS beneficiaries.

§438.063 (a) Provider screening and enrollment requirements. The State, through its contracts with a MCO, PIHP, PAHP, PCCM, or PCCM entity must ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of part 455, subparts B and E of this chapter. This provision does not require the network provider to render services to FFS beneficiaries.

1/4/2017

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<th>Title</th>
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<td>42 CFR §455.104</td>
<td>Disclosure of Control</td>
<td>State Medicaid agency must obtain disclosures from providers, fiscal agents and MC entities.</td>
<td>A person or entity that has at least a 5% or more direct, indirect or combined ownership interest must disclose their ownership.</td>
<td>Names/address of all persons or entities with ownership or control interest (includes direct and indirect ownership) • DBA and LLC (individuals) Tax ID (entities) • Includes information re: subcontractor in which the disclosing entity has a 5% or more interest • Includes information about familial relationships of owners • Includes names of other disclosing entities with same ownership.</td>
</tr>
<tr>
<td>42 CFR §455.105</td>
<td>Disclosure of Business Transactions</td>
<td>Ownership of any subcontractor with whom the provider has had business transactions.</td>
<td>Significant transactions</td>
<td>* Totaling more than $25K during the 12-month period ending on the date of the request. * Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.</td>
</tr>
<tr>
<td>42 CFR §455.106</td>
<td>Information on Persons Convicted of Crimes</td>
<td>Identity of any person with an ownership or control interest, agent, or managing employee who has been convicted of a crime.</td>
<td>Crime related to that person’s involvement with Medicare, Medicaid or CHIP program.</td>
<td>Disclosure of ownership, control, agent, or managing employee. * Conviction of criminal offense related to involvement in a Medicare, Medicaid, or CHIP program.</td>
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