Provider Compliance Obligations under Medicare Advantage and Medicaid Managed Care Plans

Anthony H. Choe	Ryan T. Lipinski
Counsel Polsinelli PC Washington, DC	Director of Government Programs Compliance Health Care Services Corporation Chicago, IL

Clinical Practice Compliance Conference
October 8, 2018

1

This Session uses Polling

To Participate in Polling
Download “HCCA Mobile” in your app store. Then under the agenda find this session, scroll to the bottom and click “Poll Question” or go to **PollEv.com/HCCA** to answer the active poll.

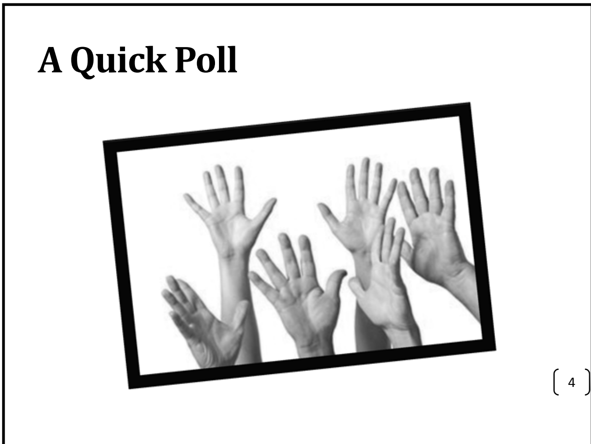
2

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.

3

A Quick Poll



4

How many audience members are:

- Compliance staff in-house
- Legal staff in-house
- Outside counsel
- Consultants
- Other

Start the presentation to see live content. Still no live content? Install the app or get help at PollEv.com/app

In our presentation, we will be reviewing attestations, how many audience members have been involved in submission of an compliance attestation for a Payor:

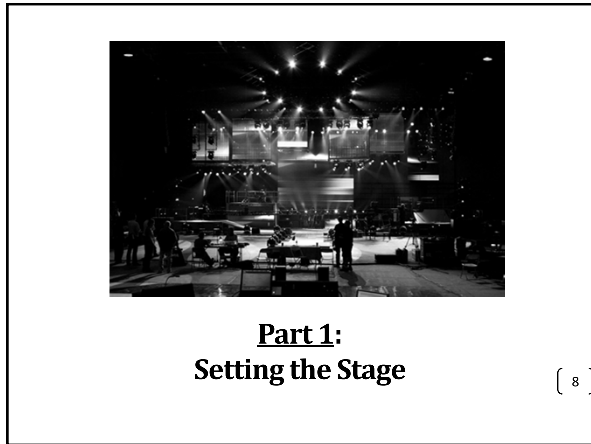
- Yes, I've reviewed
- Yes, I sign
- No, involvement

Start the presentation to see live content. Still no live content? Install the app or get help at PollEv.com/app

Does your organization participate in:

- Medicare Advantage
- Medicaid Managed Care
- Both
- Neither

Start the presentation to see live content. Still no live content? Install the app or get help at PollEv.com/app



Part 1:
Setting the Stage

8

Key Program References

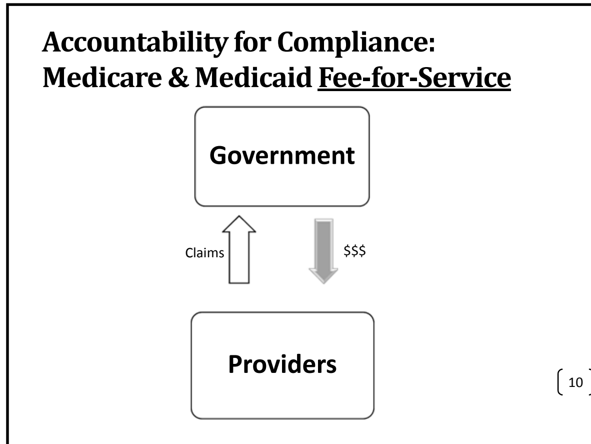
Medicare Advantage (MA)

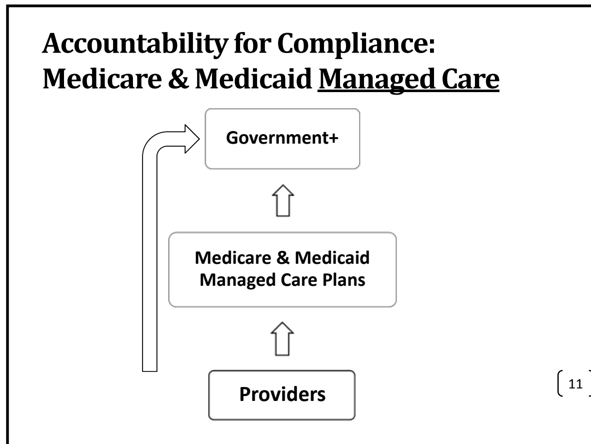
- SSA Title XVIII, Part C, Sections 1851 *et seq.*
- 42 C.F.R. Part 422
- CMS Medicare Managed Care Manuals
- Other CMS Guidance
  - HPMS
  - Call Letters

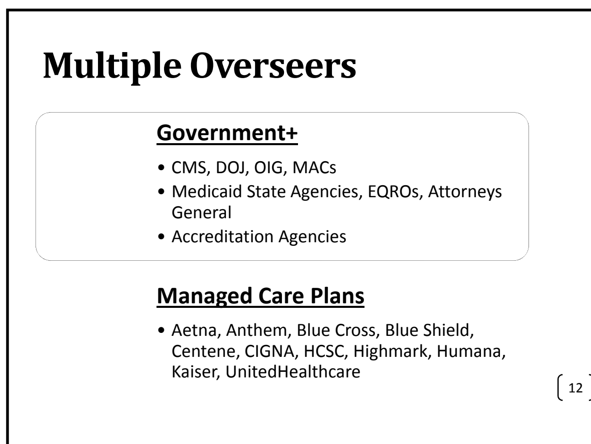
Medicaid Managed Care (MMC)

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

9


Accountability for Compliance:
Medicare & Medicaid Fee-for-Service
Government
Claims
$$$
Providers
10


Accountability for Compliance:
Medicare & Medicaid Managed Care
Government+
Medicare & Medicaid Managed Care Plans
Providers
11


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
12

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.

13

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

14

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

15

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.

16

How MA & MMC Differ from Commercial Plan Arrangements

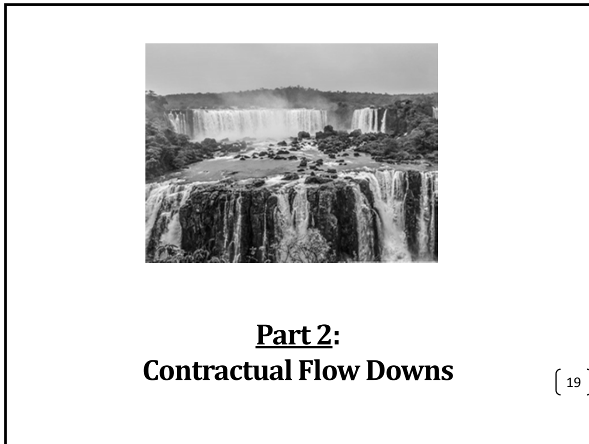
- MA & MMC plans must include program-specific compliance language in their contracts with providers.
  - For example, providers are subject to audits by and document requests from applicable governmental authorities.
- Certain processes and state law rights available under a plan's commercial product 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.

17

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.

18



Part 2: Contractual Flow Downs

19

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

20

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.

21

Do you have a process for managing FDR compliance?

Yes

No

Unsure

Start the presentation to see live content. Still no live content? Install the app or get help at PollEv.com/app

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.

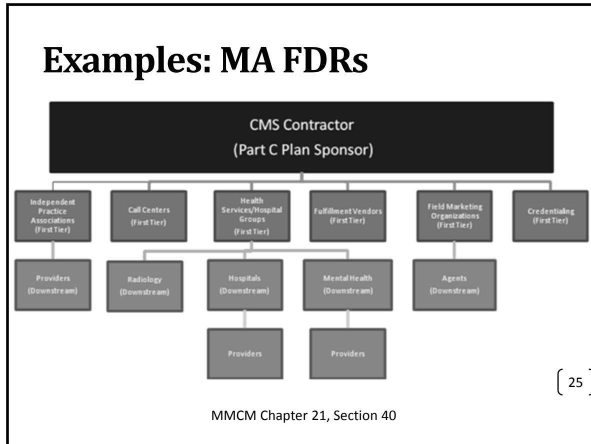
23

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**

24

Examples: MA FDRs



25

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.

26

MMC Provider and Subcontractor Oversight Requirements

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

27

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

28

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

29

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.

30

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

31

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

32

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

33

Part 3:
Handling Attestations

34

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

35

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**

36

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.**

37

Even More Things to Note

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

38

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**

39

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**

40

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?

41

Part 4:
Fraud, Waste & Abuse Compliance

42

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

43

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

44

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.

45

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

46

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

47

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***

48

Part 7:
Outlook

49

Importance of Compliance

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

50

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)

51

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

52

Questions

53