NEW YORK STATE | Department of Health | Medicaid Redesign Team

Value-Based Payment Program Integrity (PI): Issues and Considerations

Payment Integrity

November 16, 2016

VBP PI Workgroup Agenda

Meeting 1	
Data Quality	• Policy Question • Discussion
Meeting 2	
Policy Design	• Policy Question • Discussion • *Draft & Finalize* Consensus Recommendation(s)
Meeting 3	
Payment Integrity	• Finalize Policy Design Consensus Recommendation(s) • Policy Question(s) • Discussion • *Draft & Finalize* Consensus Recommendation(s)

Policy Question → **Discussion** → **Consensus Recommendation(s)**

Topics and policy questions were the output of the Regulatory Impact Subcommittee which convened in July-December 2015

Policy question frames and provides context, work subsequent workgroup discussion

Provide the State with a consensus recommendation on each of the workgroup's three policy questions

NEW YORK STATE OF OPPORTUNITY. Department of Health

Agenda

Today's agenda includes the following:

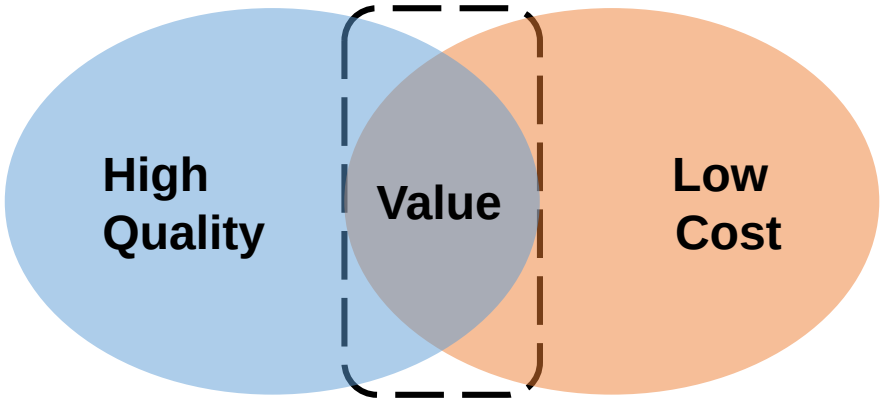
Agenda Item	Time
Policy Design Recap	10:30 am
Finalize Recommendations	10:45 am
Payment Integrity: Issues and Considerations	11:30 am
The Changing Landscape of Payment Integrity	11:45 pm
The Future of Payment Integrity: Develop Potential Recommendations	12:15 pm
Conclusion	1:30 pm

Policy Design Recap

Detailed findings and finalization of recommendations

Distinguishing Policy Design from Payment Integrity

Policy Design	Payment Integrity
Prospective adjustment to the policy, systems, and structures necessary to ensure that providers deliver high value care to all enrollees.	Fraud, waste, and abuse (FWA) control related to anti-kickback & Stark laws, inappropriate payments, inappropriately limitation of access to care, default risk reserve, VBP bundle gaming etc.
Output: changes to policy, systems and structures to prospectively avoid undesired behavior.	Output: identification of FWA activities and successful enforcement actions against violators.
The *what*	The *how*



Policy Design: Policy Question

What framework should be put in place to ensure that the transition to VBP does not create incentives contrary to the spirit of the program?

Draft Recommendations

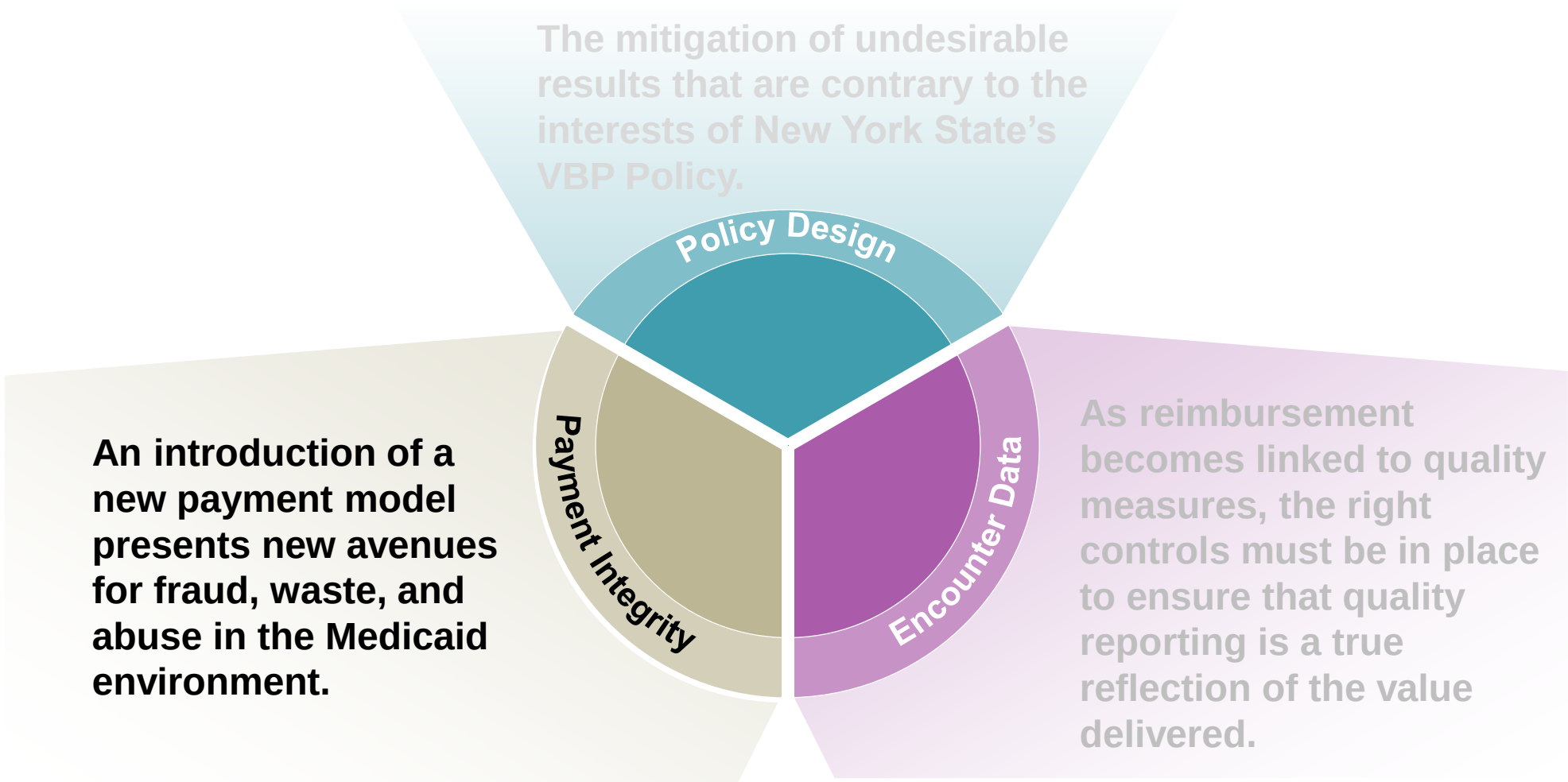
What framework should be put in place to ensure that the transition to VBP does not create incentives contrary to the spirit of the program?

1. Define patient access and patient experience measures (i.e. case closures and drops in service delivery) for the purposes of evaluating changes in access due to implementation of VBP.
2. Implement mandatory reporting of access measures and collection of patient experience measures to identify potentially inappropriate withholding of services.
3. Implement specific oversight efforts targeted at preventing “cherry picking” of populations for which it is easier to achieve desired cost and outcomes measures.

Payment Integrity: Issues and Considerations

Brief background and context

PI Component #3: Payment Integrity



Defining Payment Integrity

Within the context of Program Integrity, Payment Integrity is defined as the control of Fraud, Waste & Abuse.

Fraud[1]	Waste[1]	Abuse[1]
An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.	Encompasses the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act.	Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

[1] CMS *Health Care Fraud and Program Integrity: An Overview for Providers*

The Medicaid Managed Care Final Rule bolsters PI Requirements

In May 2016, CMS finalized a sweeping reform that will impact several components of the managed care programs that New York State (NYS) operates, including PI provisions which must be built into NYS's Model Contract. These reform initiatives include:

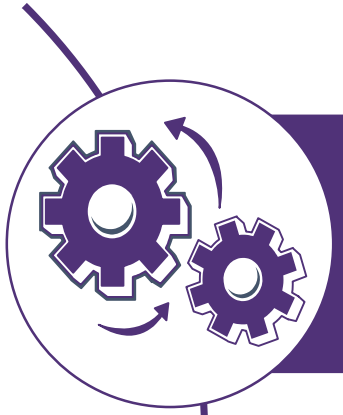
Fiscal integrity components that enhance rate setting transparency and establish a minimum medical loss ratio (MLR) of 85%

Quality improvement efforts that:

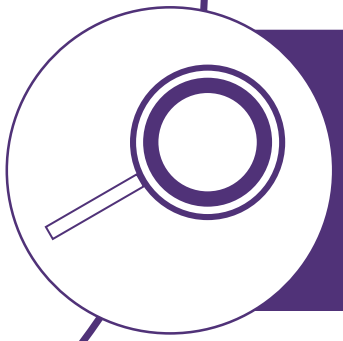
- Promote transparency
- Encourage stakeholder engagement
- Align quality measurement and improvement indicators with Marketplace standards

Network adequacy requirements that include state developed provider-to-member time and distance standards

The Medicaid Managed Care Final Rule bolsters PI requirements (cont.)



VBP and delivery system reform efforts that grant states the authority to incentivize and/or compel Medicaid managed care plans to transition to VBP



Program Integrity initiatives that require tri-annual auditing of **MCO reported encounter data** (among other requirements)

Expanding Managed Care Plans' Responsibilities In Program Integrity Efforts[1]

The final rule adds or reinforces several components to strengthen Medicaid and CHIP managed care plans' program integrity to monitor, prevent, identify, and respond to suspected fraud:

Mandatory reporting to the state by managed care plans of potential fraud and improper payments identified	Mandatory reporting to the state of information received by managed care plans about changes in an enrollee's circumstances that may affect the enrollee's eligibility	Mandatory reporting to the state of information received by the managed care plan about changes in a provider's circumstances that may affect the provider's participation in the managed care program	Suspension of payments to a network provider when the state determines a credible allegation of fraud exists	Establishment and implementation of procedures for internal monitoring, auditing, and prompt response of potential compliance and fraudulently issues within a managed care plan	CMS may defer and/or disallow FFP for expenditures under a MCO contract when the state's contract is non-compliant with standards aforementioned.

[1] (§§438.600, 438.602, 438.604, 438.606, 438.608, and 438.610) *Pages 110 - 129*

The Changing Landscape of Payment Integrity

The Transformation to VBP: How We Got Here

As delivery moves from FFS, to alternative payment models**, the value of the care delivered** becomes an increasingly important PI concern

Fee-For-Service

- Data analytics and fraud, waste and abuse (FWA) detection
- Medicaid population trends

Managed Care

- Population shift to capitation
- Quality measurements on manage care organization populations
- Encounter data and increased focus on value

VBP Arrangements

- Focus on value over volume

Program Integrity Provisions

OMIG conducts and coordinates improper Medicaid payment recovery activities

- OMIG previously shifted resources to match the change in direction away from fee-for-service (FFS) to Medicaid Managed Care (MMC).

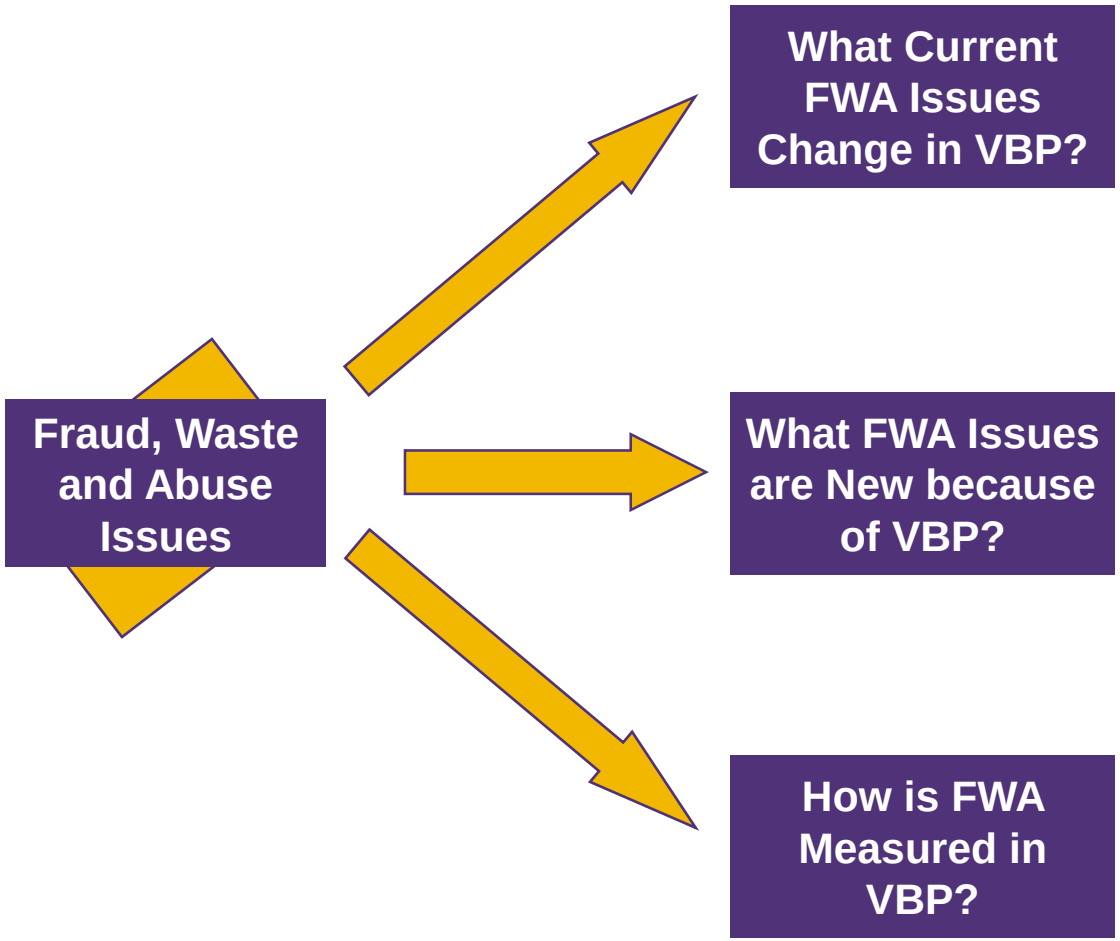
OMIG has evolved their resources to match the direction of Medicaid

- In response to the Medicaid Final rule and the shift to VBP, new prevention efforts will focus on value based payments (VBP).

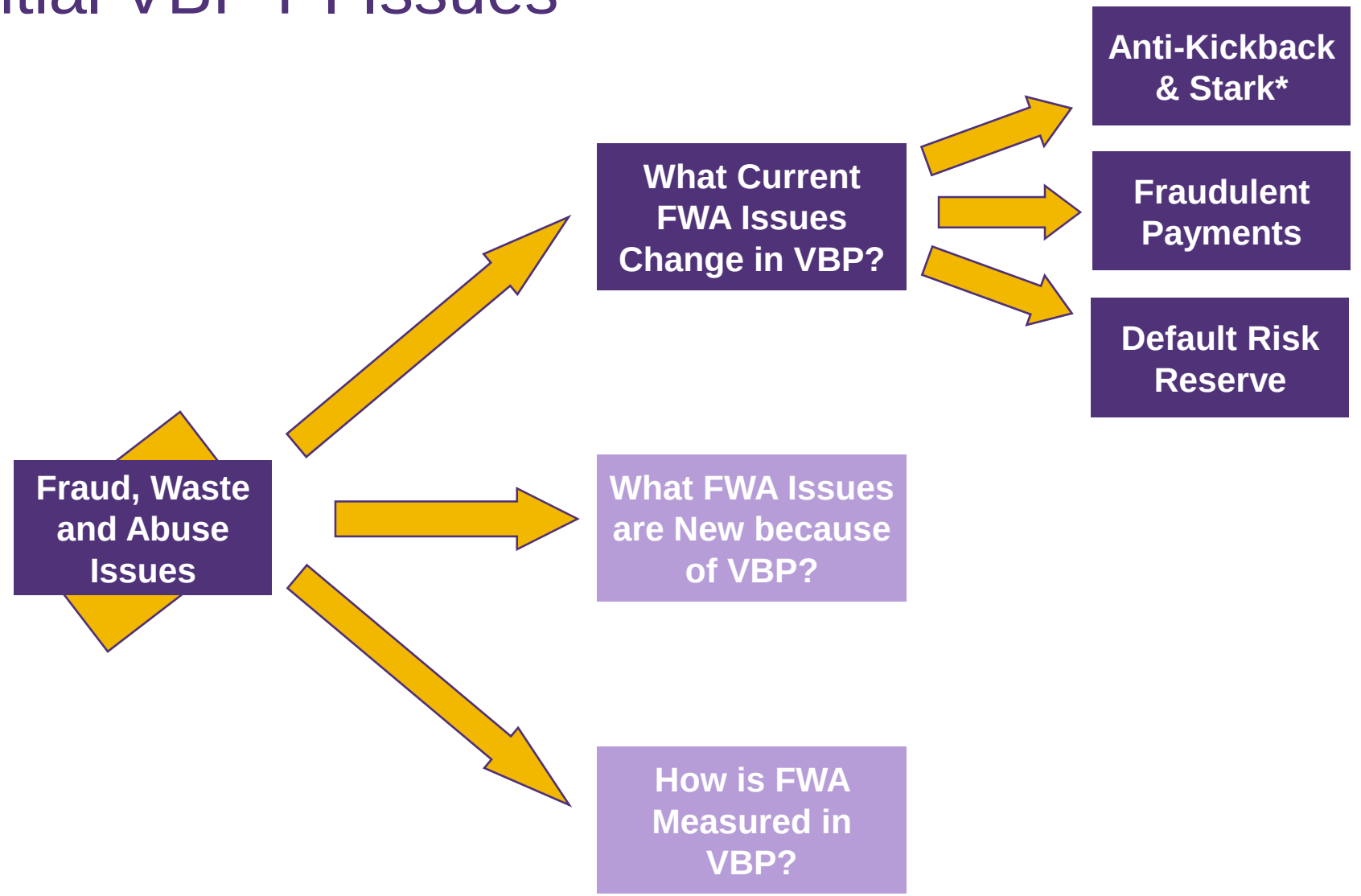
Potential VBP PI Issues

Fraud, Waste and Abuse Issues

Potential VBP PI Issues

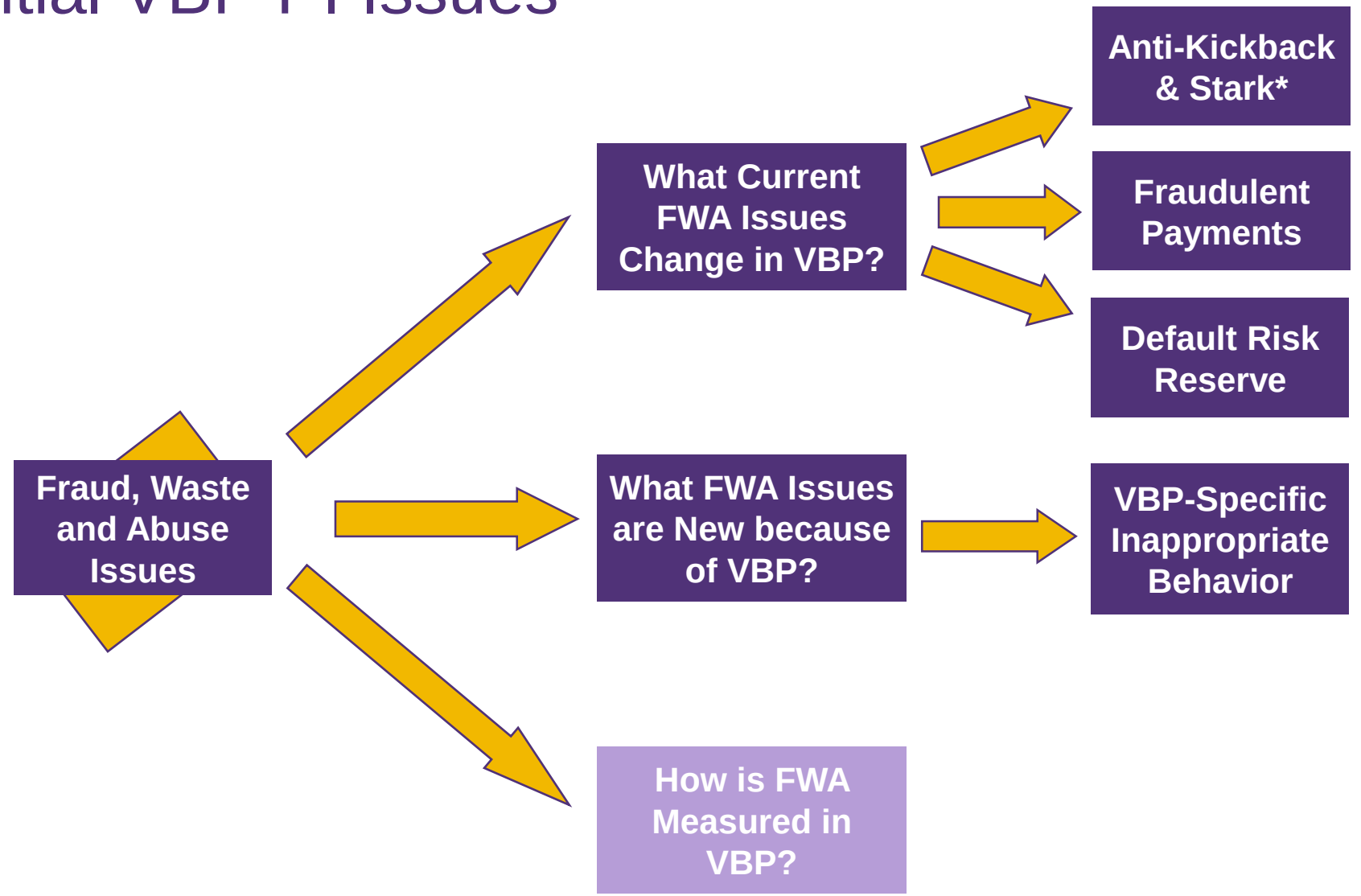


Potential VBP PI Issues



* Relevant recommendations generated by Regulatory Impact Subcommittee

Potential VBP PI Issues



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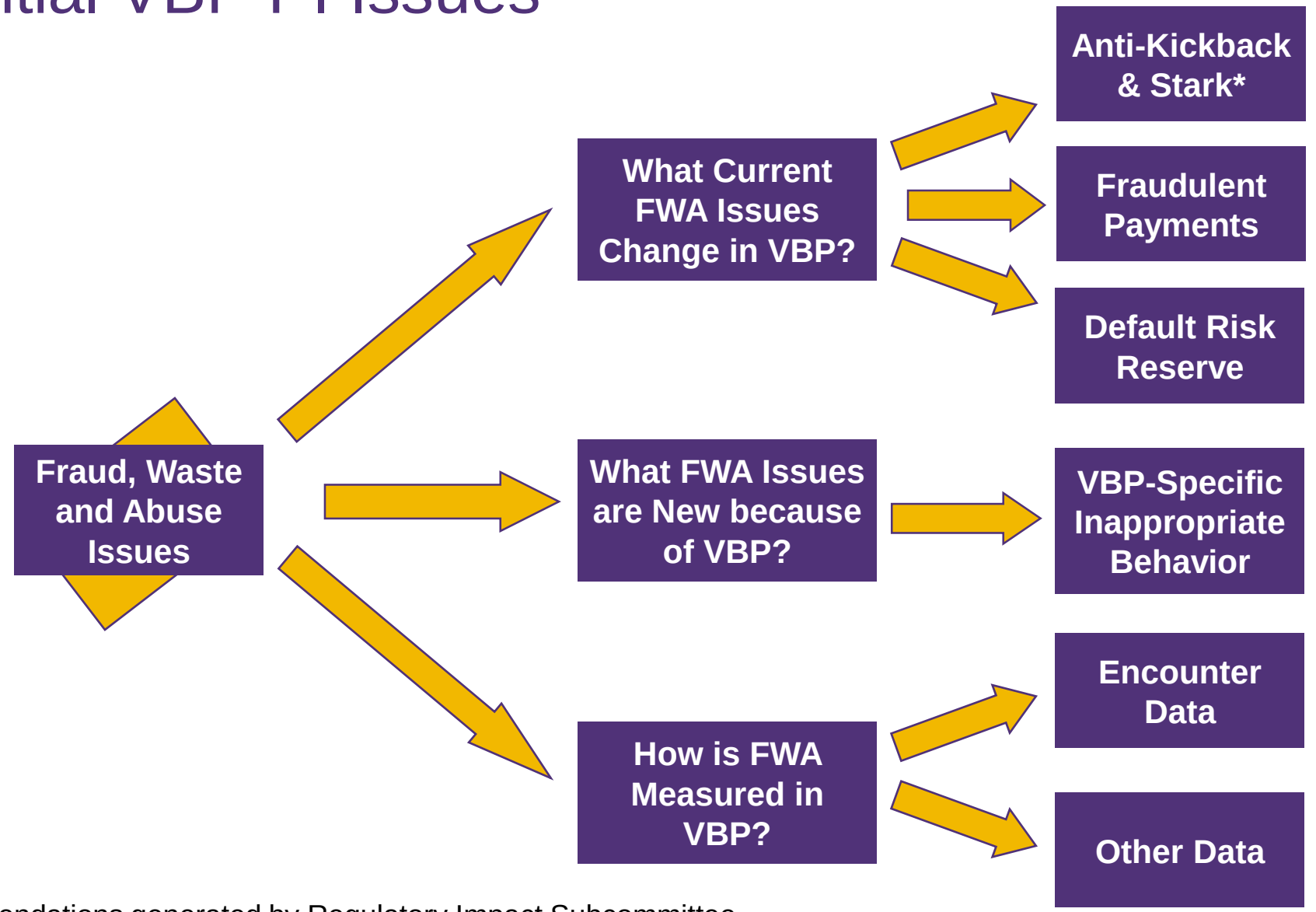
Potential VBP PI Issues



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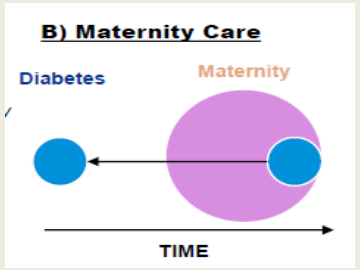
Payment Integrity Implications

FW&A: Overlapping Arrangements

A. **IPC or Total Care General Population**
B. **Maternity Care**
C. **HIV/AIDS**

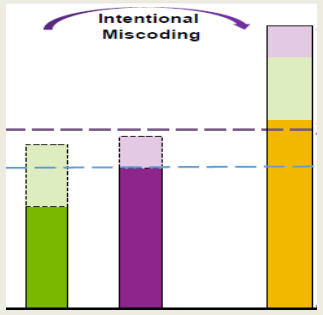
PI Implication:
Incentive for 'upcoding' and for cost-shifting to increase the changes for shared savings (or reduce changes for losses)



FW&A: Stop Loss Gaming

A. **Disproportionately expensive patients**
B. **Exceeding the stop loss threshold**.

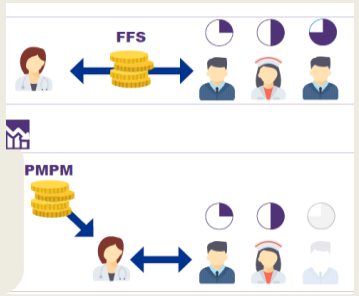
PI Implication:
New avenues of fraud exist for providers who intend to game a stop loss arrangement.



Policy: Limiting Access to Care

A. **Fee-for-Service (FFS): Payment based on volume.**
B. **Fully Capitated Arrangement: Per-Member Per-Month (PMPM) payment**

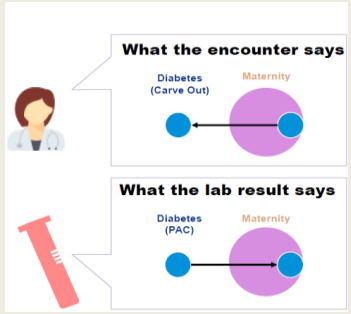
PI Implication:
The physician limits office hours, limiting access to care.



Data: Comparing Encounters to Lab Results

A) Program Enhancer

PI Implication:
A Policy Director could compare lab results to encounters to determine if there exits evidence of upcoding.



The Future of Payment Integrity

Develop Potential Recommendations

Payment Integrity : Policy Question

What Program Integrity infrastructure needs to be changed in order to establish a solid foundation for Medicaid payment integrity as it relates to VBP implementation in NYS?

A. What are the broad Program Integrity issues that manifest themselves through VBP with regard to partner agencies? What changes need to be made in response to these issues?
   i. Office of the Medicaid Inspector General (OMIG)
   ii. Office of Mental Health (OMH)
   iii. Office of Health Insurance Programs (OHIP)
   iv. Office of Quality and Patient Safety (OQPS)
   v. Office for People with Developmental Disabilities (OPWDD)
   vi. Office of Alcoholism and Substance Abuse Services (OASAS)
   vii. Other Agencies of Concern

Payment Integrity: Policy Question

What Program Integrity infrastructure needs to be put into place that establishes a solid foundation for Medicaid payment integrity as it relates to VBP implementation in NYS?

B. Where should accountabilities for payment integrity responsibilities lie in relation to Medicaid Program Integrity?

i. How will OMIG, OHIP, and other stakeholders redefine their agency roles and support each other's distinct efforts to control FW&A?

ii. With the shift to VBP, what are the priority areas of focus within NYS Medicaid Program Integrity, and how will this be communicated to stakeholders?

iii. Other

Payment Integrity: Policy Question (cont.)

What Program Integrity infrastructure needs to be put into place that establishes a solid foundation for Medicaid payment integrity as it relates to VBP implementation in NYS?

C. How can NYS determine whether the existing policies, laws, and regulations are adequate to allocate responsibility for payment integrity enforcement among stakeholders?
   i. Should the Department perform a contractual and functional assessment to determine alignment with the MCO Final Rule?
      i. Are the appropriate resources, infrastructure, and protocols in place to support necessary future state payment integrity?
   ii. Should a written protocol be developed wherein safeguards are developed and issued in a manner which can be legally enforced and where either the OMIG and/or DOH identifies high-likelihood targets for enforcement actions?

Thank You!

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