



## **Educational Webinar Series**

### **Helping MCOs Prepare for HHS Inspector General Oversight Reviews**

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#### **Presenters:**

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#### **Goals of this Webinar:**

- 1) Explain what MCOs need to know about the 2011 Inspector General Work Plan
- 2) Discuss how MCOs should prepare for the review
- 3) Offer next steps MCOs should take to make plans review-ready

#### **About the HHS Work Plan:**

Since the passage of healthcare reform over a year ago, the amount of scrutiny and number of review programs aimed at MCOs has increased exponentially. Many government agencies and third party vendors will be looking at MCOs to determine whether they're doing all they can to ensure Medicaid program integrity. The Health and Human Services (HHS) Inspector General is one such agency.

The law requires that the Office of Inspector General protect the integrity of HHS, as well as the health and welfare of beneficiaries under HHS programs. To identify problem areas, the Inspector General conducts audits, reviews, investigations, and evaluations of the programs that fall under HHS' jurisdiction, including the Medicaid program.

Each year, the Inspector General's office publishes a work plan outlining the various projects associated with its primary entities and publishes a report after each review is completed with summary findings and recommendations. A link to the full 2011 work plan is available on our website at [hms.com/webinars](http://hms.com/webinars). The Inspector General has already initiated some reviews within this work plan. MCOs should familiarize themselves with the reviews that specifically relate to them and begin to prepare.

#### **AREA OF FOCUS #1: State Oversight of MCOs' Provider Credentialing Methods**

To ensure that all enrolled providers have the correct credentials, the ACA now requires:

- Regular licensure checks of providers, including checks across state lines

- Increased oversight of new providers for specific periods after they enroll
- Additional scrutiny of initial claims submitted by new Durable Medical Equipment and Prosthetics, Orthotics, and Supplies suppliers (DME)
- Medicare and Medicaid providers to establish compliance programs that adhere to standards set by both CMS & the OIG

CMS is developing even more requirements for these compliance programs, as well as instituting mandates of its own. For example, CMS will now require:

- States to adopt additional credentialing procedures, including criminal history checks—based on risks associated with particular provider types
- States to establish levels of risk for provider types for **Medicare**
  - Home healthcare and DME at the highest level
  - Each level will be subject to specific screening requirements to mitigate associated risks
- States to establish categorical levels of risk for providers for **Medicaid**
  - Conduct site visits for moderate and high-risk providers
  - Subject high-risk providers to fingerprinting and criminal background checks
- Suppliers to meet new enrollment standards established in 2009 and finalized in August 2010

Furthermore, CMS and state agencies now have the option of declaring a moratorium on enrollment of new providers if they believe it will help fight fraud, waste, and abuse.

In addition to the ACA's and CMS' requirements, the HHS also stipulates that providers include their national provider identifier (NPI) on all Medicare and Medicaid enrollment applications and claims.

#### **AREA OF FOCUS #2: Provider Enrollment**

Even though they are forbidden from receiving Federal healthcare dollars, excluded providers often still manage to align themselves with plans and take advantage of the Medicaid program. For this reason, the ACA insists that provider enrollment standards and procedures for both Medicaid and Medicare be strengthened to deter fraud and abuse.

According to the Government Accountability Office (GAO), neither states nor MCOs have an effective method for identifying deceased providers, enabling unscrupulous individuals to use deceased providers' numbers to bill for services long after the providers have died.

The GAO also believes that Medicaid state standards do not sufficiently protect Medicaid programs from excluded providers. This belief stems from a September 2009 report, which found that in five states, Medicaid paid over \$2M for controlled substances that were written or filled by 65 doctors or pharmacies who were barred or excluded from federal healthcare programs for a variety of offenses, including illegally selling controlled substances.

As such, the ACA now requires providers to demonstrate their efforts to promote the integrity of the Medicaid program by:

- Disclosing all affiliations—past and present—with other providers who:
  - Have uncollected debt
  - Are or were subject to a payment suspension under a federal healthcare program
  - Have been excluded from participation in Medicare, Medicaid, or CHIP
  - Have had their billing privileges denied or revoked
- Enrolling in Medicare or Medicaid **prior** to ordering DME prescriptions or home healthcare services
  - Maintaining records for these orders
  - Including their NPI on claims submitted for these services

As indicated in the Federal register released on February 2, 2011, HHS will not impose additional screening or enrollment criteria on MCOs. However, the ACA and state agencies will now obligate MCOs to develop their own unique screening requirements, including:

- Assigning providers and suppliers to a level that is higher or lower than the one assigned by Medicare or Medicaid program
- Developing written policies and procedures for selecting and retaining providers
- Documenting processes for credentialing and re-credentialing providers that have signed contracts or participation agreements
- Checking the “list of excluded individuals and entities” and the “excluded parties list system” monthly to determine whether any of their providers’ employees and/or contractors have been excluded
- Developing a method for determining whether enrolled providers have satisfied these requirements

### **Recommendations for Plans**

To ensure compliance with these mandates, the Inspector General will review plans to determine if they are contracted with excluded providers to provide services, or if any entities in an MCO’s provider network employ excluded providers. The Inspector General will also review how states oversee plans’ compliance with these mandates.

To prepare, HMS recommends that plans:

- Obligate enrolled providers to adopt written compliance programs that meet the mandated requirements
- Make sure credentialing and enrollment standards and processes meet federal standards, and revise if necessary
- Evaluate their own policies and procedures for identifying excluded or other “problem” providers in their network regularly and frequently
- Implement consistent methods to ensure claims are only paid to eligible providers
- Ensure that provider databases contain all basic provider information that is needed to support their inclusion in the program, and use this information to develop verification procedures

- Keep current with new technologies and services that support close and frequent review of providers, and consider whether investing in these technologies is cost-effective
- Check state licensing files, NPI records, and Drug Enforcement Administration numbers for evidence of excluded providers, as providers that lack these credentials are ineligible to receive Federal healthcare payments
  - Tools are now available help plans access this data and verify a provider’s status—in some cases in real-time—*before* paying a claim
- Obtain the results of reviews conducted at both the state and Federal levels, as these may document excluded providers as well

**AREA OF FOCUS #3: MCOs’ Fraud and Abuse Safeguards**

CMS’ Medicaid Integrity Group (MIG) is responsible for conducting annual program integrity reviews of state agencies to determine the extent to which Medicaid programs comply with federal program integrity standards, as well as to help CMS identify program vulnerabilities and effective practices.

Historically, MIG has identified Medicaid managed care as the area most vulnerable to program integrity issues. MIG contends that:

- MCOs often fail to verify receipt of services through an explanation of benefits or other method
  - States do not track MCO fraud and abuse systematically
- States do not provide enough oversight of the integrity of their MCOs

Although CMS has not yet issued specific guidelines on this matter, the Inspector General will conduct reviews determine:

- Whether MCOs have developed adequate internal administrative and management procedures to guard against fraud, waste, and abuse—and are following them
- The extent to which states are overseeing plan compliance

Overpayments are another particularly sensitive subject for states. Many states believe that plans aren’t incentivized to report overpayments because doing so could negatively impact future rate-setting processes.

**Recommendations:**

MCOs should continue to follow their own procedures for fighting fraud, waste, and abuse, and use program integrity tools including maintaining claims editing and other processing safeguards, as well as in-house Special Investigative Units (SIUs) tasked with identifying and investigating areas prone to fraud, waste, and abuse.

At a minimum, plans should take the following *additional* actions to address the concerns expressed both by both the MIG and the ACA:

- Evaluate the areas that their state’s Recovery Audit Contractor will focus on to ensure current policies and procedures are aligned

- Assess their vulnerability and implement processes to address areas specified by the MIG— including making sure that services paid for were actually provided
- Strengthen their controls to make sure they meet the six “rights” of program integrity:
  - The right care
  - In the right amount
  - For the right patient
  - At the right time
  - In the right setting
  - With the right payment

Finally, plans must be prepared either to report more complete overpayment information to their states, or be subject to even more reviews at the encounter level.

**AREA OF FOCUS #4: Pre-Payment Reviews to Detect and Deter Fraud and Abuse**

An effective way for MCOs to prepare for the upcoming OIG review is to develop a comprehensive pre-payment review system that includes rules-based screens and edits with NCCI, “do not pay” lists, and predictive modeling for scoring claims.

**NCCI**

Effective October 2010, Medicaid agencies are required to incorporate NCCI methodologies into their claims payment system to prevent improper coding and inappropriate payment.

**“Do Not Pay” Lists**

A June 2010 Presidential Memorandum directed state agencies to check certain databases *before* making payments to be sure that Medicaid funds don’t go to dead or excluded individuals.

**Predictive Modeling**

The predictive model looks for fraudulent patterns across claims by considering a number of factors that are too subtle and complex for traditional rules-based screens and edits to identify. This approach can be significantly more effective than traditional post-payment “pay-and-chase” methods.

As claims enter the adjudication system and pass through traditional pre-pay screens and edits, each claim is “scored” for its risk of improper payment based on three factors:

- 1) Provider characteristics
- 2) Proven relationships between claim characteristics
- 3) Overpayment risk

Claims with relatively high scores would be most at risk of being overpaid if they were paid as submitted.

**Recommendations:**

The Inspector General will soon look at how Medicaid MCOs are using prepayment reviews to detect and deter fraud and abuse. These HHS reviews will likely identify plans' vulnerabilities, and may result in recommendations for future action, since clear compliance requirements have not yet been specified. Plans can help themselves, from both a compliance and financial perspective, by investigating and evaluating the available pre-payment review technologies.

MCOs should seriously consider developing a comprehensive pre-payment vision that incorporates the following functions:

- Prospective identification of recovery audit findings
- NCCI and other pre-payment edits
- Upfront coordination of benefits and cost avoiding for other insurance
- Continual reconciliation of payment methodologies and reimbursement changes with claims payment modules

#### **AREA OF FOCUS #5: Duplicate Payments and Capitation Errors**

Multiple payments are often made to providers for individuals with more than one Medicaid number, which results in wastes millions of dollars. To prevent improper spending, the OIG will now treat all concurrent fee-for-service and capitation payments as duplicate payments—even if they're paid for different Medicaid numbers.

Examples of duplicate payments may include:

- A state paying a provider on a fee-for-service basis while also paying capitation rates. This is considered a duplicate payment since it has paid both the capitation rate for the time period, and also the claims for the beneficiary.
- Fee-for-service payments for family planning services received by the beneficiary from a provider outside the MCO network. In this case, state agencies would be permitted to bill the plan for the cost of the claim.
- Overlapping inpatient claims paid on a fee-for-service basis by the state, and also by the MCO to the provider.

Capitation errors occur most often when beneficiaries are institutionalized and receiving other coverage, and when a beneficiary's death has not been recorded. To prevent these payment errors, the Inspector General will begin identifying beneficiaries who live in these facilities and reviewing capitation payments to determine if the state paid the plans while the person was institutionalized. The Inspector General will also review costs reported for beneficiaries living in long term care facilities to determine the appropriateness of the capitation rates.

The Inspector General will also review encounter data associated with supplemental capitation payments to ensure its accuracy. This type of data details services provided by an MCO to a member, and is reported to states for their records. Frequently, this data relates to the addition of a newborn to the plan.

To reduce the risk of payment errors, we recommend that plans:

- Partner with state agencies to ensure correct enrollment data, locate the source of duplicate payments, identify and recover incorrect payments, and come up with a plan to prevent future payment overlaps
- Regularly meet with states to understand and review any relevant findings
- Begin matching for deceased beneficiaries and recovering any claims paid after date of death
  - Plans may choose to share updated beneficiary information with their states once the funds have been recovered

## **OVERALL RECOMMENDATIONS**

There are a number of ways plans can prepare for the coming HHS review, both in conjunction with states and independently.

### **Partnering Approach**

You may want to work with states to develop:

- An expanded compliance program—either internally and/or through a vendor
- A provider self-reporting process to identify duplicate payments and overpayments on a claim level
- Plans for sharing information when a “problem provider” is identified
- Protocols for handling potential findings—including recovering claims paid after the death of a beneficiary or provider, and identifying and arranging plans’ access to databases to help minimize errors
- A protocol for root cause analyses where potential overlapping payments occur

The partnering approach might also entail adopting or mirroring the same standards, combining data across payors/providers, and using technology that only recently has become available to assist in these processes.

### **Independent Approach**

The most immediate action you should take independent of your state agencies is to make sure your compliance plan is updated with your approach to addressing the issues outlined in the work plan.

Then take a look at existing provider contracts and provider notifications to make sure the language does not impede accurate payment. If the language is unclear, modify it as soon as possible.

You should also take the following *additional* steps:

- Evaluate a method for identifying provider exclusions
- Make sure your credentialing approach meets review requirements
- Determine that robust editing is in place for NCCI within your claims payment system
- Expand your prepayment review efforts

- Adopt mandatory provider compliance programs—including provider self-reporting—in your contracting process
- Make sure the language of existing provider contracts and provider notifications doesn't impede accurate payment, and modify it as soon as possible if necessary

### **Looking Forward**

We encourage you to know what's coming and assess your vulnerabilities. Be able to articulate a strong business reason if you're not meeting a standard and aren't implementing a corrective action plan. And finally, identify the areas with the largest potential return on investment and address them immediately. Remember, ROI is not only measured in savings, but could also include avoidance of fines or penalties.

### **IN SUMMARY**

Eliminating wasteful spending is a major concern for both the ACA and OIG. Now that you know what the OIG will be looking for in its annual review and how you may be affected, you have the opportunity to get a head start on fine-tuning your processes and procedures. We encourage you to work together with your state's Medicaid agency to bolster your ability to prevent waste and maintain program integrity—and to make all the necessary internal changes to ensure your systems and processes can withstand the coming reviews.