Provider Compliance Obligations under Medicare Advantage and Medicaid Managed Care Plans

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Learning Goals

1. Why and how Payors are ramping up their compliance requests for providers, including a review of statutory, regulatory and contractual requirements.

2. Key obligations that arise from emerging payor-provider relationships and reimbursement modes.

3. How to monitor – an ensure compliance requirements are being met – for multiple payors; what to do when issues arise.

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A Quick Poll

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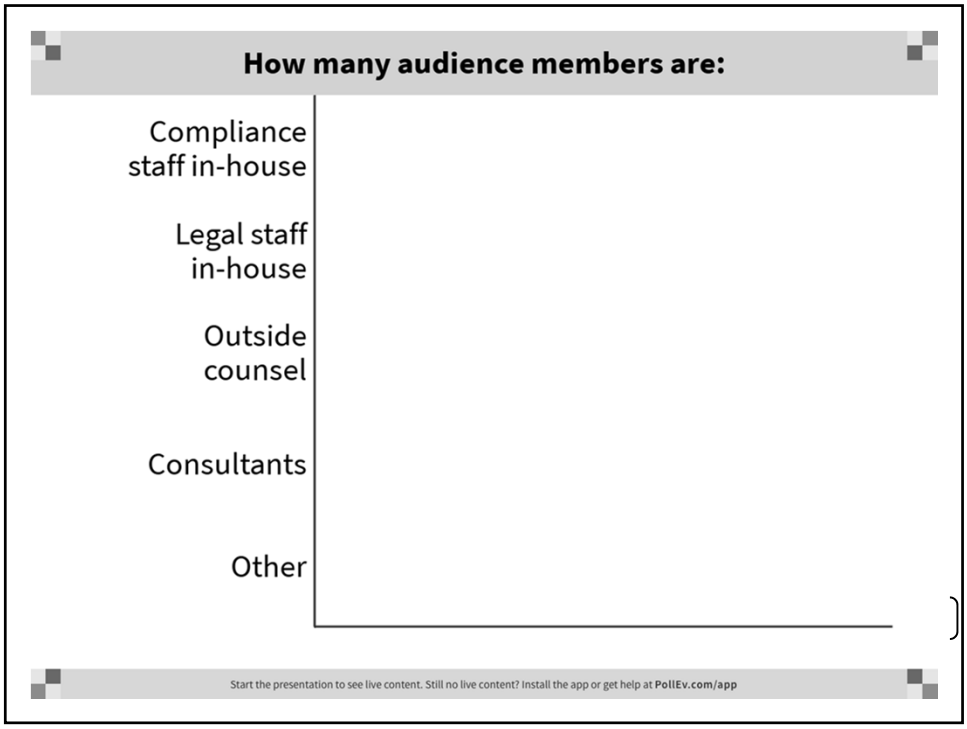
How many audience members are:
Compliance staff in-house
Legal staff in-house
Outside counsel
Consultants
Other
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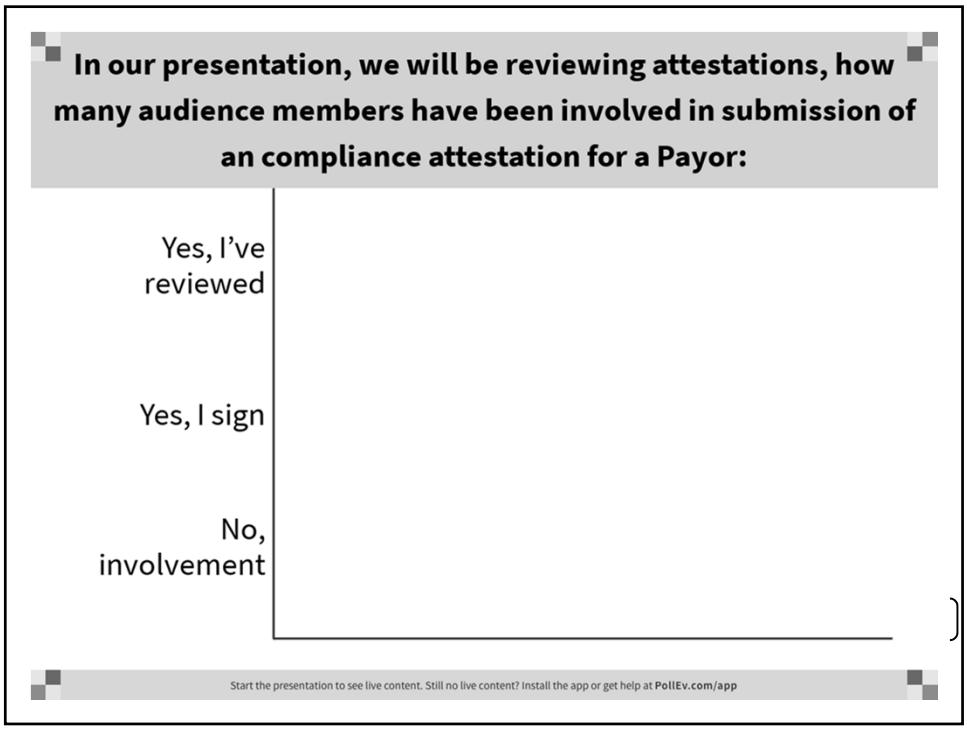
In our presentation, we will be reviewing attestations, how many audience members have been involved in submission of an compliance attestation for a Payor:
Yes, I've reviewed
Yes, I sign
No, involvement
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Does your organization participate in:

Medicare Advantage

Medicaid Managed Care

Both

Neither

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Part 1: Setting the Stage

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Key Program References

Medicare Advantage (MA)

- SSA Title XVIII, Part C, Sections 1851 *et seq.*
- 42 C.F.R. Part 422
- CMS Medicare Managed Care Manuals
- Other CMS Guidance
  - HPMS
  - Call Letters

Medicaid Managed Care (MMC)

- SSA Sections:
  - 1932(a)
  - 1915(a)
  - 1915(b)
  - 1115
- 42 C.F.R. Part 438
- State Medicaid statutes, rules and manuals

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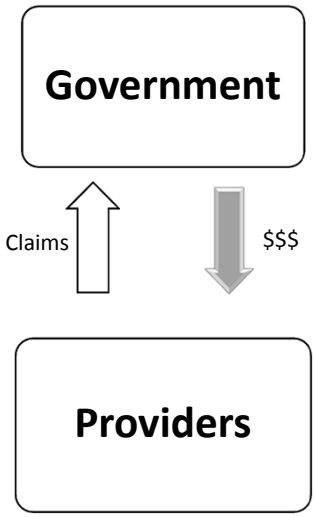
Accountability for Compliance: Medicare & Medicaid Fee-for-Service



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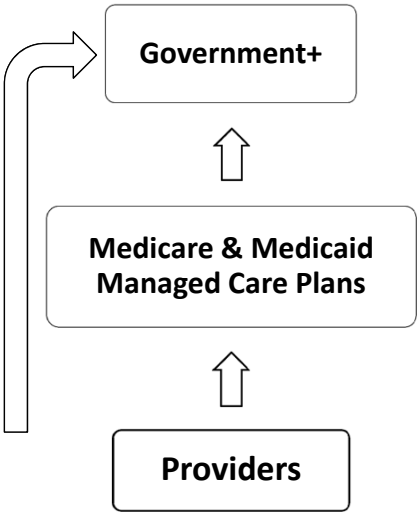
Accountability for Compliance: Medicare & Medicaid Managed Care



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Multiple Overseers

Government+

- CMS, DOJ, OIG, MACs
- Medicaid State Agencies, EQROs, Attorneys General
- Accreditation Agencies

Managed Care Plans

- Aetna, Anthem, Blue Cross, Blue Shield, Centene, CIGNA, HCSC, Highmark, Humana, Kaiser, UnitedHealthcare

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Why the MA & MMC Programs Matter for Providers

- Increasingly, the Medicare and Medicaid programs deliver benefits through managed care arrangements.
  - Triple Aim.
  - See Handouts #1 through #4.
- Growing popularity with patients.
- Providers risk losing access to patients and revenue if they find themselves outside of these programs.
  - MA and MMC network participation may be required for providers to gain/maintain access to commercial plan enrollees.

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Other Trends

- Expansion of shared savings and risk arrangements between plans and providers result in increased delegation of plan administrative functions
  - Credentialing
  - Utilization management
  - Care coordination

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Payor's Compliance Program

- What is it and why does it matter to a Provider?

- **7 Elements**
  1. Compliance policies and procedures, including standards of conduct.
  2. Compliance officer/committee
  3. Open lines of communication
  4. Training and education
  5. Monitoring and auditing
  6. Response to detected deficiencies
  7. Enforcement of disciplinary standards

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Government Expectations for Plan Oversight of Providers

Medicare Advantage

- 42 C.F.R. § 422.503(b)(4)(vi)
- 42 C.F.R. § 422.504(i)
- "CMS may hold the sponsor accountable for the failure of its FDRs to comply with Medicare program requirements. "
- Medicare Managed Care Manual, Chapter 21, Section 40

Medicaid Managed Care

- 42 CFR 438.230
- State Contracts with MCOs
- State Medicaid Statutes

THE BOTTOM LINE:

The government will hold the plans responsible for the conduct of their providers and other contractors.

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How MA & MMC Differ from Commercial Plan Arrangements

- MA & MMC plans must include program-specific compliance language in their contracts with providers.
  - For example, providers are subject to audits by and document requests from applicable governmental authorities.
- Certain processes and state law rights available under a plan's commercial product may not apply under MA or MMC due to program-specific standards or preemption.
- Certain federal and state fraud, waste and abuse laws may apply to MA/MMC related arrangements and activities.

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How MA & MMC Differ from Traditional Medicare & Medicaid

- To engage in these programs, providers must contract or have other arrangements with plans that, in turn, have MA/MMC contracts with the applicable government agency.
- Not all traditional program rules and guidelines apply to MA and MMC, allowing for greater flexibility. For example, some plans may:
  - Cover benefits that supplement those under traditional Medicare/Medicaid.
  - Adopt different billing/coding and claims requirements.
  - Have different appeals processes and timeframes.
  - Apply more stringent provider credentialing standards.
  - Enter into alternative payment arrangements with providers.

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Part 2:
Contractual Flow Downs

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Parties Subject to Plan Contractual Flow Down Provisions

Medicare Advantage

- FDRs
  - First Tier Entities
  - Downstream Entities
  - Related Entities
- Assessment of FDR status left to MA plan discretion

Medicaid Managed Care

- Varies
- Providers and vendors (referred to as Subcontractors in CFR)
  - Directly contracted
  - Indirectly contracted

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MA FDRs

First Tier Entity

- Any party that enters a written arrangement, acceptable to CMS, with an MA plan (or MA plan applicant) to provide administrative services or health care services to an MA program eligible individual.

Downstream Entity

- Any party that enters a written arrangement, acceptable to CMS, with persons/entitles involved with the MA benefit, below the level of the arrangement between an MA plan and a first tier entity.
- These written arrangements continue down to the level of the ultimate provider of health and administrative services.

Related Entity

- Any entity that is related to an MA organization by common ownership or control and: (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement, or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

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Do you have a process for managing FDR compliance?

Yes

No

Unsure

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MA FDR Factors

- The function to be performed by the delegated entity
- Whether the function is something the sponsor is required to do or to provide under its contract with CMS, the applicable federal regulations or CMS guidance
- To what extent the function directly impacts enrollees
- To what extent the delegated entity has interaction with enrollees, either orally or in writing
- Whether the delegated entity has access to beneficiary information or personal health information
- Whether the delegated entity has decision-making authority (e.g., enrollment vendor deciding time frames) or whether the entity strictly takes direction from the sponsor
- The extent to which the function places the delegated entity in a position to commit health care fraud, waste or abuse
- The risk that the entity could harm enrollees or otherwise violate Medicare program requirements or commit FWA.

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MA FDR Services

- Sales and marketing
- Utilization management
- Quality improvement
- Applications processing
- Enrollment, disenrollment, membership functions
- Claims administration, processing and coverage adjudication
- Appeals and grievances
- Licensing and credentialing
- Pharmacy benefit management
- Hotline operations
- Customer service
- Bid preparation
- Outbound enrollment verification
- Provider network management
- Processing of pharmacy claims at the point of sale
- Negotiation with prescription drug manufacturers and others for rebates, discounts or other price concessions on prescription drugs
- Administration and tracking of enrollees' drug benefits, including TrOOP balance processing
- Coordination with other benefit programs such as Medicaid, state pharmaceutical assistance or other insurance programs
- **Entities that generate claims data**
- **Health care services**

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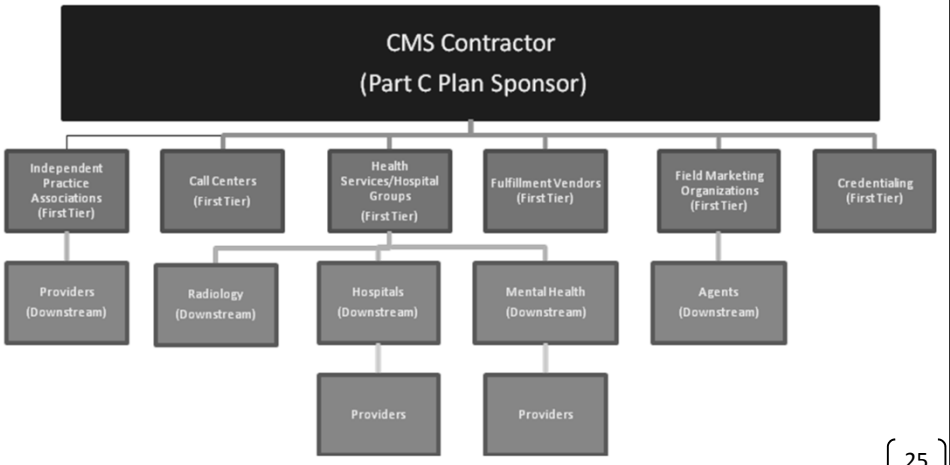
Examples: MA FDRs



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MMCM Chapter 21, Section 40

FDR Oversight by Plans

- The method by which the analysis is performed is left to the discretion of the plan.
- The plan must develop procedures to promote and ensure that all FDRs are in compliance with all applicable laws, rules and regulations with respect to Medicare delegated responsibilities.
- The plan must have a system in place to monitor FDRs.
- Sponsors must be able to demonstrate that their method of monitoring is effective.

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MMC Provider and Subcontractor Oversight Requirements

- Pre-delegation Assessment
- Written Agreement
- Sanctions for Nonperformance
- Monitoring of Delegated Entities
- Delegated Oversight Committee
- Corrective Action

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Typical Flow Down Obligations

- Audit / availability of documentation
- Confidentiality
- Record keeping/access
- Hold harmless
- Cost-sharing restrictions for dual-eligibles
- Prompt payment requirements
- Delegated services are specified and subject to revocation
- Authorizes plan to monitor performance

CMS sample flow down is available at https://www.cms.gov/medicare/medicare-advantage/medicareadvantageapps/downloads/model_contract_amendment_10_05_12.pdf

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Other Flow Down Obligations

- Compliance program
- Compliance training
  - **Medicare Advantage**
    - General compliance
    - Fraud, waste & abuse
    - CMS online training modules after June 2018
    - Looking ahead for CY 2019 and beyond
- Cultural Competency Training
- Screening requirements
- Restrictions on off-shore and other subcontractors
- Marketing
- Data privacy & security, HIPAA

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Offshoring Restrictions

Medicare Advantage

- MA plans must notify CMS when off-shore contractors are used to provide MA program services.
- MA plans will include a contract provision addressing the use of off-shore downstream contracts.
  - Not all provisions are the same.
  - Not all provisions are limited to the CMS notification requirement. Many will require advance consent.

Medicaid Managed Care

- Some state MMC programs mirror the CMS approach.
- Other MMC programs may have requirements that are more or less stringent than CMS.
  - For example, requiring plan consent to use out-of-state subcontractors.

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Marketing

- Restrictions on "marketing" in the care setting
- Restrictions on "marketing" to promote the selection of a particular health plan
  - Example: "We prefer ___ Health Plan" materials
- "Use of name" restrictions
  - Lists of contracted provider networks generally permitted

See Medicare Marketing Guidelines

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Data Privacy & Security

- Laws
  - HIPAA / HITECH
  - Gramm-Leach Bliley Act (GLB)
  - Americans with Disabilities Act (ADA)
  - Genetic Information Nondiscrimination Act (GINA)
  - State privacy laws
- Reporting & addressing potential and actual breaches
- HITRUST certification
- Cyber-liability insurance

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Key Takeaway

- Although commonalities exist, if you've seen one MA/MMC plan, you've seen **ONE** MA/MMC plan.
- No MA or MMC plan is identical to another
  - Different regulatory compliance requirements
  - Different contractual obligations

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Part 3: Handling Attestations

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Annual Rite of Passage

- Provider attestations are generally required under terms of network participation agreement.
- May track your contract's representations and warranties
- Electronic submissions to plans are becoming the norm
- Varies from payer-to-payer

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Things to Note

- **Scope and reach of compliance may vary:**
  - Owners
  - Governing body members
  - Physicians
  - Employees
  - Contractors
  - Temporary workers
  - Volunteers
  - Downstream entities
- **Certain plan and provider types may have special obligations**

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More Things to Note

- **Exclusion screening of OIG/SAM and preclusion list may just the beginning.** For example:
  - Social Security Administration's Death Master File
  - State exclusion databases
    - For example: Michigan Department of Community Health (MDCH)/Medical Services Administration (MSA) Sanctioned Provider List
- **Annual disclosures of ownership and control may be required.**

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Even More Things to Note

- **Documentation requests to evidence compliance**
  - Training materials
  - Attendance / sign-in sheets
  - Individual attestations

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Pitfalls

- **Attestations were signed by individuals who were:**
  - Unauthorized to do so
  - Unfamiliar with the substance of the representations (*i.e.*, have no clue as to what they're attesting to)
- **Attestations are not vetted by compliance and/or legal personnel**

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What if a provider was non-compliant?

- **Contact the Plan to discuss**
  - Ideally, non-compliance will already be remedied by the time of attestation
  - If not, be prepared with:
    - A corrective action plan
    - Timeframe for implementation
  - In any case, have a go-forward framework to monitor for and avoid recurrence
- **Other options**

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Flowing Attestations Downstream

- If you have downstream entities, downstream attestations may be recommended or required
- What is the best approach for a downstream attestation when you have multiple upstream attestation language?
- What if the upstream attestation language changes unexpectedly?

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Part 4: Fraud, Waste & Abuse Compliance

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Anti-Fraud Laws

- Federal False Claims Act
- Reverse False Claims Act
- 60 day overpayment refund and reporting requirement

Examples of Fraud Issues

- Similar to those under FFS programs
  - Improper billing
    - Up-coding
    - Double billing
  - Medically unnecessary services
  - Retention of overpayments
    - Potential applicability of 60 day reporting and refunding requirement

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Examples of Fraud Issues

- Similar to those under FFS programs
  - Improper billing
    - Up-coding
    - Double billing
  - Medically unnecessary services
  - Retention of overpayments
    - Potential applicability of 60 day reporting and refunding requirement

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60 Day Overpayment Reporting & Repayment Obligation

- Does this ACA requirement apply to payments made by MA and MMC plans to their providers?
  - No ACA regulation specifically addresses such overpayments.
  - Arguably, other federal laws may require compliance with the 60 day standards.
  - See U.S. ex rel. Kane v. Continuum.
- Beware of comparable contractual requirements imposed by MA, MMC and other plans.

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Part 6: Best Practices for Contract Management, Negotiation and Issue Resolution

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Best Practices

- Contract Negotiation
  - Watch out for certain upstream and downstream provisions
  - What is required and what is
- Contract Management
  - Tracking compliance obligations to plans, periodic updates
  - For Downstream provisions, consider establishing a uniform contracting approach
  - Periodic audits
- Ongoing Communications
- Responding to Plan Inquiries
- When to Involve Legal & Compliance

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Understanding Plan Investigation Processes

Overview of Types of Plan Investigation

- ***Compliance***
- ***Quality of Care***
- ***HEDIS***
- ***Grievance/Complaint***
  - ***State and non-state***
- ***Fraud Waste or Abuse***

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Part 7: Outlook

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Importance of Compliance

- Access to patients
  - Narrow Networks
  - Value-Based Insurance Design (VBID)
- Improved reimbursement opportunities
- Achieving performance-based metrics

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Hot Topics & High Risk Areas

- Provider Directory
  - Accuracy
- Network Adequacy
- Balance Billing
- Opioid/Suboxone
- Transportation
- Long Term Services and Supports (Personal Assistants, Homemakers)
- Nursing Home services (PT, OT, ST)

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There are Upsides

- **Providers enjoy certain rights**
  - Freedom to advise patients on treatment options
  - CMS prohibition of Part D sponsor/PBM gag clauses (May 17, 2018 HPMS memorandum from Seema Verma)
  - Limitation on certain types of indemnifications to plans
  - Right of conscience
  - Nondiscrimination 42 CFR 438.12 & 438.214

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Questions

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