CMS provider accuracy
Risk assessment and monitoring strategies
Medicare Advantage plans

Who is Geisinger?

• Integrated health system
• Clinical side
  – 12 hospital campuses
  – 1,600 employed physicians
  – 30,000+ employees

• Health Plan
  – All lines of business
  – 560,000+ members
  – 110 hospitals
  – 30,000+ primary care and specialist providers

Geisinger Medical Center
Agenda

- Regulations
  - Understanding the Centers for Medicare and Medicaid Services (CMS) expectations
- Assessment
  - Determining the risk for your company
- Actions
  - Improving processes to increase accuracy
- Monitoring
  - Establishing routing activities to measure compliance

Regulatory expectations

- 2016 CMS fall conference included a session dedicated to review results and outline expectations
- Complaints and congressional inquiries led to pilot audit
- Focus on accuracy
  - Marketing to prospective members
  - Informed decision making
  - Ability to contact providers
  - Network availability standards
CMS audits

• 2016 round one audit
  – February through August
  – 54 parent organizations
  – 108 providers per organization

• Provider focus
  – Primary care providers
  – Oncologists
  – Ophthalmologists
  – Cardiologists

CMS review elements

<table>
<thead>
<tr>
<th>Provider name</th>
<th>National Provider Identification (NPI)</th>
<th>Provider specialty</th>
<th>Practice name</th>
<th>Phone number</th>
<th>Street address</th>
<th>Does the provider work at the location?</th>
<th>Is the plan accepted at location?</th>
<th>Is the provider accepting/not accepting new patients?</th>
</tr>
</thead>
</table>
**Review process – phase 1**

**Phase 1**

- Up to three calls made to providers
- Results shared with sponsor
- Sponsor must respond within 2 weeks (concur/non-concur/both)
- CMS review, additional calls as needed to make final determinations
- Plan sponsor has 30 days to make all required corrections

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**Review process – phase 2**

**Overall results: 45.1% inaccurate**

- CMS validates corrections
- Online directories
- Health services delivery tables
Audit results – ‘weighted deficiency score’ based on severity

- Provider name needs updated: 0 points
- Specialty needs updated: 1 point
- Provider is accepting new patients: 1 point
- Suite number in address needs updated: 1 point
- Address needs updated: 2 points
- Provider is not accepting new patients: 3 points
- Phone number needs updated: 3 points
- Provider should not be listed in the directory at this location: 3 points

How is the weighted deficiency score calculated?

- Maximum deficiency score example
  - Provider locations x 3
  ![Illustration of calculation](image)

  - Maximum deficiency score of 360

- Weighted final deficiency score example
  - Sum of location deficiency scores/maximum deficiency score
  ![Illustration of calculation](image)

  - Final deficiency score of 12.5%
Phase one audit results

<table>
<thead>
<tr>
<th>Parent organizations</th>
<th>Deficiency score range</th>
<th>Compliance action</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>1.77% to 4.63%</td>
<td>No action taken</td>
</tr>
<tr>
<td>31</td>
<td>19.66% to 39.48%</td>
<td>Notice of non-compliance</td>
</tr>
<tr>
<td>18</td>
<td>41.37% to 58.79%</td>
<td>Warning letter</td>
</tr>
<tr>
<td>3</td>
<td>65.08% to 70.75%</td>
<td>Warning letter with business plan request</td>
</tr>
</tbody>
</table>

Regulatory expectations

State level
- Pennsylvania (Notice 2015-07 45 Pa.B. 5744)
  - Pennsylvania law prohibits unfair or deceptive acts or practices by insurers, including publishing or circulating an advertisement, announcement, or statement which is untrue, deceptive, or misleading. If a person receives health care services from a provider listed in the insurer’s provider directory as in-network, and the insurer then attempts to settle that claim as if the provider were out-of-network, her department will consider this to be an unfair claim settlement practice.
- New Jersey (§ 11:24C-4.6 Standards for accuracy of provider directory information)
  - Carriers shall confirm the participation of any provider who has not submitted a claim for a period of 12 months or otherwise communicated with the carrier in a manner evidencing the provider’s intention to continue to participate in the carrier’s network and for whom no change in provider status has been reported by CAQH.
Assessment

- How often is your online directory updated?
- Is there a process in place to make updates?
- Do you have any providers listed at more than six locations?
- Have you received any member complaints?
- How many providers have not filed a claim within the last 12 months?
- Call providers randomly
  - Compare information to what is online and verify that it is being reviewed by CMS

Actions for improvement – start now!
Direct provider outreach

- Provider outreach
  - Vendor services (call centers or those offering full range of solutions)
  - Health plan alliance-type organizations
  - Call blitz; contact all network providers
- Challenges
  - Accuracy of third party information
  - Time consuming
  - Inconsistent information depending on who you speak to at providers office

Creating tools and processes

- Create tools and develop processes to update information
  - Instruct front-line phone contact center to verify provider information upon receiving calls
  - Give providers the ability to update info via a web portal
  - Require confirmation of information at each logon
- Challenges
  - Dependent on providers initiating contact
Direct mail

- Hard copy direct mail reminders
  - Include in provider communications
- Challenges
  - Static communication
  - Does not require provider action

Update your information
It is essential that we have your current information in order to best serve GHP members and ensure you receive important communications. You can update your information conveniently through our online tool. Visit the Healthcare Providers section at TheHealthPlan.com, or look in Provider Tools on the GHP plan central page at NaviNet.net for links to the form. Options include:
  - Add – add a provider or location (credentialing required for new providers)
  - Change – indicate changes to an existing provider’s profile, office/locations, TIN, etc.
  - Both – make both additions and changes on one form
  - Term – initiate a provider termination or remove a practice location
  - Upload documents – attach existing files and documents that describe your changes

GHP asks that you review your demographic information on a monthly basis and report any changes or updates. You can verify your current provider profile by using the Find Providers function on the left navigation bar at TheHealthPlan.com to search the online directory for your office.

If you have any questions on how to use the online add/change form, please contact your account manager at 800-876-5357.

Provider orientation

- Update and/or highlight new provider orientation
  - Presentations and hard copy materials
  - Stress importance of updated/correct directories
- Challenges
  - Time between orientation and any changes
  - Amount of information distributed at orientation
  - Dependent on provider action
Utilizing claim information

- Develop reporting to identify providers with zero claims activity over the past 12 months
- Contact providers to verify network status
- Remove providers who do not respond

Challenges
- Time consuming to develop reports and send letters via mail
- Costly (especially if sending via certified mail for no first response)

Correcting addresses

- Develop process to contact providers with incorrect address (returned mail, incorrect fax number, etc.)
  - Notify employee(s) responsible for accuracy of returned mail or fax
  - Utilize alternative information such as e-mail and phone

Challenges
- Timeliness
- Manual process
- Limited alternative information
Updating contractual language

- Update contractual language
  - Include provision to hold provider financially responsible for any compliance actions taken by regulators; including monetary reimbursement
- Challenges
  - Provider acceptance
  - Legal costs associated with contract changes and enforcement

Verifying contact information

- Verify contact information whenever a provider calls with a prior authorization request
  - Modify call scripts to gather information at the beginning of every call
- Challenges
  - Additional time on phone for staff
  - Provider discontent
Audit readiness for immediate improvement

Focus on updating areas highlighted by CMS

- Cardiology
- Oncology
- Ophthalmologists
- Primary care

Perform call blitz activities

Monitoring

- Communication
  - Compliance and audit staff call providers weekly to verify information
  - Develop process to notify provider network team of changes
  - Improve communication channels
- Tracking and reporting
  - Implement tracking system to identify providers that have not been contacted
  - Report results via metrics
  - Mimic CMS scoring
References/Resources

• November 13, 2015 CMS Memo “Provider Directory Requirements – Update”
• May 26, 2016 CMS Memo “Continued Monitoring of Medicare-Medicaid Provider and Pharmacy Directories”
• September 8, 2016 HPMS E-mail “Follow Up to the MMP Provider and Pharmacy Directory Technical Assistance Webinar”
• January 13, 2017 HPMS E-mail “Release of CMS’s Online Provider Directory Report and Supporting Data
• January 17, 2017 CMS Memo “Provider Directory Policy Updates”

Contact information

• Philip Masser
• Phone: 570-214-9281
• pjmasser@thehealthplan.com
Questions?