

HEALTH CARE COMPLIANCE
ASSOCIATION 2008 ANNUAL
MEETING: THE FUTURE OF
MEDICAID COMPLIANCE

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USUAL DISCLAIMERS

- Rapidly developing area
- Each state is different
- Propagation is not plagiarism-if you see a good idea, I probably borrowed it
- Propagation is not plagiarism-if you would like to use these slides in your own presentation, feel free

MEDICAID-

- 2006 spending:\$303 billion in US (state and federal)
- 2006 spending: \$44 billion in New York (Kaiser Family Foundation)
- Medicaid spending growth has slowed recently, remains our national safety net program
- Majority of adult Medicaid enrollees in New York work

“Patient-centered care” - The Paterson Administration’s Plan for New York

- Institute of Medicine 2001 - Committee on Quality of Health Care in America-focus on individual patient -goal of 21st Century Health Care
- New York 2007-8 - focus on care of patient, not needs of institutions
- What happens to patients in in-patient facilities? What happens when they leave?
- What do enrollees want to manage chronic conditions?
- How can we support interventions that help patients stay in the community (asthma, diabetes, hypertension, aging)

FOR MEDICAID PAYOR, PATIENT-CENTERED CARE IS DATA DRIVEN

- QUALITY, CONTINUITY OF CARE
- COST-EFFECTIVENESS
- BENCHMARKING, MEASUREMENT, CONTINUOUS IMPROVEMENT
- Here's what we care about, here's where you stand
- ALLOWING PATIENTS AND THEIR FAMILIES TO PARTICIPATE IN HEALTH CARE DECISIONS
- Information/Data
 - Accuracy
 - Availability
 - Transparency
 - Ease of use

FOR HEALTH CARE ORGANIZATIONS PATIENT-CENTERED CARE IS LEADERSHIP, TEAM, AND DATA DRIVEN

- BENCHMARKING, MEASUREMENT, CONTINUOUS IMPROVEMENT
- HEROES OF PROCESS
- RESPECT, RECOGNITION, SUPPORT
- BENEVOLENT CYCLES AND FEEDBACK LOOPS

FOR PATIENT-CENTERED CARE, GOVERNMENT RELIES ON DATA AND PROFESSIONAL STANDARDS

- “furnishing medical care. . . that fails to meet professionally recognized standards of health care. . .” is in both federal and most state systems, a legal basis for sanction and program exclusion
- “professionally recognized standards” are rapidly improving in health care organizations- what does this tell us about the others?

PROGRAM INTEGRITY-A QUALITY AND DATA PROBLEM

- OUR GOAL-BUILD PROGRAM INTEGRITY INTO PROGRAM OPERATIONS
- MEDICAID IMPROPER PAYMENT RATE-18% (PRELIMINARY PERM REPORT, 2007)(NEW YORK WAS NOT REVIEWED)
- CREDIT CARD LOSS RATE FROM IMPROPER PAYMENTS-.07%
- USING DATA TOOLS AND SYSTEMS TO REDUCE IMPROPER PAYMENTS AND UNNECESSARY OR HARMFUL SERVICES

**FOR MEDICAID, PROGRAM
INTEGRITY MUST BE LEADERSHIP,
TEAM, AND DATA DRIVEN**

- BENCHMARKING, MEASUREMENT,
CONTINUOUS IMPROVEMENT
- HEROES OF PROCESS
- RESPECT, RECOGNITION, SUPPORT
- BENEVOLENT CYCLES

**FOR PROGRAM INTEGRITY,
GOVERNMENT MUST RELY ON
DATA AND PROFESSIONAL
COMPLIANCE STANDARDS-(LET'S
TRY THIS THOUGHT)**

- “an organization furnishing medical care. . .
that fails to meet professionally recognized
compliance standards . . .” would be in both
federal and most state systems a candidate
for lower payments and possible sanctions
- “professionally recognized standards” are
rapidly improving in health care organizations-
what does this tell us about the others?

PROGRAM INTEGRITY

- PROSECUTIONS ARE APPROPRIATE FOR SOME PROVIDERS, BUT-HOW DO THEY AFFECT RATES OF IMPROPER CLAIMS? WHAT RESULTS ARE WE TRYING TO ACHIEVE?
- . *"The argument of responsive regulation is that regulators are more likely to succeed if they use strategies that are responsive to the culture of those being regulated.. . bringing about change in hospitals must take into account professional and organisational cultures."* John Braithwaite
- Performance reporting and measurement have become core values of best health care providers

BRAITHWAITE:PUNISHMENT AND PERSUASION

- " Consistent punishment is too costly, and consistent cajoling of the incorrigibly unethical or incompetent is naïve. A study of 410 chief executive officers of small health care organisations found that expected severity of sanctions did not predict compliance, but regulators who were consistently "tolerant and understanding" increased non-compliance."
- Where was their data?

BRAITHWAITE

- “The more complex and dynamic the care process (as in a hospital) , the more relevant a policy of devolution of management decisions closer to the complexities of managing staff and patients. In addition, a regulatory strategy that harnesses management creativity to deliver continuous improvement in quality allows leaders to raise the standards of the whole sector.”

GUNNINGHAM AND KAGAN Regulation and Business Behavior Law & Policy (2005)

- “ If socio-legal research has taught us anything, it is that legal coercion is expensive and difficult. Law can rarely hope to be meaningful and effective without the cooperation, indeed the normative accord, of the vast majority of populations it hopes to control. . .”

PROGRAM INTEGRITY- ENCOURAGE THE LEADERS, REPORT DATA ON THE LAGGARDS

- Between 1990 and 2005, the proportion of residents physically restrained in nursing homes dropped from 40% to 4%.
- Cystic fibrosis survival rates/Iraq battlefield survival discussed by Dr. Atul Gawande in Better.
- Quality in hospitals (as measured by avoidable deaths) has consistently improved in the best institutions over past five years
 - Focus on specific issues-central line infections, pneumonia vaccine, antibiotics at surgery, medication errors, bedsores
 - Focus on never events and never payments
 - Focus on discharge and readmission with same diagnosis
 - Report cards and comparisons

MEDICAID-GOVERNMENT LAGGARDS IN PROGRAM INTEGRITY AND DATA

- 2003-GAO REPORT “ GAO added Medicaid to its list of high-risk programs, owing to the program's size, growth, diversity, and fiscal management weaknesses.” See,GAO, Major Management Challenges and Program Risks: Department of Health and Human Services, GAO-03-101 (Washington, D.C.: January 2003).
“ We noted that insufficient federal and state oversight put the Medicaid program at significant risk for improper payments. ”

MEDICAID 2005 GAO REPORT

- "CMS lacks a strategic plan to drive its Medicaid antifraud and abuse operations."
- "CMS officials were unable to provide any publicly available planning documents specifying short- or long-term Medicaid program goals that target fraud and abuse."
- Less than 20 employees at CMS with Medicaid fraud and abuse responsibility.

MEDICAID LEADERS AND LAGGARDS-2005

- CMS Review of Program Integrity Procedures-New York State
- "As the largest single Medicaid program in the nation, New York's anti-fraud efforts over the last several years have not been proportionate to its vulnerability."
- "New York must do more to meet its program integrity obligations."

MEDICAID 2006-CONGRESS- DEFICIT REDUCTION ACT

- Congress specifically required the use of contractors to review the actions of those seeking payment from Medicaid, conduct audits, identify overpayments and educate providers and others on payment integrity and quality of care. It further mandated that CMS employ 100 full-time equivalent employees to provide support to the States.
- Congress has appropriated funds to CMS which will reach a total of \$75 million annually in 2009.
- Primary role assigned to program agency, not oversight agency

2007 FOCUS-LEADERS AND LAGGARDS

- CMS-WHAT ARE THE STATES DOING?
 - Program reviews
 - PERM (Payment Error Rate Measurement) reviews-improper claims
 - Training, meetings, advice,
 - ROI calculation

CMS MEDICAID INTEGRITY-2007 IDENTIFY LEADERS AND LAGGARDS

- "State Program Integrity Assessment (SPIA) – This strategic planning and development contract, awarded in August 2006, has assisted CMS in detailing State agencies' efforts to combat fraud, waste, and abuse. SPIA deliverables include surveying the Medicaid integrity landscape, identifying State program integrity profiles, and recommending performance measures and standards by which State performance may be assessed in the future."
- THESE ASSESSMENTS ARE ALREADY TAKING PLACE

OIG/HHS 2008 WORK PLAN

- **Medicare/Medicaid Credit Balances**
- We will review providers, including independent laboratories and hospitals, to determine whether there are Medicare/Medicaid overpayments in patient accounts with credit balances.
- For Medicaid, section 1902(a)(25) of the Social Security Act, 42 CFR
- 433 Subpart D, and various States' laws require that Medicaid be the payer of last resort and that providers identify and refund overpayments received.
- *(OAS; W-00-08-31311; various reviews; expected issue date: FY 2009; new start)*

CMS MEDICAID INTEGRITY CONTRACTORS-2008

- New Medicaid Integrity Contractors Are to Begin Work SPRING 2008 What will they be doing?
- Model from "Recovery Audit Contractors" in Medicare -Status Report on the Use of Recovery Audit Contractors (RACs) in the Medicare Program (February,2008)
- Claimed recoveries \$371 million in FY 2007 from California, New York, Florida.

CMS 2008

- What has been data focus of RAC efforts?
- Debridement (requires actual cutting) (Coding Clinic)
- Heart failure and shock-failure to meet criteria for inpatient care (Interqual)
- Ambulatory surgery-no complications to justify inpatient stay (APC list of procedures)
- Provider failed to submit documents in response to RAC's request
- Ambulance or dme billed during hospital stay

DATA AND INTEGRITY LESSONS FROM RAC

- Significant state differences
- In Florida, if you are a Medicare enrollee passing by some hospitals, you will be in
- In New York, some hospitals do not believe in Medicare ambulatory surgery
- California providers were more likely to appeal RAC determinations, less likely to succeed

Data Mining Systems and Data Driven Reviews

- Data mining is a developing area – processing speed doubles every two years, software and analytic approaches move at same speed.
- Existing state data systems, at best, reflect reliable, tested systems and the state-of-the-art at the time of procurement. Existing systems procured three years ago.
- Significant opportunities for post-payment recoveries

DATA-PROGRAM INTEGRITY LEADERS AND LAGGARDS 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**
 - **Two states in top five had no reported recoveries**

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

New York Data Mining Approaches Data Matches/Demographics

- Fillings in crowns
- Hospital in-patient ambulance trips
- Dead people having prescriptions filled
- One enrollee-two managed care numbers
- For More Data, go to session 603 at 1:15
- Cathy McCulskey/Carol Booth

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.
- 85% of patients at in-patient detox center J are treated at discharge by D and TC clinic K
- 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
- Unreported adverse events
- Unreported adverse outcomes/unanticipated deaths
- Ranking/rating facilities-audit focus
- Condition of participation failures (structure)

Data Mining Investigative Tools

- Investigator/auditor experience-data analysis integration
- What do we want to accomplish?
- Visualization, data integration, data manipulation
- Super crunchers - algorithms, regression analysis, standard deviations
 - Who can do this?
 - Who can use this?

WORKING TO BE A LEADER Where We Plan to be in FFY 2008

- Data mining will be significant contributor to \$220 million recovery goal set by CMS contract
- 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

THE FUTURE OF MEDICAID PROGRAM INTEGRITY-DATA AND PROFESSIONAL STANDARDS

- We want to use/share data mining for quality improvement and error reduction as well as improper payment issues.
- We think New York has great opportunities in Medicaid data mining for identification of improper payments.- data warehouse with \$200 billion in claims
- We want to develop compliance and reporting systems which build on the cultures of hospitals and professions
- We want to do better in quality improvement, error reduction, and identification of improper payments using best practices and advice from employees, state agencies, contractors, CMS and other states.

LEADERS AND LAGGARDS- SUPPORTING THE COMPLIANCE CULTURE

- We want to measure what we do, and report on it.
- We want to build in program integrity on the front end. We want to make data mining tools that work available to providers and their organizations.
- We want to distinguish among organizations that have effective compliance programs, and those that don't, in our response to identified improper payments.
- We want health care organizations to respond to identified improper payments, not just by repaying money, but by identifying the root causes of the improper payment and correcting them

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- OMIG 2008-9 Work Plan-available this week