Managed Care/Enforcement in Compliance
HCCA Annual Regional Conference - Lake Buena Vista, FL
February 2, 2018

Agenda

Topic	
Meet your speakers	
What is compliance enforcement?	
What are enforcement penalties?	
Focus areas of enforcement	
Provider directories	
Provider outreach	
Plan-directed care	
Q&A	

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Meet your speakers

Kim Ramey
Specialist Leader
Deloitte Risk and Financial Advisory
Deloitte & Touche LLP

Kim Ramey has over 20 years of experience in the health care industry in the areas of revenue cycle management including charge capture; coding (CPT, HCPCS, ICD-9, and ICD-10), billing and reimbursement; compliance, internal audits and regulatory risk. Most recently, Kim has served as interim compliance officer for multiple hospitals in a large health care system. Kim has developed and assisted in implementation of multiple compliance programs in large health care systems and academic medical centers. Prior to joining Deloitte, Kim served as the Chief Compliance Officer for a national leading provider of home-delivered diabetes testing supplies, mail order prescription medications and other Durable Medical Equipment (DME) products to eligible patients. Kim has assisted clients with developed and implemented the Corporate Compliance and Ethics Program and led provider through Corporate Integrity Agreement mandates.
Kim is a Registered Health Information Administrator (RHIA) and maintains her credentials through the American Health Information Management Association (AHIMA), of which she is an active member.

Dan Seifried, CIA, CFE
Manager
Deloitte Risk and Financial Advisory
Deloitte & Touche LLP

Dan is a Manager in Deloitte & Touche LLP's Life Sciences and Health Care practice, specializing in consulting for health plans with more than 13 years of experience in consulting and the health care/plan space. Dan has extensive experience in compliance program implementation, execution and oversight; compliance program effectiveness reviews; delegated entity compliance program implementation and oversight; vendor oversight and auditing; government program mock audit ands; risk and control implementation and assessment; process review improvement (standard business and Medicare core processes); auditing; monitoring and quality assurance.

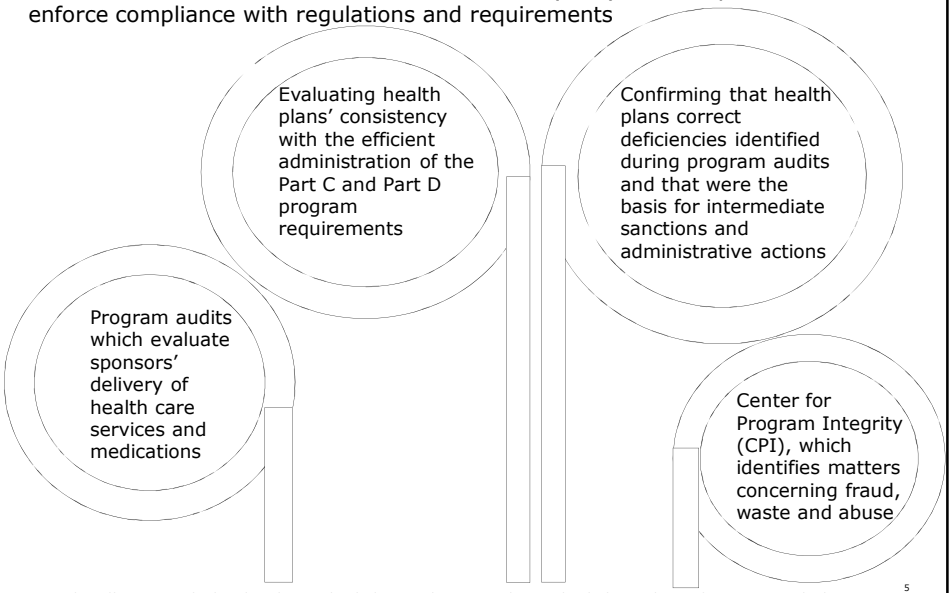
Getting to know the audience

What type of organization do you work for?

a) Hospital or health system
b) Independent physician practice
c) Other health care provider or supplier
d) Health insurance company
e) Pharmacy benefit manager (PBM)
f) Other third-party firm

What is compliance enforcement?

The Centers for Medicare and Medicaid Services (CMS) has many mechanisms to enforce compliance with regulations and requirements



Source: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html

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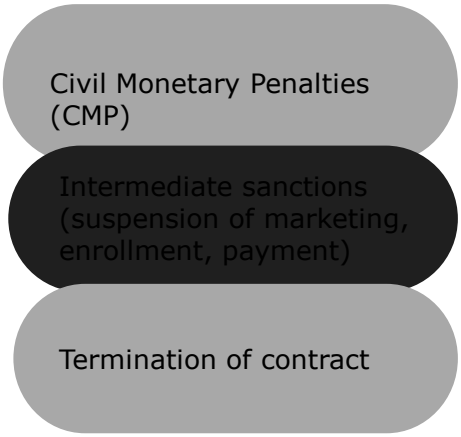
What are compliance penalties?

CMS has a wide-ranging disciplinary measures at their disposal when enforcing compliance



Source: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/2016_Program_Audit_Enforcement_Report.pdf

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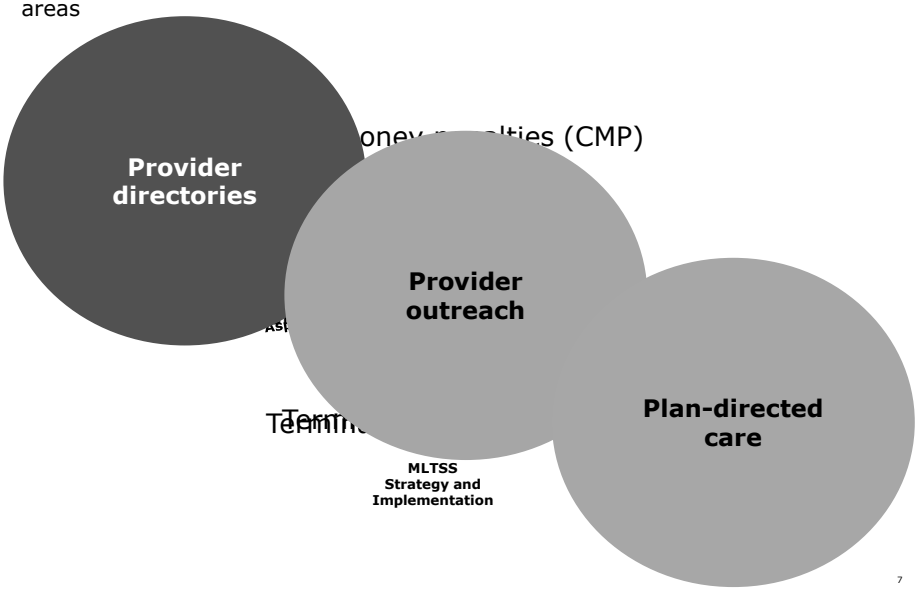
Focus areas of enforcement

During the last several audit periods, CMS has honed in on several enforcement areas



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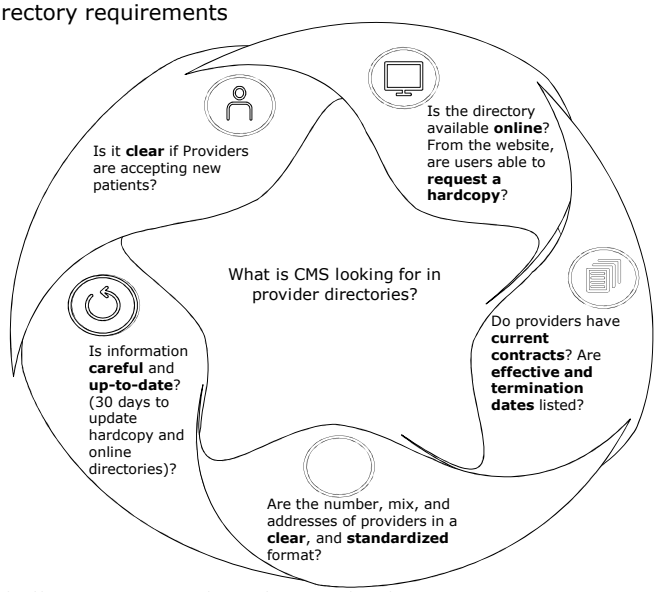
Provider directories: Background

CMS issued a memorandum, January 17, 2017, reiterating guidance related to provider directory requirements



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Source: Department of Health & Human Services Memorandum, Provider Directory Policy Updates, January 17, 2017

Provider directories: Background (cont'd)

Provider directory accuracy remains a focus of CMS audit and oversight activities

Provider directories are required to provide:

- provider's name
- address(es)
- telephone number(s)
- specialty area(s)
- hospital affiliation
- language(s) spoken
- whether new patients are being accepted

CMS found that **45%** of directories contained inaccuracies[1]

CMS is able to fine health plans up to **$25,000** per Medicare beneficiary for errors in Medicare Advantage Plan directories[2]

Source: 1) http://managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/inaccurate-provider-directories-create-barriers-care; 2) http://managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/inaccurate-provider-directories-create-barriers-care

Provider directories: Prospective

Maintenance of provider directories has a significant impact on both health plans and providers

Provider Perspective	vs	Health Plan Perspective
• Difficult to establish **communication preferences** due to **undefined communication expectations** • **Reporting burden**; too many health plans to notify • Failure to recognize **role** in proper maintenance, **access to care** issues, and **patient dissatisfaction** • Inaccuracies may lead to higher **administrative costs**		• **Dynamic** provider information may makes maintenance difficult • Inflated numbers of **provider practice locations** may lead to **access to care** issues • **Limited resources** may restricts ability to compare provider directory data • Historical reliance on **credentialing** services and vendor support • Inaccuracies may lead to consumer **dissatisfaction and confusion**

Provider directories: Proactive approaches

Maintaining careful provider directories requires cooperation from both health plans and providers

Routine Oversight and Monitoring
of online and hardcopy directories should be performed by both health plans and providers for accuracy

Hotline Number
which may likely put enrollees/plan staff in direct contact with providers if they discover an error or have a question

Provider Newsletter,
which may likely be frequently sent, reminding staff of requirements

Contractual Agreements,
which include provisions and penalties surrounding relaying careful and timely provider directory data, should be maintained between health plans and providers

Leverage Internal Data,
which is already available to health plans (such as claims), to update directories

Data Repositories
where providers and health plans, after proving their identify, could compare and update their information

Provider outreach: Background

CMS audits continue to focus on and evaluate processes surrounding outreach by health plans

Health plans should consider making reasonable efforts to obtain required information, including medical records documentation, from the enrollee's provider if they do not have the information needed to make a coverage decision

Health plans are required to conduct outreach within the applicable adjudication timeframe and to document their efforts

Outreach

"Sponsor did not demonstrate sufficient outreach to prescribers or beneficiaries to obtain additional information…" was on the list of five most commonly cited conditions in 2016's Program Audit Enforcement Report (for both CDAG and ODAG)[1]

On February 22, 2017, CMS wrote a memorandum, updating guidance on outreach for information to support coverage decisions[2]

Source: 1) https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/2016_Program_Audit_Enforcement_Report.pdf 2) Department of Health & Human Services Memorandum, Updated Guidance on Outreach for Information to Support Coverage Decisions, February 22, 2017

Provider outreach: Background (cont'd)

CMS clarified guidance and leading practices regarding outreach by health plans

Organization Determinoations, Appeals & Grievances (ODAG)

	Timeframe	# Attempts
Standard Organization Determinations (OD) - Payment	30 days	3
Standard OD – Pre-Service	14 days	3
Expedited OD	72 hours	3
Standard Reconsiderations (RC)	30 days (pre-service) 60 days (payment)	3
Expedited RC	72 hours	3

Coverage Determinations, Appeals & Grievances (CDAG)

	Timeframe	# Attempts
Coverage Determinations (CD) - Payment	14 days	3
Standard CD - Benefits	72 hours	3
Expedited CD	24 hours	3
Standard Redeterminations (RD)	7 days	3
Expedited RD	72 hours	3

- **Timing of Outreach Attempts**, varies (between a day to 4 days) depending upon type of coverage decision
- **Ways of Contact,** should differ to increase the likelihood of making contact with the provider
- **Methods for Requesting Information,** should vary depending on the type of request and the adjudication timeframe (i.e. telephone, fax, email, mail)

Source: Department of Health & Human Services Memorandum, Updated Guidance on Outreach for Information to Support Coverage Decisions, February 22, 2017

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Provider outreach: Prospective

Health plans and providers both have a different perspective on addressing the enforcement trend related to provider outreach

Provider	vs	Health Plan
• Providers are not trained on **health plan requirements** • **Administrative** burden • Lack of **accountability/ incentive** • Not having a **centralized person or group submitting/responding to** requests for coverage (lack of institutional knowledge) • Defective outreach may leads to limited **access to care**, increased **administrative costs** and patient **dissatisfaction**		• Reliance on receiving **timely responses** from providers • Inadequate **quality processes** to confirm outreach processes • Making coverage decisions on **limited information** • Increased **administrative** costs, **appeal rates** and consumer **dissatisfaction** • Incomplete **policies/procedures** and **inadequate resources** to conduct outreach results in not meeting CMS expectations

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Provider outreach: Proactive approaches

Obtaining the information required to make coverage decisions is a two-way relationship, and health plans and providers should work together to achieve a common goal

	**Contractual relations** between health plans and providers which allow health plans to obtain requested documentation from contracted providers in a reliable and timely manner
	**Provider preferred methods/times of contact** should be recorded and updated on regular basis
	**Review enabling tools**, including technology, dashboards and performance indicators which track and monitor outreach effectiveness with providers and provide recommendations to enhance program monitoring
	**Establish automated tools**, which help document outreach attempts and manage workflow

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Plan-directed care: Background

There has been an increase in the number of health plans receiving audit findings related to plan-directed care

Who?	What?	How?	Why?
• **Members** receive **direction from a plan-contracted** physician (which CMS considers a health plan representative)	• **Care** a member believes he or she was **instructed to obtain** • CMS requires health plans to **pay for plan-directed care** (except for items or services which are not covered, or if a member notified in advance of an adverse coverage)	• Member **receives care** from a out-of-network provider or physician at the direction of his/her primary care physician or network specialist • Claim is rejected and service not covered when submitted by the out-of-network provider	• Neither provider nor enrollee **request a pre-service organization determination** from health plan

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Source: Medicare Managed Care Manual Chapter 4 – Benefits and Beneficiary Protections

Plan-directed care: Prospective

Health plans and providers should consider jointly assume responsibility for minimizing unapproved out-of-network referrals

Provider	vs	Health Plan
• Participating providers should consider be aware of the **network status** of physicians and facilities • Lack of **resources** to determine if providers are in-network • Providers are not trained on **health plan requirements** • Lack of **accountability/ incentive** • **Loss of patients** due to confusion and stress of appeals process		• **Ultimate responsibility** for a referral to an out-of-network provider by an in-network provider • **Inadequate contracting** and oversight tools to confirm that participating providers abide by regulations • Paying for **plan-directed care services** can be a **financial burden** • **Administrative burden** to **confirm the compliance** of contract providers and to maintain appropriate claims to review referrals

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Plan-directed care: Proactive approaches

Health plans and providers should work together to achieve a common goal of reducing the financial burden of unapproved out-of-network referrals

Training

Contracting physicians/providers should receive additional training on how to determine whether specific items and services are covered in which their patients/members are enrolled and their responsibilities related this requirement

Data

Health plans should consider data analytics to identify and follow-up with contracted providers who are frequently in violation of referring members to non-contracted physicians and providers

Penalties

Health plans should consider contractual requirements to implement penalties (up to terminating in-network status) for frequently referring members to non-contracted physicians and providers without prior authorization

Team

Providers should consider dedicating an individual or team to confirm insurance requirements related to specific provider referrals and establish an internal database for this

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Questions?

Contact your speakers

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