

THE INSPECTOR GENERAL'S TOP
TEN:
MEDICAID RISK AREAS AND
HEALTH PROGRAM INTEGRITY

-2008 Health Care Compliance
Conference-University of Rochester

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Before you see the top ten list, a few words from OMIG. . .

- Environmental scan/SWOT
- Medicaid and New York-perfect together
- MICs
- OIG work plan
- Universal health care vs. socialized medicine
- Conservative think tanks-why are we as a nation spending more federal health money in richer states?
- Liberal think tanks-why can't New York be more like France-where you don't need an original birth certificate and 3 tax returns to get health care?
- Newspapers and TV-why spend money to travel when we can find problems here?

NEW YORK MEDICAID DATA ANALYSIS-THE NATIONAL LEADER

- Biggest program and payments
- Second biggest program integrity unit-500 employees
- Biggest data warehouse-\$200 billion in claims
- Leader in transition from prosecution emphasis to program integrity emphasis
- Everyone is watching

OLD MODEL-PROSECUTION FOCUS

- FOCUS ON INTENT OF INDIVIDUAL AND ENTITY ACTORS
 - What did they do that was wrong?
 - How did they know it was wrong?
 - How do we prove that they knew?
 - How do we punish them for conduct they knew was wrong, and recover the money they obtained through wrongful behavior?

CONSEQUENCES OF PROSECUTION MODEL

- PAY AND CHASE
- CRIMINAL FOR LITTLE GUYS, CIVIL FOR BIG GUYS, MONITORS FOR THE BIGGEST GUYS
- OBSTRUCTION IS THE EASIEST CRIME TO PROVE
- SKILL-good lawyers make huge difference
- LUCK
 - Was there a whistleblower?
 - Emails, record destruction, undercover, recorded conversations

NEW MODEL: PROGRAM INTEGRITY-FOCUS ON REDUCING IMPROPER PAYMENTS

- What improper payments occur?
- Why do they occur?
- What systems and controls were in place (at provider, outside professionals, payor, and enrollee) to prevent and detect improper payments?
- What improvements are required to systems and controls to prevent recurrence?
- How do we distinguish between organizations with effective systems and controls and those without?
- If they can't do it right, we don't want them in program

PROGRAM INTEGRITY MEANS A FOCUS ON EFFECTIVE COMPLIANCE PROGRAMS

- NY-mandatory “effective” compliance programs for hospitals and snfs
- Failure to have effective compliance program is basis for exclusion
- “effective” compliance program requires disclosure to state of overpayments received, when identified
- “effective” compliance program requires risk assessment, remedial measures

PROGRAM INTEGRITY AND COMPLIANCE REQUIRE RISK ASSESSMENT

- What are system vulnerabilities?
- What are areas of interest to OMIG, CMS, OIG?
- What are recent projects and recoveries?
- Work plans, reports, websites

PROGRAM INTEGRITY REQUIRES PROVIDER AND PROFESSIONAL COMMUNICATION

- April 2008 Work Plan
- October 2008 Annual Report for 2007
- Beginning 10/1/08, all new final audit reports will be on OMIG website
- Model compliance guidance coming for hospitals and managed care
- Voluntary disclosure guidelines-10/08

PROGRAM INTEGRITY REQUIRES AUDIT FOCUS

- AREAS OF SIGNIFICANT COST WITH LIMITED PRIOR AUDIT WORK
 - Managed care
 - Hospitals
 - Diagnostic and Treatment centers/outpatient clinics
 - Personal care

PROGRAM INTEGRITY REQUIRES AUDIT PROTOCOLS

- OHIP WRITES REGULATIONS/OMIG
AUDITS TO REGULATIONS
- “WHERE IS IT WRITTEN?”
- SHARING AUDIT PROTOCOLS WITH
AGENCIES AND PROVIDERS
- PROVIDING SUPPORTING
DOCUMENTATION ON ADVERSE
FINDINGS TO AUDITED PROVIDER

NOT JUST OMIG-MEDICAID INTEGRITY CONTRACTORS ARE COMING TO NY IN 2010

- Conduct post-payment audits of Medicaid providers
- Perform combination of field audits and desk reviews
- Begin with fee-for-service providers and cost report audits
- CMS: "Audits will identify overpayments, but Audit MICs WILL NOT be involved in collection of overpayments." (translation: CMS will take money from states, leave it up to states to collect from providers)

CMS VIEW: State's Role with MICs

- "Vet the monthly audit list to make sure MICs are not duplicating/interfering with State activities"
- "Review draft and final audit reports"
- "Recover overpayments from providers"
- "Adjudicate appeals"
- From CMS MIC (Medicaid Integrity Contractor) Slide presentation July 2008

#10-NEVER EVENTS

- Starting October 1,2008
- Present on admission-where did this patient come from?
- Acquired during hospital stay
 - Reported?
 - Attending physician?
 - Lab,pharmacy
 - Records integrity

HHS/OIG, CMS WORK PLAN GOALS AND ISSUES

- LOOK FOR INITIATIVES UNDER MEDICAID
- OUT IN NEXT TWO WEEKS

#8-Credit balances

- Must be refunded within 30 days of receipt of reimbursement from third party
 - 18 NYCRR 540.6 (e)(4)
 - OMIG will be reviewing major providers for credit balances

#7-rebilling of denied, disallowed, voided claims

- How do you know what your billing system is doing?
 - Dead patients
 - Impossible claims

#6-DRG assignments and support

- Historical approach-refunds
- 2008 approach-clinical review, Pareto analysis
- Investigation/compliance program analysis on Pareto 20%

#5-SUPPLEMENTAL/DUAL PAYMENTS

- Supplemental newborn and maternity payments
- GME supplemental payments with no encounter data

#4 DUPLICATE PAYMENTS/SAME TIME PERIOD

- Ambulance during hospital stay
- DME during nursing home stay
- Included drugs billed separately
- Home health/personal care during hospital stay
- Desk audit match reveals issues

#3-Payment Error Rate Measurement (PERM)

- CMS contractor
- First claims reviewed and researched 10/08
- Please help us-flag internally for response
- Average rate in first 17 states-18%

#2 Home Health/Personal Care

- Physician authorization
- Timely, appropriate assessments
- Records of services
- Trained, qualified, screened staff
- Enrollee

#1-Compliance Program

- Eight requirements +
- Effective?
- Risk assessment
- Role/reporting of compliance officer
- Critical if other issues discovered
- Employee/staff knowledge
- Board knowledge/involvement
- Add to work plan for 2009

DATA MINING TECHNIQUES

- Claims analysis-5 years, \$200 billion in claims in data warehouse
- Patient demographic feed and match-age, sex, marital status, addresses, licensing, ssns
- Electronic diagnostic and treatment feeds-ICD-9s, DRGs, key words-claims, managed care encounters, authorizations
- In-depth medical record analysis for given disease conditions using integrated health care organization systems (Bennett and colleagues, Northwestern)
- Geographic analysis for sales, patients, providers, relationships
- Modality analysis-which physicians use injectibles? Which physicians are early adopters? Which physicians use lab and physiological diagnostic tests?
- Every mining toolmaker wants to mention New York as a customer

DATA MINING

Where we were FFY 2007¹

- New York leads the nation in reported fraud and abuse recoveries - \$136 million of \$308 million national total (second is Georgia, with \$22 million)
- Data mining drives match projects and recoveries
- Using Fraud Collections as a percentage of Total Expenditures, NY (.31%) ranks third to Utah (.48%) and Wyoming (.46%).
- Of the top 5 states in expenditures, New York's \$136 million in fraud and abuse recoveries is followed by:
 - **California** **\$21 million**
 - **Florida** **One of 7 states with no reported recoveries**
 - **Illinois** **One of 7 states with no reported recoveries**

1: All slide figures as reported on CMS form 64 for FFY 2007

DATA MINING

Where we were in FFY 2008

- Data mining was a significant contributor to \$215 million recovery goal required by CMS contract with New York for 2008
- Pilot projects with contractors and DOH
- Expanded capabilities for out years-systems, contractors and personnel
- OMIG task force to enhance use of data mining results in audits, investigations and enforcement

DATA MINING 2008

- PERM (Payment Error Rate Measurement)- New York is being evaluated for 2008 claims
- Average error rate in 17 states evaluated in 2007-18%
- Stratified sample of all claims
- Test-is claim supported by documentation supplied by provider upon request

DATA MINING 2008

- NEW YORK-PERM PLUS
- NOT JUST AN ERROR RATE
 - Contact with patients as well as providers
 - Capture potential fraud as well as lack of documentation
 - California Model 2006 7 % improper payment rate, 2.5% fraud rate

Data Mining Approaches

Data Matches/Demographics

- Men having babies
- Fillings in crowns
- Deceased enrollees
- Children under 10 years old having babies
- Women giving birth every 5 months
- Women over 50 years old having babies without infertility treatments

Data Mining Approaches

Data Match on Providers & Networks

- Doctor P was excluded from Medicaid, but is ordering services
- Doctor in Amagansett serves only patients from Bronx.
- Every patient who goes to clinic y gets multiple prescriptions filled in pharmacy Z
- Dr. A in Rochester writes 10% of the prescriptions filled at chain pharmacy location B.
- Dr. P died in 1997, is still a referring physician
- Managed care plan Q has never paid for a mental health visit for a Medicaid member

Data Mining Quality Tools

Providers Not Meeting Minimum Standards

- Never events not reimbursable-New York Medicaid 10/08
- Unreported adverse events
- Unreported adverse outcomes/unanticipated deaths
- Ranking/rating facilities-audit focus
- Condition of participation failures (structure)
- Drug outcomes in populations and in facilities

DATA MINING QUALITY TOOLS

- Interventions and Outcomes-not just claims data
- Drug, device, practice pattern outcomes
 - Epogen and cancer growth
- Off-label prescription practices
 - What drugs and devices are used for patients who do not have on-label diagnoses?
 - What works?

Conclusion

- Building in Program Integrity is key to future of Medicaid
- Data Mining is Future in Program Integrity and Compliance
- Rich new data sources-electronic medical records, data integration
- Which tools? How to evaluate tools?
- Focus on Outcomes vs. Focus on Intent?
- Focus on Systems vs. Focus on Events?
- Measures for Data Mining in Compliance
- Relation to Enterprise Risk Management and COSO measures

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