Provider Forum
September 8, 2015
1:00 PM

Agenda

Welcome and Updates (10 minutes)	Larry Holcombe Provider Network Manager
Plans of Correction (15 minutes)	Larry Holcombe
Site or No Site (10 minutes)	Natalie McBride Provider Network Manager
Specialty Review Unit (10 minutes)	Kathleen Meriac
RFP Residential Level III (10 minutes)	Judy Dahlstrom Network Development Specialist
HUBS (30 minutes)	Jennifer Greene, Lincoln Wellness Center Mike Shoupe, Burke Integrated Health
Provider Search Tool Miscellaneous (10 minutes)	Jamie Sales Network Development Specialist
Closing	Larry Holcombe

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The Service Provider's Responsibilities When Responding to a Plan of Correction Request

Larry Holcombe

Purpose of the Plan of Correction

- Having to submit a Plan means that we found something is out of compliance or not up to standards.
- The purpose of the Plan is to correct the problem and prevent the problem from reoccurring.
- The Plan is your tool to improve your agency's performance and to assure the LME that performance will improve.
- It is a Quality Management Issue!

Step 1
Review the Request

- Do you understand the Issues sited?
- What are the rules, service definitions or regulations that the issues relate to?
- Do you understand what the desired outcome of the correction should be?
- Are you able to correct the issues?

Step 2
Developing the Plan of Correction

Once you understand the request, develop a plan to include the following:

- Clear restatement of the issues and what needs to be corrected.
- Clear interventions that will resolve the problem at a systemic level and prevent the problem from reoccurring.
- Clear, reasonable and achievable timeframes for each intervention.

Things to consider

- What policies and procedures do you need to revise, change completely or develop?
- Should you implement immediately, or must you divide the issue into smaller steps?
- What staff should be involved in developing the Plan?
- Do you need assistance from consultant/outside trainer etc?
- Do you have a way to train staff on changes?
- Can you self-monitor your performance?

Step 3
Submit Plan of Correction within timeframes

- Plan should be submitted on or before the due date
  - The Provider has 15 calendar days from the receipt of the POC request or first attempted delivery to submit a POC for approval.
  - All POC letters sent out by Partners BHM are sent certified return/receipt mail for tracking purposes.
- Keep a copy of the Plan
- Provide any/all supporting documentation that you have made changes or that support your intention to make changes

Step 4
Participating in the review of the Plan of Correction

- Partners BHM will let you know if we need your staff available when we review the Plan.
- Make sure you have staff who are knowledgeable about the service/issues and who can speak on behalf of your agency.
- Note: If the initial POC submission is found to be unacceptable/not meet criteria to be approved, a request will be sent out to resubmit the POC. The provider will have 10 calendars from the date of receipt or first attempted delivery to submit the second plan for review and approval.

Step 5
Implement the Plan of Correction

- Implement the Plan within specified timeframes
- Some Plans need to be implemented immediately
- Assigned Provider Network Specialists will conduct a follow up review within 60 calendar days from the date the plan was approved to verify implementation of the Plan.
- If a the follow up review reveals that the Plan was not implemented, then an additional review will be conducted within 20 calendar days from the first review date.

Step 6
Follow-up on your Plan of Correction

- You should continuously monitor your performance on your Plan.
- It is your Plan and its purpose is for you to be sure that your are doing things right.
- Make it part of your Quality Management process.

Maintain Quality

Quality Service Delivery Requires:
Year-round,
Agency-wide,
Self-Monitoring
Against well understood
Rules
Regulations
Service Definitions and
Other Guidelines

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PROVIDER FORUM 9/8/15 -- BUSINESS ASSOCIATE AGREEMENTS/ADDENDA (BAAs)

Overview: *Under HIPAA (Health Insurance Portability and Accountability Act), a BAA is generally required between an LME/MCO as a "Covered Entity" and its subcontractors to ensure privacy of consumers' protected health information (PHI). However, this is only if the subcontractor is a "business associate" and not subject to an exception. Exceptions include sharing of PHI for purposes of treatment, payment or healthcare operations (TPO) or where the subcontractor is also a Covered Entity. While a September 2013 DMA Communication Bulletin urged BAAs between LME/MCOs, DMA has since acknowledged these exceptions apply as to many providers based on the highlighted language below. As a result, Partners BHM is eliminating any unnecessary BAAs with select providers and vendors. Regardless, providers remain subject to HIPAA and might continue to need BAAs with their subcontractors.*

EXCERPTS US DHHS Office of Civil Right (OCR) Website:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/businessassociates.html (as of 20150907)

Business Associates

45 CFR 164.502(e), 164.504(e), 164.532(d) and (e) (Download a copy in PDF)

Background

By law, the HIPAA Privacy Rule applies only to covered entities – health plans, health care clearinghouses, and certain health care providers. However, most health care providers and health plans do not carry out all of their health care activities and functions by themselves. Instead, they often use the services of a variety of other persons or businesses. The Privacy Rule allows covered providers and health plans to disclose protected health information to these "business associates" if the providers or plans obtain satisfactory assurances that the business associate will use the information only for the purposes for which it was engaged by the covered entity, will safeguard the information from misuse, and will help the covered entity comply with some of the covered entity's duties under the Privacy Rule. Covered entities may disclose protected health information to an entity in its role as a business associate only to help the covered entity carry out its health care functions – not for the business associate's independent use or purposes, except as needed for the proper management and administration of the business associate.

How the Rule Works

General Provision. The Privacy Rule requires that a covered entity obtain satisfactory assurances from its business associate that the business associate will appropriately safeguard the protected health information it receives or creates on behalf of the covered entity. The satisfactory assurances must be in writing, whether in the form of a contract or other agreement between the covered entity and the business associate.

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Examples of Business Associates.

- A third party administrator that assists a health plan with claims processing.
- A CPA firm whose accounting services to a health care provider involve access to protected health information.
- An attorney whose legal services to a health plan involve access to protected health information.
- A consultant that performs utilization reviews for a hospital.
- A health care clearinghouse that translates a claim from a non-standard format into a standard transaction on behalf of a health care provider and forwards the processed transaction to a payer.
- An independent medical transcriptionist that provides transcription services to a physician.

A pharmacy benefits manager that manages a health plan's pharmacist network.

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Exceptions to the Business Associate Standard. The Privacy Rule includes the following exceptions to the business associate standard. See 45 CFR 164.502(e). In these situations, a covered entity is not required to have a business associate contract or other written agreement in place before protected health information may be disclosed to the person or entity.

- Disclosures by a covered entity to a health care provider for treatment of the individual. For example:
    - A hospital is not required to have a business associate contract with the specialist to whom it refers a patient and transmits the patient's medical chart for treatment purposes.

    - A physician is not required to have a business associate contract with a laboratory as a condition of disclosing protected health information for the treatment of an individual.
    - A hospital laboratory is not required to have a business associate contract to disclose protected health information to a reference laboratory for treatment of the individual.
- Disclosures to a health plan sponsor, such as an employer, by a group health plan, or by the health insurance issuer or HMO that provides the health insurance benefits or coverage for the group health plan, provided that the group health plan's documents have been amended to limit the disclosures or one of the exceptions at 45 CFR 164.504(f) have been met.
- The collection and sharing of protected health information by a health plan that is a public benefits program, such as Medicare, and an agency other than the agency administering the health plan, such as the Social Security Administration, that collects protected health information to determine eligibility or enrollment, or determines eligibility or enrollment, for the government program, where the joint activities are authorized by law.

Other Situations in Which a Business Associate Contract Is NOT Required.

- When a health care provider discloses protected health information to a health plan for payment purposes, or when the health care provider simply accepts a discounted rate to participate in the health plan's network. A provider that submits a claim to a health plan and a health plan that assesses and pays the claim are each acting on its own behalf as a covered entity, and not as the "business associate" of the other.
- With persons or organizations (e.g., janitorial service or electrician) whose functions or services do not involve the use or disclosure of protected health information, and where any access to protected health information by such persons would be incidental, if at all.
- With a person or organization that acts merely as a conduit for protected health information, for example, the US Postal Service, certain private couriers, and their electronic equivalents.
- Among covered entities who participate in an organized health care arrangement (OHCA) to make disclosures that relate to the joint health care activities of the OHCA.
- Where a group health plan purchases insurance from a health insurance issuer or HMO. The relationship between the group health plan and the health insurance issuer or HMO is defined by the Privacy Rule as an OHCA, with respect to the individuals they jointly serve or have served. Thus, these covered entities are permitted to share protected health information that relates to the joint health care activities of the OHCA.
- Where one covered entity purchases a health plan product or other insurance, for example, reinsurance, from an insurer. Each entity is acting on its own behalf when the covered entity purchases the insurance benefits, and when the covered entity submits a claim to the insurer and the insurer pays the claim.
- To disclose protected health information to a researcher for research purposes, either with patient authorization, pursuant to a waiver under 45 CFR 164.512(i), or as a limited data set pursuant to 45 CFR 164.514(e). Because the researcher is not conducting a function or activity regulated by the Administrative Simplification Rules, such as payment or health care operations, or providing one of the services listed in the definition of "business associate" at 45 CFR 160.103, the researcher is not a business associate of the covered entity, and no business associate agreement is required.
- When a financial institution processes consumer-conducted financial transactions by debit, credit, or other payment card, clears checks, initiates or processes electronic funds transfers, or conducts any other activity that directly facilitates or effects the transfer of funds for payment for health care or health plan premiums. When it conducts these activities, the financial institution is providing its normal banking or other financial transaction services to its customers; it is not performing a function or activity for, or on behalf of, the covered entity.

Please review our Frequently Asked Questions on Business Associates as well as other Frequently Asked Questions about the Privacy Rule.

OCR HIPAA Privacy December 3, 2002 Revised April 3, 2003

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Site or No Site? What is a site anyway?

Natalie McBride

Why are we talking about sites?

- Authorization
- Billing
- NCTracks Enrollment
- Monitoring
- Program Integrity Reviews
- Licensure Requirements
- Credentialing
- Provider Search Tool

Authorization, Billing and NCTracks

Authorization and billing for services must be tied to the SAME site in order for payment to be approved.

NCTracks must MATCH the sites loaded in Alpha including the NPI number(s) and taxonomy number(s) in order for payment to be approved.

Monitoring/Program Integrity

For each site where services are being authorized and billed Partners expects:

- Medical Records for those services to be available for review at that site.
- Personnel Records for those services to be available for review at that site.
- Team composition (when applicable) and work schedules to be available for review at that site.

Licensed Services Require Licensed Sites

All services that require a license MUST be authorized and billed to the licensed site with the following exceptions:

- AFL Homes should **NOT** be included as sites.
- TFC Homes should **NOT** be included as sites.
- Independent placement services should **NOT** be included as sites.

These sites are private consumer homes and should NOT show up in our system as service locations.

These services and ALL periodic services provided at ANY licensed location should be associated with a provider site where the authorization, billing and medical record is generated and stored.

How Do We Collect Site Information?

Partners collects your site information through the credentialing process…

- Sites should be included on the application for credentialing and recredentialing when one or more service(s) is being authorized and billed to that site.
- Sites where no services are authorized and billed should not be included on the credentialing/recredentialing applications.
- Sites where no services are authorized and billed will be removed from your Alpha profile as applications are received.

How Do We Use Site Information?

Provider Search Tool and Needs Assessment

The provider search tool on Partners' website uses the sites loaded in Alpha to help consumers and referral sources find the services they need.

- If the site information is wrong then the search tool and our needs assessment information is inaccurate and not helpful to your agency or to the consumers in need of services.
- If your sites are set up based on corporate billing locations and not based on the actual location where services originate from then the search tool and the needs assessment is inaccurate and not beneficial.

How to Make a Change?

Request for Nomination - To add a site or change the site address in your provider profile in Alpha you need to complete the Request for Nomination Form.

Provider Change Form – To remove a site completely or to remove a service associated with a particular site in your provider profile in Alpha you need to complete the Provider Change Form.

So, in summary….

A site is the location where:

- The authorization is attached
- The claim is attached
- The medical record is available
- The personnel record/schedule is available
- The NCTracks site information matches exactly
- The search tool picks up services at this location

Contact Information

Requests for Nomination -
enrollment@partnersbhm.org

Provider Change Forms –
credentialingteam@smokymountaincenter.com

Provider Network Specialist Assigned -
Provider Specialist Assignments for Agencies
Provider Specialist Assignments for Licensed Independent Practitioners

Questions?