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

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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

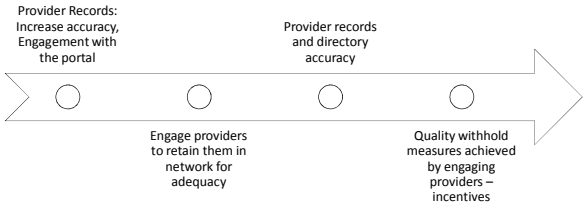
Provider & Payer Relations

- 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



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
- *Universal Health Services, Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989 (2016)

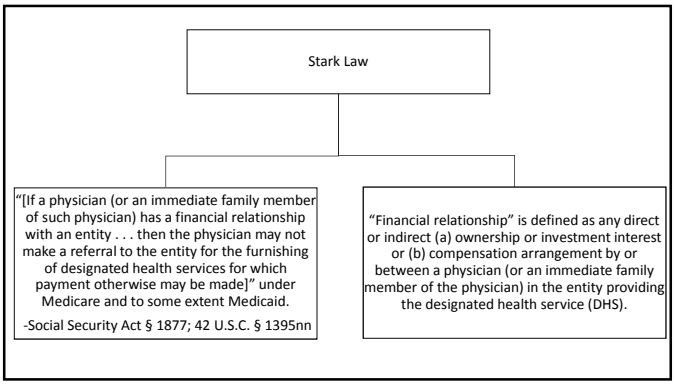
New Standard for Implied Certification

(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.

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



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

GAO-16-771: Aug. 2016, HHS Needs to Strengthen Security and Privacy Guidance and Oversight

- "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 if 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 it provides 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 emails

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

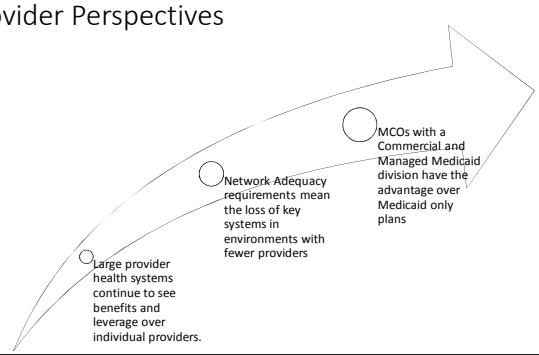
The MCO and provider relationship is much like a therapist and patient.

- 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

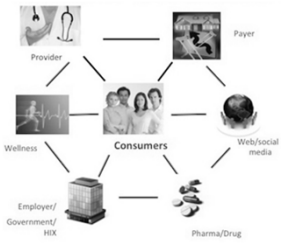


Policies – what you have and what you do

- 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

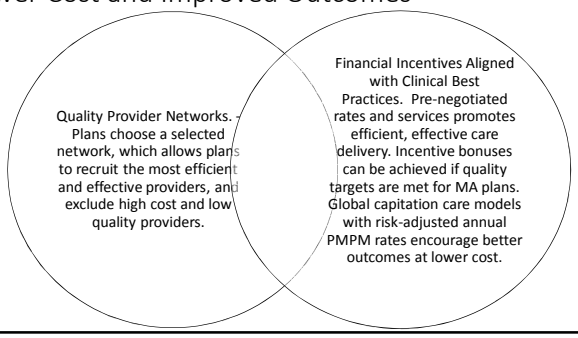
Meaningful Consumer Engagement Requires Collaboration

- 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



Source: IDC Health Insights

Lower Cost and Improved Outcomes



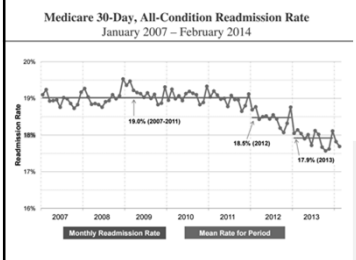
Compliance Tools and Techniques

- 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

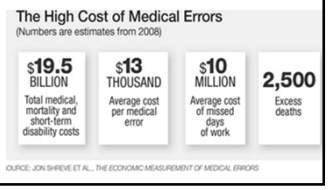
Medical Waste and Inefficiencies Ongoing



It costs over $250 billion each year to process over 30 billion healthcare transactions, ~half of those being faxes

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

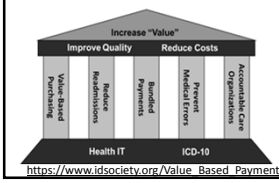
–Fisher, Elliott S.; Wennberg, David E., The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care.



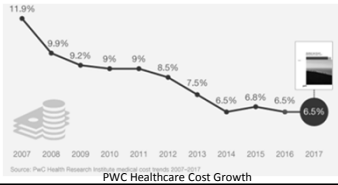
SOURCE: JON SHREVE ET AL., *THE ECONOMIC MEASUREMENT OF MEDICAL ERRORS*

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

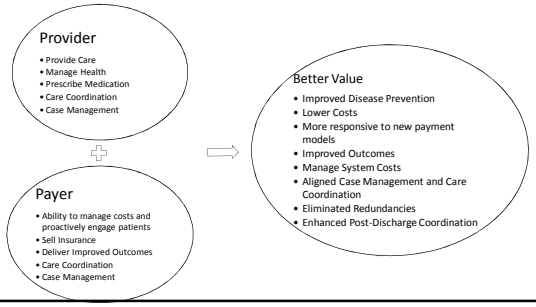


https://www.idsociety.org/Value_Based_Payments/

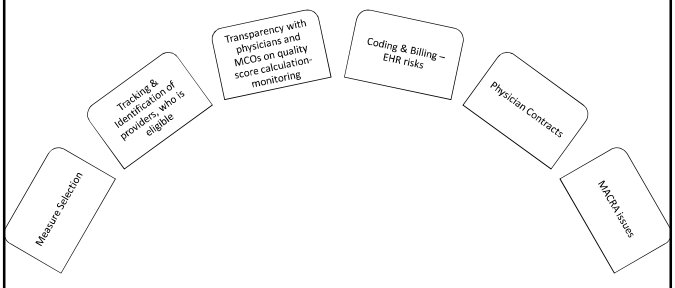


PWC Healthcare Cost Growth

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



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

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

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

A BETTER WAY to fix HEALTH CARE

Questions and Contact

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Appendix

State Managed Care – VBP Contracts

State	Contract	Value-Based Payment Mechanism
Arizona	A minimum of 20 percent of the value of total prospective payments, VBP and non-VBP, contracted and non-contracted, must be governed by VBP strategies for the measurement year. AHCCCS expects the minimum value threshold to grow each year	• Value-oriented contracting target of 20%,+ health plans have flexibility in determining the arrangement, but value-based payments are defined as being in fields such as primary care incentives, performance-based contracts, bundled/episode payments, shared savings, shared risk, and capitation plus performance-based contracts. • MCOs compete for incentive payments based on performance. • Value Based Purchasing Initiative
New York	80–90% of managed care payments to providers using value based payment methodologies by end of demonstration year five (DY 5)	**A Path toward Value Based Payment** (June 2016) • Slow movement towards value: • 80-90 percent of all provider payments in value-based payment models by 2020, and 35% covered in risk-based arrangements
Tennessee	2.9.6.13.5.10 The ability to provide system-generated reporting regarding each provider's compliance with scheduling requirements, late and missed visits, and other data specified by TennCare for purposes of a provider report card and value-based payment approach;	• Standard payment model across State: PCMH and Episode of Care payment mechanisms • CMMI: State Innovation Model Initiative State • Multipayer model required for all MCOS with standard performance metrics.
Minnesota	Quality Strategy: "Did the delivery system provide care and services in the appropriate quantity, quality and timing to realize the maximum attainable health care improvement at the most advantageous balance between cost and benefit?"	• Standard payment model across State: Shared Savings and risk payment model with Integrated Health Partnerships, ACO-like entities. • CMMI: State Innovation Model Initiative State • Value Based pilot project with Integrated Care System Partnerships for dual eligible population, across MCOs, primary, acute, long-term care, and mental health providers. • MCOs submit proposals and quality metrics for State approval
Pennsylvania	RFP: Describe initiatives or processes your organization already has in place to support a movement toward increasing Value Based Purchasing (VBP) strategies within your network contracts?	• Specific Percentage of Provider Payments tied to Value-Based Payments: • physical health managed care program, 2% withhold if less than 7.5% of medical capitation and maternity revenue expended via VBP in 2017;
South Carolina		• Value-oriented contracting target, with 20% in 2017, plans have flexibility.
New Mexico		• VBP projects, encompassing specific goals, payment models, and provider partners. The state would require MCOs to submit VBP proposals for input, review, and approval. State used these to develop quality and cost metrics and created a template for reporting

July 1, 2017 MegaReg Implementation Measures

§ 438.207(b)	availability and accessibility of services, including the adequacy of the provider network
§ 438.602	(c) *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 § 438.608(c)
§ 438.602	(d) *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
§ 438.602	(a) *Monitoring contractor compliance.* Consistent with § 438.66, the State must monitor the MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's compliance…
§ 438.604.	(5) Documentation described in § 438.207(b) on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in § 438.206.
§ 438.604	(6) Information on ownership and control described in § 455.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors as governed by § 438.230.
§ 438.604	(7) The annual report of overpayment recoveries as required in § 438.608(d)(3)
§ 438.608	(a) *Administrative and management arrangements or procedures to detect and prevent fraud, waste*

July 1, 2018 MegaReg Implementation Measures

§ 438.602	(b) *Screening and enrollment and revalidation of providers.*	(1) 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.	(2) MCOs, PIHPs, and PAHPs may execute network provider agreements pending the outcome of the process in paragraph (b)(1) of this section of up to 120 days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider, and notify affected enrollees.
§ 438.608	(b) *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.	

Provider Compliance Information Sent to States

Regulation	Title	Summary	Disclosure	Details
42 CFR §455.104	Disclosure of Control	State Medicaid agency must obtain disclosures from providers, fiscal agents and MC entities	a person or entity that has at least a 5% or more direct, indirect or combined ownership interest must disclose their ownership.	• Name/address of all persons or entities with ownership or control interest (includes direct and indirect ownership) • DOB and SSN (individuals); Tax ID (entities) • Names, addresses, DOB, SSN of any "managing employees" of disclosing entity (officers, directors, etc.) • Includes information re: subcontractors 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
42 CFR §455.105	Disclosures: business transactions	Ownership of any subcontractor with whom the provider has had business transactions	Significant business transactions	• Totaling more than $25K during the 12- month period ending on the date of the request; and • 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
42 CFR §455.106	Information on persons convicted of crimes	Identity of any person with an ownership or control interest, agent, or managing employee who has been convicted of a crime	Crime related to that person's involvement with Medicare, Medicaid or CHIP programs	• Disclose ownership, control, agent, or managing employee. • Conviction of criminal offense related to involvement in a Medicare, Medicaid, or CHIP program.