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

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 has assisted clients with delegation of compliance program responsibilities to third party vendors. Kim has served as Chief Compliance Officer for a national leading provider of home-delivered diabetes testing supplies, mail order prescription medications and other Qualified Medical Equipment (QME) 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, Specialist 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; provider directory management; provider outreach and plan-directed care, provider quality improvement; process implementation and oversight; vendor oversight and auditing; government program fraud and abuse; risk and control implementation and assessment; products 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.

Evaluating health plans’ consistency with the efficient administration of the Part C and Part D program requirements

Confirming that health plans corrected deficiencies identified during program audits and that were the basis for intermediate sanctions and administrative actions

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

Civil Monetary Penalties (CMP)
Intermediate sanctions (suspension of marketing, enrollment, payment)
Termination of contract
During the last several audit periods, CMS has honed in on several enforcement areas.

Focus areas of enforcement

- Civil money penalties (CMP)
- Intermediate sanctions (suspension of marketing, enrollment, payment)
- Terminations of contract

Provider directories

Plan-directed care

Provider outreach

Focus areas of enforcement

Provider directories: Background

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

Provider directories: Background (cont’d)

CMS found that 45% of directories contained inaccuracies.

CMS is able to fine health plans up to $25,000 per Medicare beneficiary for errors in Medicare Advantage Plan directories.
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 make maintenance difficult
- Inflated numbers of provider practice locations may lead to access to care issues
- Limited resources may restrict 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**

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

**Contractual Agreements**

- which include provisions and penalties surrounding relaying current and timely provider directory data, should be maintained between health plans and providers

**Provider Newsletter**

- which may likely be frequently sent, reminding staff of requirements

**Hotline Number**

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

**Leverage Internal Data**

- where providers and health plans, after proving their identity, can compare and update their information

Provider outreach: Background

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

**Outreach**

- 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

*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)*

On February 22, 2017, CMS wrote a memorandum, updating guidance on outreach for information to support coverage decisions.
Provider outreach: Background (cont’d)

CMS clarified guidance and leading practices regarding outreach by health plans

Provider outreach: Prospective

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

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

<table>
<thead>
<tr>
<th>Timeframe</th>
<th># Attempts</th>
<th>Standard</th>
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<tbody>
<tr>
<td>OD - Payment</td>
<td>30 days</td>
<td>3</td>
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<tr>
<td>OD - Pre-Service</td>
<td>14 days</td>
<td>3</td>
</tr>
<tr>
<td>Expedited OD</td>
<td>72 hours</td>
<td>3</td>
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</table>

Coverage Determinations, Appeals & Grievances (CDAG)

<table>
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<tr>
<th>Timeframe</th>
<th># Attempts</th>
<th>Standard</th>
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<tr>
<td>CD - Payment</td>
<td>14 days</td>
<td>3</td>
</tr>
<tr>
<td>Benefits CD</td>
<td>72 hours</td>
<td>3</td>
</tr>
<tr>
<td>Expedited CD</td>
<td>72 hours</td>
<td>3</td>
</tr>
</tbody>
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There has been an increase in the number of health plans receiving audit findings related to plan-directed care.

**Plan-directed care: Background**

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

- 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.
- Members receive care from an out-of-network provider or physician at the direction of his/her primary care physician or network specialist.
- Neither provider nor enrollee request a pre-service organization determination from health plan.

**Who?**
- Members

**What?**
- Care a member believes he or she was instructed to obtain.

**How?**
- Members receive care from an out-of-network provider or physician at the direction of his/her primary care physician or network specialist.
- Neither provider nor enrollee request a pre-service organization determination from health plan.

**Why?**
- Members receive care from an out-of-network provider or physician at the direction of his/her primary care physician or network specialist.
- Neither provider nor enrollee request a pre-service organization determination from health plan.

**Plan-directed care: Prospective**

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

**Provider**
- 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.

**Health Plan**
- 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.

**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 to this requirement.

- **Data**
  - Health plans should consider data analytics to identify and follow-up on contractions 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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