

DATA MINING AND COMPLIANCE IN MANAGED CARE-HCCA MANAGED CARE COMPLIANCE PROGRAM-2010

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TODAY'S GOALS

- DATA MINING IN MANAGED CARE-ASSESSING COMPLIANCE AND OUTCOMES IN GOVERNMENT PROGRAMS
- IDENTIFIED DATA ISSUES FROM MATCHES, CASES AND REGULATORY ACTIONS
- REVIEW OF EXISTING COMPLIANCE REQUIREMENTS
- PREDICTION OF MANAGED CARE COMPLIANCE FUTURE

THANK YOU TO HCCA-WE STILL REALLY NEED THIS PROGRAM

- NO FEDERAL OIG GUIDANCE SINCE 1999
- FEW CORPORATE INTEGRITY AGREEMENTS W/MANAGED CARE
- NO TRADE/INDUSTRY GROUP WITH GUIDELINES ON MANAGED CARE COMPLIANCE
- LIMITED EXTERNAL SUPPORT/TRAINING FOR MCO COMPLIANCE OFFICERS
- HOW USEFUL IS CMS GUIDANCE?
- CMS (1/1/2009) says Part C plans **should** have "procedures to voluntarily self-report potential fraud or misconduct related to the MA program to CMS or its designee."

New York State Medicaid Managed Care

- 2008 direct expenditures over \$8.9 billion/year (14% increase over prior year)
- 65% of Medicaid beneficiaries (2.5 million people) now enrolled in managed care (75% in greater New York area) (more than doubled in five years)
- Significant supplemental payments to health providers serving managed care patients

MANDATORY COMPLIANCE PROGRAMS IN NEW YORK

- ON OCTOBER 1, 2009, THE NEW YORK OMIG REGULATIONS REQUIRING EVERY MEDICAID PROVIDER, INCLUDING MCOS, WHICH RECEIVES MORE THAN \$500,000 IN MEDICAID PAYMENTS PER YEAR, TO HAVE AN "EFFECTIVE" COMPLIANCE PROGRAM WENT INTO EFFECT
- CERTIFICATION REQUIRED 12/31/09-PROVIDER CERTIFIES THAT IT SATISFIES COMPLIANCE PROGRAM REQUIREMENTS. PENALTY FOR FAILURE TO HAVE "EFFECTIVE" COMPLIANCE PROGRAM-EXCLUSION
- Section 363-d of the Social Services Law, 18 NYCRR 520
- www.omig.state.ny.us

NEW YORK STATE REQUIREMENTS SPECIFIC TO MEDICAID MCOS

- Plans are required to submit report of fraud and abuse prevention activities due each year
- 10 NYCRR Sub-Part 98

PROGRAM INTEGRITY-A QUALITY AND DATA PROBLEM

- MEDICAID IMPROPER PAYMENT RATE-(Payment Error Rate Measurement Report ("PERM") 2008 (NEW YORK WAS ONE OF 17 STATES REVIEWED) Median fee for service error rate about 8% (combines beneficiary eligibility and provider service documentation)
- MEDICARE FFS-ABOUT 4%
- MEDICARE ADVANTAGE- ABOUT 10%
- USING DATA TOOLS AND SYSTEMS TO REDUCE IMPROPER PAYMENTS AND UNNECESSARY OR HARMFUL SERVICES
- USING DATA TOOLS TO FOCUS ENFORCEMENT

MEDICAID DATA ISSUES

- ENROLLMENT
- ROSTER MANAGEMENT
- IDENTITY THEFT/TRANSFER
- THIRD PARTY PAYOR IDENTIFICATION AND LIABILITY
- EXCLUDED PROVIDERS AND EMPLOYEES
- BILLING FOR OUT OF NETWORK/CARVE OUT SERVICES
- INAPPROPRIATE PRESCRIBING/ORDERING
- DRUG-SEEKING PATIENTS

MEDICAID'S BIGGEST DATA CHALLENGE-ENROLLMENT, DISENROLLMENT, TRANSFER

- 20% of plan members cycle out of Medicaid each year-problem particularly acute in managed care (healthier, younger population)
- Data match projects demonstrate enrollment issues
- Where plans have role in recruitment, data match can demonstrate enrollment agent fraud
- Favorite report issue for media, IGs, AGs, Controllers, Auditors, GAO

ENROLLMENT DATA MATCH PROJECTS-OLDEST AND MOST PRODUCTIVE DATA MINING

- Use recognized identity algorithms-date of birth, sex, first and last name, ssn, addresses, place of birth
- Rely on standardized enrollment systems designed to capture unique identifiers
- Immutable (mostly) characteristics
- Significant recoveries

ENROLLMENT DATA MATCH PROJECTS-AUTHORITY AND ACCESS TO DATA

- Program Agencies
- Program Integrity Agencies
- HHS Office of Inspector General
- Government Accountability Office (GAO)
- State Comptrollers (Controllers), Auditors General
- Legislative Audit staff
- Program Integrity Contractors?
- Third party liability contractors

DATA MATCH PROJECTS

- PARIS Match-national data run by CMS since 1999 to show enrollees participating in Medicaid in two states-distributed to both states
- PARIS Match-60% of dual-covered months involve persons under age 18
- How do states (or plans) figure out what state the enrollee is a resident of?
- CASE LAW: You are the resident of the state you think you are
- ISSUE: Does anyone ask enrollees if they are currently enrolled in Medicaid in another state or county?

DATA MATCH PROJECTS- ENROLLMENT

- Enrolled persons incarcerated
- Enrolled persons deceased
- Enrolled persons in two or more plans
- Enrolled persons in fee-for-service and managed care-
- Easier to use identity duplication (e.g., Entity Analytics) software on back end

DATA MATCH PROJECTS- ENROLLMENT

- *Capitation Payments Made When Enrollees are Institutionalized in a Skilled Nursing Facility*
- *Prior to Date of Birth Payments*
- *Recovery of Capitation Payments for Retroactive Disenrollment Transactions*
- *Improper Retroactive Supplemental Security Income Capitation Payments*

ROSTER ISSUES

- Match between pcip roster and payment and state payment roster
- Is there a delay after enrollment?
- Is there a delay after notice of disenrollment or disqualifying event?
- Does the MCO clinical system capture data (death, nursing home status) related to eligibility which is not used for roster purposes?

IMPLICATIONS FOR MCOS IN ENROLLMENT DATA MINING BY STATES

- "IMPROPER" RETENTION OF CAPITATION PAYMENTS FOR INELIGIBLE ENROLLEES?
 - 2009 False Claims Act amendments-
 - Qui tam exposure
 - After recoveries, was there any system in place—
 - To determine whether enrollee currently active (encounter information)
 - To match pcip roster vs. enrollee roster
 - To determine whether NCQA quality measures based on encounters were accurate

IDENTITY THEFT/TRANSFER

- Controls on multiple cards for same individuals
- Enrollment in two plans owned by same parent
- Born again/modified dates of death
- Dental services-multiple dental visits per month
- Pharmacy-prescriptions inconsistent with diagnosed conditions
- NY Deceased Patients project
- Need to focus on billed services as well as paid services to identify fraud issues-measure of extent of provider control weaknesses

THIRD PARTY PAYOR IDENTIFICATION AND RECOVERY

- Federal law-Medicaid is always payor of last resort-cannot be billed for services if other coverage exists
- Is patient with other coverage eligible for MC coverage by plan?
- Whose responsibility (between state and plan, within plan) is TPL determination and payment?
- About 6% of Medicaid enrollees in New York have other insurance coverage.
- Are your plans pursuing coverage and payment where the other payor is another plan managed by the same parent, or is an ERISA plan managed by an affiliate

THIRD PARTY LIABILITY IN MEDICAID

- DEFICIT REDUCTION ACT OF 2005 EXPANDS LIABILITY, IMPOSES DUTY ON STATES TO MAKE RECOVERIES, IMPOSES DUTIES ON THIRD PARTY PAYORS
- MEDICAID IS ALWAYS PAYOR OF LAST RESORT
- CREDIT BALANCE REVIEWS
- CMS.HHS.GOV/ThirdPartyLiability

THIRD PARTY LIABILITY IN MEDICAID

- THIRD PARTY MATCH AND RECOVERY CONTRACTS-HMS AND OTHERS
- THIRD PARTY DATA DOWNLOADS ON COVERAGES
- MATCHING OF PAYMENTS BY PBMS, TAFT-HARTLEY PLANS, THIRD PARTY ADMINISTRATORS AND INSURORS WITH MEDICAID
- LOOK BACK PROVISIONS

THIRD PARTY LIABILITY IN MEDICAID AFTER THE 2005 DEFICIT REDUCTION ACT

- PROVIDERS-TAKE BACK PAYMENTS, SUBMIT CLAIMS TO OTHER PAYORS FIRST
- PAYORS-SOME OF YOUR COST AND PAYMENT CONTROLS NOT APPLICABLE TO MEDICAID ENROLLEES-TIMELINESS, PRIOR AUTHORIZATION (IN SOME CIRCUMSTANCES)
- ENROLLEES-ACCURATE INFORMATION ABOUT OTHER INSURANCE AT ENROLLMENT
- MANAGED CARE ENROLLMENT ISSUES

EXCLUSIONS

- section 1932(d)(1) of the Social Security Act prohibits organizations:
- from having an employment, consulting, or other agreement with an individual or entity for the provision of items and services that are significant and material to the entity's obligations under its contract with the State where the individual or entity is debarred, suspended, or excluded.

CREDENTIALING-NEW YORK

- a. managed care organizations shall have in place a formal credentialing process as set forth in the Medicaid Managed Care and Family Health Plus Model Contract section 21.4.
 - b. managed care organizations must retain oversight and control if delegating credentialing function
 - c. managed care organizations shall ensure, in accordance with Article 44 of the Public Health Law, that persons and entities providing care and services for the organization in the capacity of physician, dentist, physician assistant, registered nurse, other medical professional or paraprofessional, or other such person or entity satisfy all applicable licensing, certification, or qualification requirements under New York law and that the functions and responsibilities of such persons and entities in providing Benefit Package services do not exceed those permissible under New York law.
 - . A managed care organization's compliance program should ensure that any required credentialing processes are in place and functioning effectively.^[1]
- [1] See 10 NYCRR § 98-1.12(k) and (l)

CREDENTIALING AND EXCLUSION

- WHERE ARE THEY NOW? PROBLEM DOCTORS , NURSES, PHARMACISTS, THERAPISTS, AND PROVIDERS-STRAIGHTFORWARD FALSE CLAIM ACTION-CMS, OIG CITE 1999 STANDARD
- KEEPING BAD AND EXCLUDED PROVIDERS OUT OF HEALTH CARE- USING AUTOMATED BACKGROUND CHECKS, PRIOR LICENSE ACTIONS, PRIOR EXCLUSIONS(state and federal)
- WHOSE RESPONSIBILITY IS IT TO IDENTIFY EXCLUDED PROVIDERS? IF SUBCONTRACTORS, WHO IS CHECKING?
- EASY RUN FOR STATES-ARTICULATED POLICY (Co,In,Ma., RI, Ky)

Effect of Exclusion From Participation in Medicaid

- September 1999 OIG bulletin
- No excluded person can receive any compensation from federal health care programs
- In effect, this bars even janitors if their compensation is derived in any part from Medicaid
- <http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/effected.htm>

Provider Exclusions – State Medicaid Directors Letter 08-003 (available on CMS website)

- Issued on June 12, 2008
- Clarifies CMS policy
- Reminds States of their duty to report to HHS-OIG about excluded persons
- Tells States where and when to look for exclusions
- Reminds States of the consequences of paying excluded providers

WHEN IS IT FRAUD OR ABUSE?

- USING EXCLUDED PROVIDERS IN MEDICAID MANAGED CARE NETWORK IS ILLEGAL, AND CAN SUBJECT PLAN TO CMPs AND RECOVERY
- PROVIDING SERVICES ORDERED BY EXCLUDED PROVIDER IS ILLEGAL AND NONREIMBURSABLE
- USING SUBCONTRACTORS TO ARRANGE FOR SERVICES OR PROVIDE THEM, WHERE THOSE SUBCONTRACTORS EMPLOY EXCLUDED PERSONS, CAN BE ILLEGAL AND NONREIMBURSABLE

CARVE-OUT SERVICES-Dual payment

- Prenatal care
- Maternity care
- Psychiatric services
- Supplemental payments to fee for service providers for certain cases-e.g., safety net

INAPPROPRIATE PRESCRIBING/ORDERING

- Physician role in carve-out services
 - Prescription drugs
 - Personal care/ home health
 - Writing orders without seeing patient
 - Volume
 - Physician enrollment in Medicaid

DRUG-SEEKING PATIENTS

- Multiple prescribers
- Multiple pharmacies
- Multiple opioids
- Problem prescribers, pharmacies
- Algorithm for identifying drug-seeking patients
- Investigation, referral rates

NY OFFICE OF MEDICAID
INSPECTOR GENERAL - SEE OUR
NEW COMPLIANCE REGULATION
AND OUR WORK PLANS, AND GET
REGULAR UPDATES

- www.omig.state.ny.us
- Sign up for our listserve (many of our subscribers are outside New York)
- Learn the coming attractions in other states-we share ideas and audit/investigative techniques, as well as our annual work plan

We are in this together

- THERE IS FRAUD IN MANAGED CARE, AND FRAUD DETECTION AND CONTROL NEED TO BE BUILT INTO BUSINESS PROCESSES FOR STATES, MCOS, AND SUBCONTRACTORS
- WE NEED TO ASSURE THAT MANAGED CARE ENROLLEES HAVE ACCESS TO NEEDED CARE
- WE NEED TO SUPPORT AND COLLABORATE WITH MANAGED CARE SIUs, AND ADDRESS PROVIDER FRAUD AGAINST MCOS
- MCOS NEED TO INVEST IN COMPLIANCE AND SIU PROGRAMS WHICH ADDRESS FRAUD, ABUSE, AND UNACCEPTABLE PRACTICES

EXISTING FEDERAL SOURCES OF INFORMATION ON MANAGED CARE FRAUD ISSUES

- "Guidelines for Addressing Fraud and Abuse in Managed Care" -HCFA 10/2000 from the National Medicaid Fraud and Abuse Initiative
- "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations" CMS Medicaid Alliance for Program Safeguards-May 2002

EXISTING FEDERAL COMPLIANCE REQUIREMENTS FOR MEDICAID HMOS

- Medicaid HMO must have administrative and management procedures, and a mandatory compliance plan to guard against fraud and abuse. 42 CFR 438.608
- Usual seven elements of compliance program
- Compliance officer and compliance committee accountable to senior management

EXISTING FEDERAL COMPLIANCE REQUIREMENTS FOR MEDICAID HMOS

- Cannot use services or accept orders from providers who have been excluded from Medicare, Medicaid, or SCHIP
- Plan must have system to verify that services are actually provided-42 CFR 455.1
- Plan must report suspected fraud and abuse to the state- 42 CFR 455.1
- Plan report to state must include:
 - Number of complaints made to state that warrant preliminary investigations
 - For each complaint that warrants investigation
 - Name/id number, source of complaint, type of provider,
 - Nature of complaint, dollars involved, disposition
-

IN YOUR SPARE TIME. . .

- Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care (October 2000)
http://www.cms.hhs.gov/FraudAbuseforProfs/02_MedicaidGuidance.asp#TopOfPage
 Scroll to bottom of page and select Managed Care - click on fraudgd.pdf.
- Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans (May 2002)
http://www.cms.hhs.gov/FraudAbuseforProfs/02_MedicaidGuidance.asp#TopOfPage
 Scroll to bottom of page and select Managed Care – click on mcomplan.pdf.
- The Florida Senate Interim Project Report 2006-133 (November 2005)
<http://www.flsenate.gov/Publications/2006/Senate/reports/Workprogram/pdf/workprogram.pdf> (Page 97)
- Ohio Performance Audit (December 2006)
http://www.auditor.state.oh.us/AuditSearch/Reports/2006Ohio_MedicaidProgram_12_19.pdf
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