Medicaid Innovation Accelerator Program (IAP)

IAP Learning Collaborative: Substance Use Disorders (SUD)

Program Integrity for SUD Programs

Targeted Learning Opportunity #6

8/17/15
Logistics Placeholder

• Please mute your line and do not put the line on hold
• Use the chat box on your screen to ask a question or leave comment
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• Moderated Q&A will be held periodically throughout the webinar
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Facilitator

- Cathy Fullerton, MD, MPH
- Senior Research Leader, Truven Health Analytics
Speakers (1 of 5)

- Karen Johnson, CPA
- Chief Deputy Director, California Department of Health Care Services
Speakers (2 of 5)

- **Tanya Homman**
- Chief, Provider Enrollment Division, California Department of Health Care Services
Speakers (3 of 5)

• Rusty Dennison, MA, MBA
• President and Founder, Parker Dennison & Associates
Speakers (4 of 5)

• Susan Parker, CPA, MT
• Executive Vice President and Founder, Parker Dennison & Associates
Speakers (5 of 5)

- Adam Falcone, JD, MPH
- Partner, Feldesman Tucker Leifer Fidell LLP
• Overview of program integrity
• State experience: California
• Health plan experience: Parker Dennison & Associates
• Provider experience: Feldesman Tucker Leifer Fidell
Goals of Webinar

• Participants will examine various aspects of program integrity with respect to substance use disorder treatment programs and providers
• Participants will discuss major challenges and successful strategies for preventing and investigating fraud, waste and abuse
• Participants will hear state, health plan and provider perspectives on program compliance
Overview of Program Integrity

• SUD programs are at a greater risk than physical health programs
  – Confusion from multiple oversight agencies
  – Less familiarity with billing practices, more familiar with Block Grant funding and other sources
  – Conflicting compliance measures in state and health plan regulations can result in unintentional fraud

• What does program integrity encompass?
  – Fraud
  – Waste
  – Abuse
  – Provider misunderstanding
  – Prevention measures
Key Terms in Program Integrity

- **Upcoding**
  - Billing for higher cost services or medical devices rather than the lower cost service/device that was actually rendered

- **Unbundling**
  - Billing for components of a service submitted piecemeal over time
Key Terms in Program Integrity (cont’d)

• **Kickbacks**
  – Monetary and non-monetary gifts offered, solicited and/or provided in exchange for referral of Medicare or Medicaid patients for medical services which may or may not be unnecessary

• **Excessive/Unnecessary services**
  – Providing and billing too many services that may also be inappropriate for the patient’s care plan
Polling Question (1 of 5)

• Which of the following do you think poses the biggest program integrity risk for substance use disorder service programs in your state?
  – Upcoding
  – Unbundling
  – Provision of excessive or unnecessary services
  – Unintentional billing mistakes by providers
California

State Experience
Investigating and
Strengthening Program
Integrity

Karen Johnson, CPA, Chief
Deputy Director, DHCS

Tanya Homman, Chief, Provider
Enrollment Division, DHCS
Agenda (2 of 12)

• Overview of Medi-Cal
• 2013 Investigation of Drug Medi-Cal providers
• Challenges for Program Integrity
• Lessons Learned
Overview of Medi-Cal

• Total budget: $98 billion
  – $19 billion in state funds
• Average weekly check-write: $382 million
• Average monthly capitation payments: $3.3 billion
• 71% Managed care
• 29% Fee-For-Service

• Beneficiaries served
  – 12 million
• Providers enrolled
  – 135,000

Medicaid.gov
Keeping America Healthy

Medicaid Innovation Accelerator Program
Agenda (3 of 12)

- Overview of Medi-Cal
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- Challenges for Program Integrity
- Lessons Learned
2013 Investigation of Drug Medi-Cal Providers

- DHCS Investigation
  - May 2013

- CNN / CIR story airs citing significant program fraud in DMC program; Criminal Investigations
  - July 2013

- Legislative Hearings
  - September 2013

The programs are supposed to help struggling addicts. But scammers make millions running troubled rehab clinics, even inventing fake clients to rip off taxpayers.
DHCS Strike Team

Deliverables:
- Intelligence
- Data
Analytics

• Data Analytics
  – Tremendous resource and asset to DHCS strike team efforts
  – Accelerate audits and investigations’ case development efforts
  – Allows a “deeper dive” into a program that is significantly increasing scope and dollar magnitude annually

• Network Analytics
  – Identify fraudulent patterns
  – Identify possible relationships and their interconnections
  – Identify the universe of the enterprise
Identifying Evidence of Fraud

1. DMC Program
   DHCS performs intense review of Drug Medi-Cal Program & identifies significant fraud

2. Data analytics
   and investigative work identifies potential fraud links to programs

3. Skilled Nursing Facilities
   Identification of:
   - Shared beneficiaries between provides
   - Business affiliates w/ criminal histories
   - Suspicious activities w/in Medi-Cal & other government programs

4. ADHC/CBAS
   Concerns at select ADHC/CBAS facilities

5. Pharmacy
   Common pharmacies are linked to DMC, SNF, CBAS facilities that are on our radar for potential fraud/waste/abuse

Others at risk?
Beneficiary Swim Lanes

- These swim lanes represent duplicate services being provided to one beneficiary on the same day
  - Chart review revealed that the beneficiary did not actually require drug treatment services
Criminal Investigation: Agency Collaboration

• May 2014: The US DOJ main office – Criminal Fraud Section and State DOJ accepts case and opens a criminal investigation
  – Contributors to the case include DHCS as lead agency along with the CMS zone program integrity contractors and State DOJ
  – The FBI and federal OIG have since joined the US DOJ to assist the case
  – CMS remains intimately involved in the care because of significant Medicare program implications
Actions Taken on Drug Medi-Cal Providers (as of 3/27/15)

- 547 sites visited
  - 100% of DMC providers
- 79 providers temporarily suspended
  - 93 Parents
  - 124 Satellites
  - 217 Sites in total
- 4 good cause exceptions
  - Sanctioned not imposed
- Approved billings for temporarily suspended sites
  - FY12/13 = $57 million
Actions Taken on Drug Medi-Cal Providers (as of 3/27/15) (cont’d)

• Out of the all 96 fraud referrals sent to the Medicaid Fraud Control Unit
  – 56 are currently under active investigation
  – 17 resulted in criminal filings by the CA DOJ
    • 12 DMC referrals will be filed in the next 90 days
  – 5 were consolidated due to multiple referrals associated with same provider
  – 17 have been closed
## Drug Medi-Cal Recertification Process

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<th>2</th>
<th>3</th>
<th>TOTAL</th>
<th>%</th>
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<tr>
<td>Sites Targeted</td>
<td>337</td>
<td>226</td>
<td>243</td>
<td>806</td>
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<tr>
<td>No Response</td>
<td>139</td>
<td>48</td>
<td>48</td>
<td>235</td>
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### Applications Inventory

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<th>178</th>
<th>195</th>
<th>571</th>
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<td>Approved</td>
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<td>73</td>
<td>34</td>
<td>209</td>
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<td>Decertified, Terminated</td>
<td>41</td>
<td>14</td>
<td>62</td>
<td>117</td>
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<tr>
<td>Remediation, Assigned, Onsite, QC</td>
<td>55</td>
<td>91</td>
<td>99</td>
<td>245</td>
<td>42.91</td>
</tr>
<tr>
<td>TOTAL</td>
<td>198</td>
<td>178</td>
<td>195</td>
<td>571</td>
<td>100.00</td>
</tr>
</tbody>
</table>

**Jul 2013:** Notice of intent to recertify

**Aug-Dec 2013:** Recertification forms to providers

**Jan 2014:** PED assumes DMC certifications

**Feb 2014:** Provider training, Remediation time extended, provider training online

**Apr 2014:** Backlog transitional to PED

[Medicaid.gov](https://www.medicaid.gov) - Keeping America Healthy

IAP: Medicaid Innovation Accelerator Program
Drug Medi-Cal Recertification Activities

- **August 2014**: Stakeholders meeting high-risk designation
- **September 2014**: High-risk designation, Stakeholders meeting provider agreements
- **October 2014**: Fingerprint-based criminal background checks, Provider Agreements
- **January 2015**: Stakeholders meeting DMC regulations
- **February 2015**: Monthly monitoring
- **March 2015**: All-day provider training
- **April 2015**: New training tutorial online
- **June 2015**: Stakeholders meeting DMC regulations
- **August 2015**: Emergency regulations (Medical Director enrollment, eliminations, align with other FFS)
- **September 2015**: Enrollment of Medical Directors
- **Ongoing**: Waiver preparations
Protecting & Recovering Public Health Care Dollars

Civil Investigation & Prosecution
(Federal and/or State)

DHCS & CMS Administrative Agencies
(Sanctions, Penalties, Recoveries)

Criminal Investigation & Prosecution
(Federal and/or State)

Protecting & Recovering Funds
Agenda (4 of 12)

• Overview of Medi-Cal
• 2013 Investigation of Drug Medi-Cal providers
• Challenges for Program Integrity
• Lessons Learned
Challenges for Program Integrity: Not Doing Enough

• Oftentimes Medicaid programs are scrutinized for not doing enough

• Focus on proactive program oversight and program integrity measures

• Up-front due diligence

Lack of oversight in billing matters questioned at DOA

By NICOLE CARTRETTE Staff Writer | Posted: Friday, March 22, 2013 3:00 pm
Challenges for Program Integrity: Doing Too Much

• Overly aggressive program integrity measures can have negative consequences

• Provider communities in New York and Texas have been less than pleased with fraud-fighting tactics in past years

NY Inspector General ousted for overaggressive Medicaid penalties

June 22, 2011 | By Karen Cheung-Larivee


In Medicaid Fraud Investigations, a Controversial Tool

by Emily Ramshaw | July 20, 2012 | 8 Comments

This article is the third of an occasional series on the consequences of state efforts to curb spiraling health costs, and the dollars lawmakers might target in the future.
Agenda (5 of 12)

- Overview of Medi-Cal
- 2013 Investigation of Drug Medi-Cal providers
- Challenges for Program Integrity
- Lessons Learned
Lessons Learned: Finding the Right Balance

- Aligning Visions: Ensure that program integrity efforts are aligned with the vision of the Director’s Office.
- Data Driven: Let the data drive your decisions.
- Consistency: Ensure consistency in execution.
- Proactive: Everyone must be proactive, not reactive, based upon identified areas of exposure and evidence.
Lessons Learned:
Keys to Future Success (1 of 2)

New Technology
- Continued use of new technologies to help us do more with less and keep pace with ever-evolving fraud schemes

Collaborate
- Continued cooperation and collaboration among internal and external business partners

Data Sharing
- Work toward expanded data sharing

Policies & Procedures
- Continued efforts to strengthen policies and procedures

Funding
- Continued funding for anti-fraud activities and resources
Lessons Learned: Keys to Future Success (2 of 2)

- Ensure the Division remains a relevant and value-added organization to the DHCS and Medi-Cal program as a whole
- Continue adapting to the changing landscape by being flexible, versatile and responsible to programmatic needs
Polling Question (2 of 5)

• Which of the following strategies does your state currently engage in to ensure program integrity? (select all that apply)
  – Proactive technology
  – Reactive data mining
  – Collaboration w/ other agencies
  – Clear, widely disseminated policies
  – Training, info sharing w/ providers
Program Integrity from a Health Plan Perspective

Susan Parker, Executive Vice President, Founder
Rusty Dennison, MA, MBA, President, Founder
Parker Dennison & Associates
Agenda (6 of 12)

• Background of Program Integrity Efforts & New Mexico’s Experience
• Monitoring Integrity: Financial Viability Reviews
• Monitoring Integrity: Claims Analysis
• Proactive Efforts: Provider Self-Assessments
New Mexico has experienced network disruptions and risk of access to mental health and SUD services
  - Program integrity
  - Financial viability

Medicaid health plan developed a plan to proactively identify risks and intervene with TA and QI for behavioral health providers
Background on Program Integrity Efforts & New Mexico’s Experience (2 of 2)

Reaching program integrity goals through two foci:

- Financial Viability Reviews
- Claim Analysis

**Goal:** Ensuring Access to Behavioral Health Services

Replacing services is challenging, particularly in rapid response to program integrity problems and in rural areas.
Agenda (7 of 12)

• Background of Program Integrity Efforts & New Mexico’s Experience
• Monitoring Integrity: Financial Viability Reviews
• Monitoring Integrity: Claims Analysis
• Proactive Efforts: Provider Self-Assessments
Monitoring Integrity: Financial Viability Reviews (1 of 4)

• Self-identified provider problems led to responses at two levels
  – Inability to make payroll
  – Unplanned, significant service reductions or contract termination notices

• In-depth onsite reviews
  – Indicators
    • Performance in total and by service
    • Productivity, staffing
    • Cost of services compared to rates
    • Payer mix, service mix
    • Billing timeliness
    • Collections, denials

• Offer TA with work plan and timeliness to improve performance
Monitoring Integrity: Financial Viability Reviews (2 of 4)

Broad reviews should be completed by financial professionals

YTD financial reports

Profiles

Additional investigation with targeted providers
- TA
- Additional monitoring

Develop network contingency plans for high-risk utilizers

Previous audits

Benchmarks
- Delayed audits
- <30 days of cash or days in A/R > 30 days

Correlate with problematic claims and utilization patterns

Continue monitoring all or part of network based on results
Monitoring Integrity: Financial Viability Reviews (3 of 4)

Broad review techniques, including profiles help identify at-risk providers

Net A/R balance / annual net revenues / 365
Cash + ST investment / average monthly expenses / 30 days

I.e. Increasing debt, A/P, intercompany payables or decreasing cash, profits
Monitoring Integrity: Financial Viability Reviews (4 of 4)

- Broad reviews should be completed by financial professionals
- YTD financial reports
  - Profiles
- Additional investigation with targeted providers
  - TA
  - Additional monitoring
- Develop network contingency plans for high-risk utilizers
- Previous audits
- Benchmarks
  - Delayed audits
  - <30 days of cash or days in A/R > 30 days
- Correlate with problematic claims and utilization patterns
- Continue monitoring all or part of network based on results
Agenda (8 of 12)

- Background of Program Integrity Efforts & New Mexico’s Experience
- Tools for Integrity: Financial Viability Reviews
- Tools for Integrity: Claims Analysis
- Tools for Integrity: Provider Self-Assessments
Monitoring Integrity: Claims Analysis (1 of 3)

- Identification of higher risk services
  - Historical problems
  - Type of service or practitioner
  - Compliance complexity
  - Rate
  - Provider type

- Stratify by provider and service

- Identify outliers (top 5 – 10%)
  - Total units
  - Units per member
  - LOS
  - Mitigating information (i.e. populations served)
Monitoring Integrity: Claims Analysis (2 of 3)

- Site visit for program and chart review
- QI approach unless referral for program integrity review indicated
- Service fidelity tool
  - State Medicaid rule
  - Service definitions
  - Regulations

- Program review
  - Leadership
  - Clinical supervision
  - Basic compliance checks
    - Presence of current assessment, treatment plan, progress note
Monitoring Integrity: Claims Analysis (3 of 3)

• Chart audits (small sample)
  – Selection of high utilizers (not statistically valid)
  – Audit team composition

• Outcomes
  – Utilization found acceptable—training and technical assistance
  – Corrective action plan (CAP) required with training and technical assistance
  – Referral for program integrity review
Agenda (9 of 12)

• Background of Program Integrity Efforts & New Mexico’s Experience
• Monitoring Integrity: Financial Viability Reviews
• Monitoring Integrity: Claims Analysis
• Proactive Efforts: Provider Self-Assessments
Proactive Efforts: Provider Self-Assessments

Prevent
- Efforts are designed to be proactive and preventative

Act
- Claims analysis by service and practitioner to identify problematic areas
- Use existing service fidelity tools or develop tools based on regulations and service definitions
- Complete chart audits as part of internal program integrity program

Plan
- Develop improvement plan
- Payback for any billing “errors” identified during the internal audit
Polling Question (3 of 5)

• Which of the following strategies does you state use to monitor program integrity in substance use disorder programs/providers? (select all that apply)
  – ID suspicious financial trends
  – Claims analysis- high risk services
  – Routine SUD program reviews
  – Site visits and chart reviews
  – Cont. monitoring risk providers
  – Other strategies
Questions and Discussion (2 of 3)
Program Compliance from a SUD Provider Perspective

Adam Falcone, JD, MPH,
Partner, Feldesman Tucker Leifer Fidell LLP
Agenda (10 of 12)

- The Provider Perspective
- Common Challenges for Compliance
- Strategies for States to Assist Providers
• SUD providers comprise a fragile safety net system, frequently composed of non-profit organizations whose business model does not allow for creation of a rainy day fund for hard times (i.e., no deep pockets)
Program Integrity Concerns (2 of 2)

- Fearful of program integrity efforts that utilize statistical extrapolation to recover “overpayments” due to unintentional mistakes when services have been legitimately rendered to patients
  - Insufficient documentation
  - Human errors
  - Legal technicalities
Agenda (11 of 12)

- The Provider Perspective
- Common Challenges for Compliance
- Strategies for States to Assist Providers
Common Challenges for Compliance

- Lack of organizational knowledge of applicable licensing, scope of practice laws, credentialing/enrollment, billing, documentation rules
  - Compounded when subject to different rules for multiple payers
- Fear of directly asking State/payers for guidance in applying or interpreting vague rules
  - Questionable reliability of advice in audit context
- Inadequate internal procedures in place to identify non-compliance within specific rules
  - Consequently, overreliance on external audits to identify issues
Agenda (12 of 12)

• The Provider Perspective
• Common Challenges for Compliance
• Strategies for States to Assist Providers
Strategies for States to Assist Providers (1 of 2)

- Offer annual trainings to provider staff
  - Based on key risk areas
- Establish a mechanism for providers to ask questions without repercussion
  - Ensure answers are binding on state
- Solicit provider recommendations to revise and clarify rules
Strategies for States to Assist Providers (2 of 2)

• Distribute self-audit tools
• Root cause analyses on audit findings to determine underlying issue:
  – Poor knowledge of rules
  – Inability to recognize non-compliance
  – Operational challenges
• Greater transparency and fairness in audit procedures
Polling Question (4 of 5)

- Using the ReadyTalk platform options, select the 'raise your hand' tool if your state is currently using an innovative, proactive method of assisting providers in their compliance efforts.
Polling Question (5 of 5)

• Would your state be interested in having a post-webinar discussion with the speakers to address any additional questions or reflections on today’s webinar?
  – Yes
  – No
Resources (1 of 2)

• Common Types of Health Care Fraud, Centers for Medicare & Medicaid Services
  – Common Types of Health Care Fraud

• Medicaid Program Integrity Education, Centers for Medicare & Medicaid Services
  – Medicaid Program Integrity Education
Resources (2 of 2)

• Medicaid Program Integrity Program, Centers for Medicare & Medicaid Services
  – Program Integrity

• Medicaid Integrity Institute, United States Department of Justice
  – Medicaid Integrity Institute (MII)
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