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

Payment Integrity
## VBP PI Workgroup Agenda

<table>
<thead>
<tr>
<th>Meeting 1</th>
<th></th>
</tr>
</thead>
</table>
| Data Quality | • Policy Question  
• Discussion |

<table>
<thead>
<tr>
<th>Meeting 2</th>
<th></th>
</tr>
</thead>
</table>
| Policy Design | • Policy Question  
• Discussion  
• *Draft & Finalize Consensus Recommendation(s)* |

<table>
<thead>
<tr>
<th>Meeting 3</th>
<th></th>
</tr>
</thead>
</table>
| Payment Integrity | • Finalize Policy Design Consensus Recommendation(s)  
• Policy Question(s)  
• Discussion  
• *Draft & Finalize Consensus Recommendation(s)* |

### Policy Question

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

### Discussion

Policy question frames and provides context, work subsequent workgroup discussion.

### Consensus Recommendation(s)

Provide the State with a consensus recommendation on each of the workgroup’s three policy questions.
## Agenda

Today’s agenda includes the following:

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Design Recap</td>
<td>10:30 am</td>
</tr>
<tr>
<td>Finalize Recommendations</td>
<td>10:45 am</td>
</tr>
<tr>
<td>Payment Integrity: Issues and Considerations</td>
<td>11:30 am</td>
</tr>
<tr>
<td>The Changing Landscape of Payment Integrity</td>
<td>11:45 pm</td>
</tr>
<tr>
<td>The Future of Payment Integrity: Develop Potential Recommendations</td>
<td>12:15 pm</td>
</tr>
<tr>
<td>Conclusion</td>
<td>1:30 pm</td>
</tr>
</tbody>
</table>
Policy Design Recap

Detailed findings and finalization of recommendations
# Distinguishing Policy Design from Payment Integrity

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

![Diagram showing overlap of High Quality and Low Cost with Value in the middle.](image)
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
An introduction of a new payment model presents new avenues for fraud, waste, and abuse in the Medicaid environment.

The mitigation of undesirable results that are contrary to the interests of New York State’s VBP Policy.

As reimbursement becomes linked to quality measures, the right controls must be in place to ensure that quality reporting is a true reflection of the value delivered.
Defining Payment Integrity

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

<table>
<thead>
<tr>
<th>Fraud¹</th>
<th>Waste¹</th>
<th>Abuse¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Encompasses the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act.</td>
<td>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.</td>
</tr>
</tbody>
</table>

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<sup>1</sup>

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. |

<sup>1</sup> (§§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

- Fraud, Waste and Abuse Issues
- What Current FWA Issues Change in VBP?
- What FWA Issues are New because of VBP?
- How is FWA Measured in VBP?
Potential VBP PI Issues

Fraud, Waste and Abuse Issues

- What Current FWA Issues Change in VBP?
- What FWA Issues are New because of VBP?
- How is FWA Measured in VBP?

- Anti-Kickback & Stark*
- Fraudulent Payments
- Default Risk Reserve

* Relevant recommendations generated by Regulatory Impact Subcommittee
Potential VBP PI Issues

**Fraud, Waste and Abuse Issues**

- What Current FWA Issues Change in VBP?
- What FWA Issues are New because of VBP?
- How is FWA Measured in VBP?

- Anti-Kickback & Stark*
- Fraudulent Payments
- Default Risk Reserve
- VBP-Specific Inappropriate Behavior

* Relevant recommendations generated by Regulatory Impact Subcommittee
Potential VBP PI Issues

1. What Current FWA Issues Change in VBP?
2. What FWA Issues are New because of VBP?
3. How is FWA Measured in VBP?

- Anti-Kickback & Stark*
- Fraudulent Payments
- Default Risk Reserve
- VBP-Specific Inappropriate Behavior
- Encounter Data
- Other Data

* Relevant recommendations generated by Regulatory Impact Subcommittee
## Payment Integrity Implications

<table>
<thead>
<tr>
<th>FW&amp;A: Overlapping Arrangements</th>
<th>FW&amp;A: Stop Loss Gaming</th>
<th>Policy: Limiting Access to Care</th>
<th>Data: Comparing Encounters to Lab Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. IPC or Total Care General Population</td>
<td>A. Disproportionately expensive patients</td>
<td>A. Fee-for-Service (FFS): Payment based on volume.</td>
<td></td>
</tr>
<tr>
<td>B. Maternity Care</td>
<td>B. Exceeding the stop loss threshold.</td>
<td>B. Fully Capitated Arrangement: Per-Member Per-Month (PMPM) payment</td>
<td></td>
</tr>
<tr>
<td>C. HIV/AIDS</td>
<td>PI Implication: New avenues of fraud exist for providers who intend to game a stop loss arrangement.</td>
<td>PI Implication: The physician limits office hours, limiting access to care.</td>
<td></td>
</tr>
</tbody>
</table>

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

**PI Implication:**
FW&A: Stop Loss Gaming

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

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

**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
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!
Contact Us:

Jeffrey Gold  
Co-Chair  
jgold@hanys.org

Robert Hussar  
Co-Chair  
rhussar@barclaydamon.com

Jonathan Bick  
DOH Sponsor  
Jonathan.bick@health.ny.gov