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New York State Medicaid Work Plan: A sign of the times?

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On April 18, 2008, New York's Office of the Medicaid Inspector General (OMIG) issued a detailed Work Plan (the Work Plan) specific to the state's Medicaid program.[1] New York is the first state to publish an individual state Work Plan of such a detailed and comprehensive nature. Given the obligations imposed by the Deficit Reduction Act of 2005, it is likely that many states will take notice, possibly even follow New York's lead, and perhaps even use the Work Plan as a model. Consequently, compliance officers, regardless of the state in which they are located, should review the Work Plan and consider incorporating applicable focus areas into their organization's audit plans and risk assessments.

Overview of the New York Work Plan

Through its Work Plan, OMIG has provided a detailed description, often with the supporting authority, of the specific areas of review of the Medicaid program for state fiscal year 2008-2009 (April through March). The Work Plan is ambitious, wide-ranging, and will require technical expertise to execute. The state apparently recognizes this fact and has earmarked funds for up to 750 staff and has set aside additional resources for investments in technology. Additionally, the New York Medicaid Inspector General has announced his intentions to collaborate with other state agencies to carry out the work; nine agencies (including the Attorney General's Medicaid Fraud Control Unit, and 13 counties that are participating in OMIG demonstration projects) are specifically identified in the Work Plan. This type of interagency collaboration has traditionally been more common on the federal level.

There are similarities between the New York Work Plan and that of the Department of Health and Human Services, OIG annual Work Plan, including the general format and certain focus areas, but providers and suppliers should know that this is not the "same old, same old." The New York Work Plan identifies a number of new target areas that OMIG intends to scrutinize. Perhaps the most significant new focus area is managed care. The Work Plan lists more than 20 specific areas related to Medicaid managed care that OMIG intends to review. Some of the focus areas include payments for deceased enrollees, payments for enrollees who moved out of state, stop loss payments, and improper crossover/duplicate payments. OMIG also intends to review data matches where there is no encounter data for newborns, but where Medicaid has paid monthly capitation payments. This review will focus on identifying incorrect payments and addressing quality-of-care issues.

Some other areas in the Work Plan focus on laboratory services, physicians' prescription ordering practices, and pharmacy providers. OMIG will review Medicaid payments for some independent laboratories. OMIG plans to review a sample of claims to determine whether the tests were ordered, that the results were available, and that the laboratory billed in accordance with applicable regulations. Specifically, OMIG will review the claims to ensure that there was no inappropriate bundling.

OMIG will also audit physicians who have ordered high volumes of controlled substances that are covered by Medicaid. In connection with this review, OMIG intends to conduct a chart review to determine if documentation supports medical necessity.

The pharmacy review will focus on claims information and comparing that documentation to the actual prescriptions. In addition, OMIG will conduct a review of selected out-of-state pharmacies that bill New York State Medicaid to determine whether the pharmacies are properly dispensing and delivering medications. In connection with the pharmacy reviews, OMIG also intends to verify the licenses of all ordering providers in an effort to detect fraudulent practices, such as stolen provider ID numbers, unlicensed physicians, and excluded providers who prescribe drugs.

The New York Work Plan also devotes attention to the usual targets. Five audit areas are applicable to hospitals. OMIG will:

- Perform reviews designed to detect providers that are upcoding.
- Examine ambulatory surgical services to determine whether the services were provided in the appropriate setting. One focus of this review is to determine whether the service

was provided in an ambulatory surgery setting because of patient safety reasons and the administration of anesthesia.

- Review patient billing records to determine whether any claims were improperly submitted to medical assistance programs that should have been submitted to another payor, because Medicaid is the payor of last resort.
- Look at Disproportionate Share Hospital (DSH) payments. OMIG will review trends in hospitals' claims for DSH payments, and it will conduct a review of records relating to uncompensated care at selected hospitals to determine whether the DSH payments were appropriately claimed and paid.
- Review hospital-based physician compensation to detect duplicate payments for direct patient care services and administrative services.

Implications for the future

The Deficit Reduction Act of 2005 made it official; the New York Work Plan makes it clear: Medicaid enforcement is a top priority for federal and state regulators. This is understandable, given that the Medicaid program is the largest health insurance program in the United States and provides coverage to approximately 44 million people in low-income families and 14 million elderly and disabled people.[2]

What does this mean for providers and suppliers? The obvious answer is that there will be a heightened level of focus on providers and suppliers through potentially duplicative, but most certainly, additional audits. One way that providers and suppliers will see this play out is with the Payment Error Rate Measure (PERM) program, a federal initiative to determine national payment error rates for the Medicaid program. As part of the PERM program, the Centers for Medicare and Medicaid Services uses contractors to review medical records and to perform statistical calculations of Medicaid, the State Children's Health Insurance Program, and managed care claims. For participating states, the PERM review takes place every three years. As explained in the Work Plan, OMIG intends to use PERM samples to collect additional information that the PERM program does not require, but which OMIG might use to identify other possible areas of fraud, waste, and abuse in the New York Medicaid program. OMIG will also use the PERM model to perform continuous random sampling of Medicaid claims between the three-year cycles.

Regardless of whether other states follow New York's lead with a similarly detailed plan, the Work Plan demonstrates the direction of regulatory enforcement methods. First, federal and state regulators are going to be relying more and more on data mining in their efforts to detect fraud and abuse. Data mining provides auditors with an efficient way to extract and detect specific billing practices. With data mining, providers may not even know the government is auditing them, because the review occurs off-site with previously submitted information. Consequently, compliance officers should maintain systems and protocols to ensure that the data being submitted to the government is accurate.

Second, medical necessity reviews are becoming the norm, and not just quality improvement organizations conduct them. Clinical expertise is needed to effectively review medical records; however, as evidenced by concerns raised in the Recovery Audit Contractor reviews, the auditors may not always possess this background. Compliance officers should continue to conduct reviews of medical record documentation to ensure that the services provided are appropriately documented. Although this is not a new area, it should be a priority.

Finally, state Corporate Integrity Agreements are likely to become commonplace.

As announced in the Work Plan, providers and suppliers can expect OMIG to require a Corporate Integrity Agreement as part of any settlement with the state of New York's Medicaid program. Given the focus on Medicaid enforcement, providers and suppliers should expect other states to do the same.

What should compliance officers do now?

New York has taken significant steps to be a leader in its Medicaid enforcement efforts with the development of the Work Plan and through OMIG. The New York Work Plan is yet another sign that Medicaid compliance demands the same level of attention that providers and suppliers have been dedicating to Medicare. Whether or not other states follow with a similarly detailed plan, the Work Plan provides a preview of what states may deem important focus areas in Medicaid enforcement. Compliance officers, regardless of their state of residence, should review the Work Plan, evaluate the identified focus areas, and consider incorporating applicable items into their organization's compliance work plan and auditing and risk assessment tools. The steps that compliance officers take now can better prepare their organizations for the future of Medicaid enforcement activities.

1 Available at http://www.omig.state.ny.us/data/images/stories//omig_workplan2008_2009v2.pdf.
2 Kaiser Family Foundation, Kaiser Commission on Medicaid Facts, State Fiscal Conditions & Medicaid 1 (2007). Available at http://www.kff.org/medicaid/upload/7580-02.pdf