Medicaid Program Integrity for Managed Care Entities (MCEs)

Investigations

FISCAL AND OPERATIONS DIVISION
Office of Program Integrity

PRESENTATION

This training is intended to assist Oregon Managed Care Entities (MCE) to responsibly carry out their fraud, waste and abuse prevention, and compliance and oversight obligations under the applicable contract with OHA and federal and state Medicaid laws.

This presentation and the links imbedded in this document were prepared as educational resources; they are not intended to grant or create any rights, privileges, or benefits for you or your organization. No part of this training should be taken as the opinion of, or as legal advice from, any of the Office of Program Integrity (OPI), the Oregon Health Authority (OHA) or the State of Oregon.

Although every reasonable effort has been made to ensure the accuracy of the information within these training materials, the ultimate responsibility for complying with the federal and state fraud and abuse laws and Medicaid program requirements lies with the provider of services.

What we will cover

- CFR and contract requirements
- What is an investigation?
- How does an investigation start?
- Stages of an investigation
- Best practices for records and documentation
- Referrals and reporting

Federal and state MCE requirements

Federal requirements

- In Medicaid, unpacking this term and what an investigation means starts with the Code of Federal Regulations (CFR).
- This CFR defines the investigation requirement for all MCEs.

42 CFR § 438.608(a)

- MCE must **implement and maintain arrangements or procedures to detect** and prevent **fraud, waste, and abuse.** These arrangements or procedures must include a system, with dedicated staff, for prompt response to compliance issues as they are raised, **investigation of potential compliance problems as identified in the course of self-evaluation and audits,** correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

Contract requirements

- The federal requirements are included in Exhibit B, Part 9, Sec. 11 of the managed care contracts.
- This contract language provides more detail about how OHA expects MCEs to comply with the federal regulation in 42 CFR § 483.608(a).

Contract requirements: Exhibit B, Part 9 Sec. 11

Subparagraph (b)(3)

- Establishment of a division, department, or team of employees that is dedicated to, and is responsible for, implementing the Annual FWA Prevention Plan and which includes at least one professional employee who reports directly to the Chief Compliance Officer. Examples of a professional employee are an investigator, attorney, paralegal, professional coder, or auditor. Contractor must demonstrate continuous work towards increasing qualifications of its employees. Investigators must meet mandatory core and specialized training program requirements for such employees. The team must employ, or have available to it, individuals who are knowledgeable about the provision of medical assistance under Title XIX of the Act and about the operations of health care Providers. The team may employ, or have available through consultant agreements or other contractual arrangements, individuals who have forensic or other specialized skills that support the investigation of cases;

Subparagraph (b)(10)

- Systems to respond promptly to allegations of improper or illegal activities and enforcement of appropriate disciplinary actions against employees, Participating Providers, or Subcontractors who have violated Fraud, Waste and Abuse policies and procedures and any other applicable State and federal laws

Subparagraph (b)(14)

- A system to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance from employees, Participating Providers, Subcontractors, and Members, while maintaining the confidentiality of the Person(s) posing questions or making reports

What is an investigation?

What is an investigation?

- **Investigation**
  - the review of Medicaid claims for suspicious aberrancies, and/or to establish evidence that potentially fraudulent activity and/or improper payment has occurred.

What is an investigation?

- What do CMS and OHA expect as part of an 'investigation'?
- These are some examples of activities associated with an investigation.
- A "pre-investigation" is an investigation.

Verifying facts

- Member enrollment dates
- Network providers
- Data-mining or other review of claims reports

Gathering information

- Employee, provider or member interviews
- Request documentation from providers (e.g., medical or financial records, contracts, attestations)

Review

- Post-payment review of claims/encounters
- Auditing for third party liability and usual and customary charges

Determinations

- Overpayments
- Referrals to the state for potential payment suspension or termination actions

Staffing for effectiveness

- Who performs investigations?
  - In most organizations this is a team effort.
  - Not every investigation is the same so investigations may need different expertise.

- Certified Professional Coders
- Registered Nurse
- Certified Fraud Examiner
- Program and Policy Expertise
- Financial Auditor
- Medical auditor/medical reviewer
- Research Analyst/Statistician
- Highly experienced management

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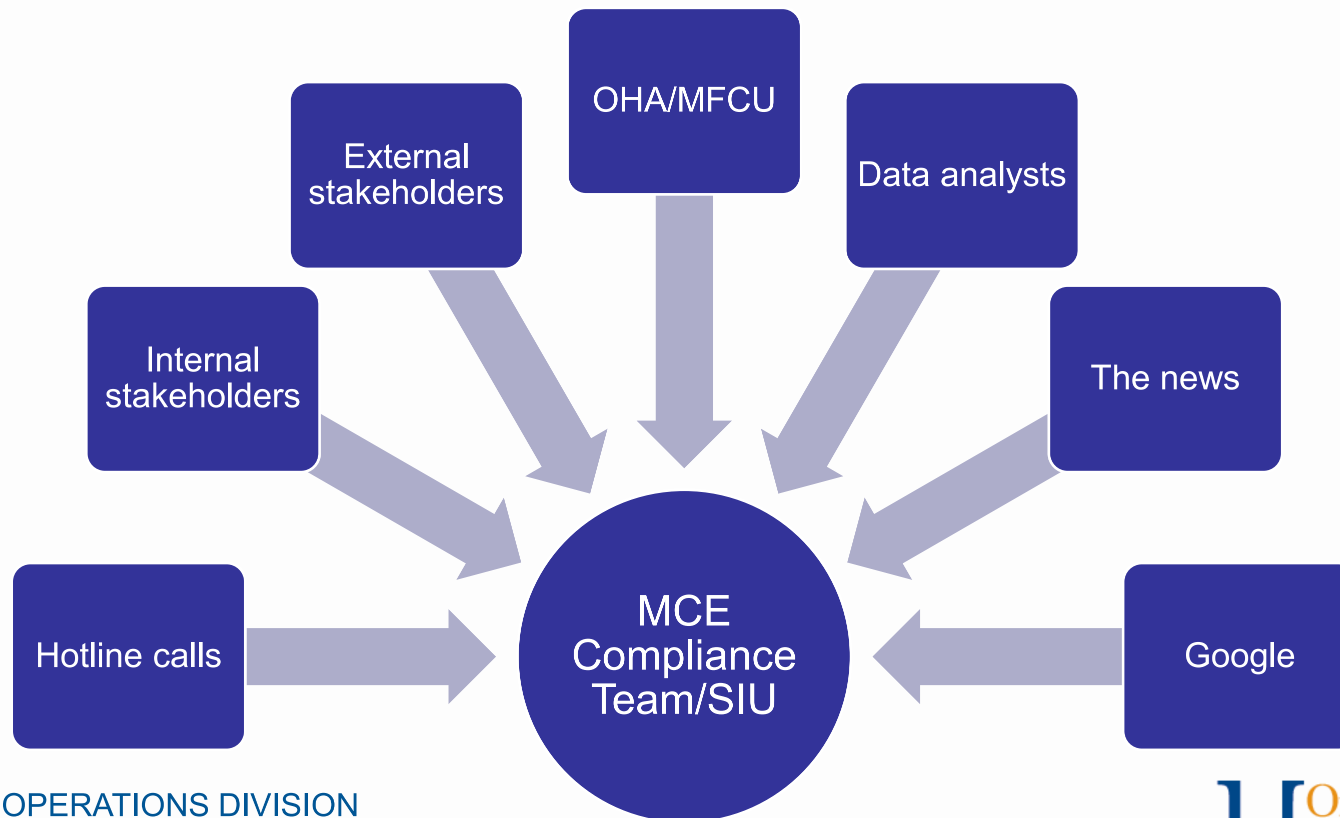
How does an investigation start?

- An investigation can come from many places, as shown here.



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Health care fraud trends

- An investigation can come from many places -- looking at recent trends in health care fraud may help point you to an issue you need to investigate within your organization.
- Many of the fraud schemes identified by federal Office of Inspector General (OIG) involve multiple providers.
- These are some examples:

Current trends

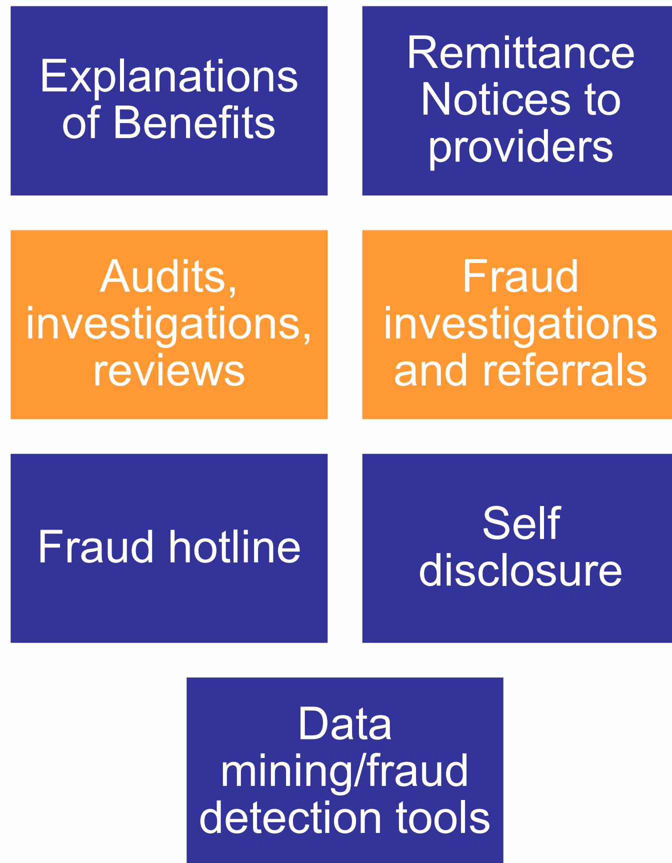
- Behavioral Health
- Home and Community Based Services (home health agencies, hospice, PCS)
- Pharmacies/drug diversion
- Pharmacies/non-control drug diversion
- Dental
- DME
- Ancillary physician relationships (e.g., specialty labs/pharmacies)
- EHR and identity theft
- Kickbacks
- Telehealth
- Genetic testing
- COVID-19

One recent trend: Drug diversion

- OIG investigations show that opioid drug diversion is on the rise
  - This has a higher risk of inappropriate use and
  - Significant OHP member harm and risk of overdose.
- Diversion of potentiator drugs is also high-risk. These drugs:
  - Exaggerate euphoria and
  - Escalate the potential for misuse when combined with opioids.

Post-payment safeguards

- Investigation is one tool among several post-payment safeguards.
- An investigation can also originate from any of these safeguards.



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Stages of an investigation

Stages of an investigation

- The exact investigative process may differ for each incident.
- Upon receipt of information or allegation of noncompliance or potential FWA, the MCE will:

Preliminary investigation

- Scope - establish the facts and the magnitude of the alleged/suspected/possible FWA
- Determine potential exposure (overpayment)
- take any appropriate action to protect Medicaid dollars.

Expanded investigation

- Putting the facts into context
  - More data, other services?
  - Other members, other issues?
  - Other providers in the network involved? Kickbacks etc.
- Rare that it's a single incident –usually a pattern is identified.

Recoupment action

- May open audit to identify scope of dollars involved/lost over time.
- Recover dollars or adjust future payment(s)

Preliminary investigation

- Gather information to establish the facts and the magnitude and scope of the violation.
  - Review relevant documentation.
  - Talk with people who have knowledge.
  - Identify the standard that applies.
  - Ask these questions (Who, What, When, Where).
- Make a preliminary determination of whether there has been a possible violation (Sec. 16, Exhibit B, Part 9).
- Calculate potential exposure.

Who:

- Is the complainant?
- Is the provider?
- Is the member?
- Are the other people identified by the explanation of the allegation or the details of the reported issue?
- Contracts, enrollment, licensing, certification, SOS business registry, encounters/claims, call logs, complaints etc.

What:

- is the allegation?
- rule or standard that applies?
- Information do you have about each person?
- Can you validate from the allegation against other sources?

When:

- Did the incident or issue occur?
- Is it alleged to be still happening, or is it over?

Where:

- Did the issue or incident occur?

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Stages of an investigation

- Any suspicion of abuse, actual or potential physical harm, of a member must be immediately reported.
  - Email the OTIS safe line or call:
    - Oregon abuse reporting hotline: 1-855-503-SAFE (7233)
  - Contact law enforcement.

Investigation recordkeeping

- Document all steps of the investigation in detail.
- Keep a case activity log for all stages of the investigation – preliminary, expanded and recoupment.
- Regardless of the phase of the investigation, in the end all materials may become evidence.

What should you document?

- Regardless of where or how you get the case, document everything.
  - Any piece of material that may be directly or indirectly used to support or refute allegations must be documented.
- Do you have a case management system?
- How are you tracking and storing these cases?

Who:

- The tip came from
- How to contact them again

What:

- The complaint or allegation

When:

- When (and how) did you receive the tip?
- What timeframe was involved?

Where:

- Sources:
  - Background checks on subjects and witnesses
  - Internet checks
  - Data collection and analysis
  - Legal research: Rules, laws, legal opinions (not yours)
  - Collecting records/evidence
  - Coding analyses

Expanded investigation

Putting the facts into context

- More data, other services?
  - Other members, other issues?
  - Other providers in the network involved? Kickbacks etc.

rule or standard that applies?

- What information do you have about each person?
- Identify the time period of the non-compliance or potential violation.

Rare that it's a single incident –usually a pattern is identified

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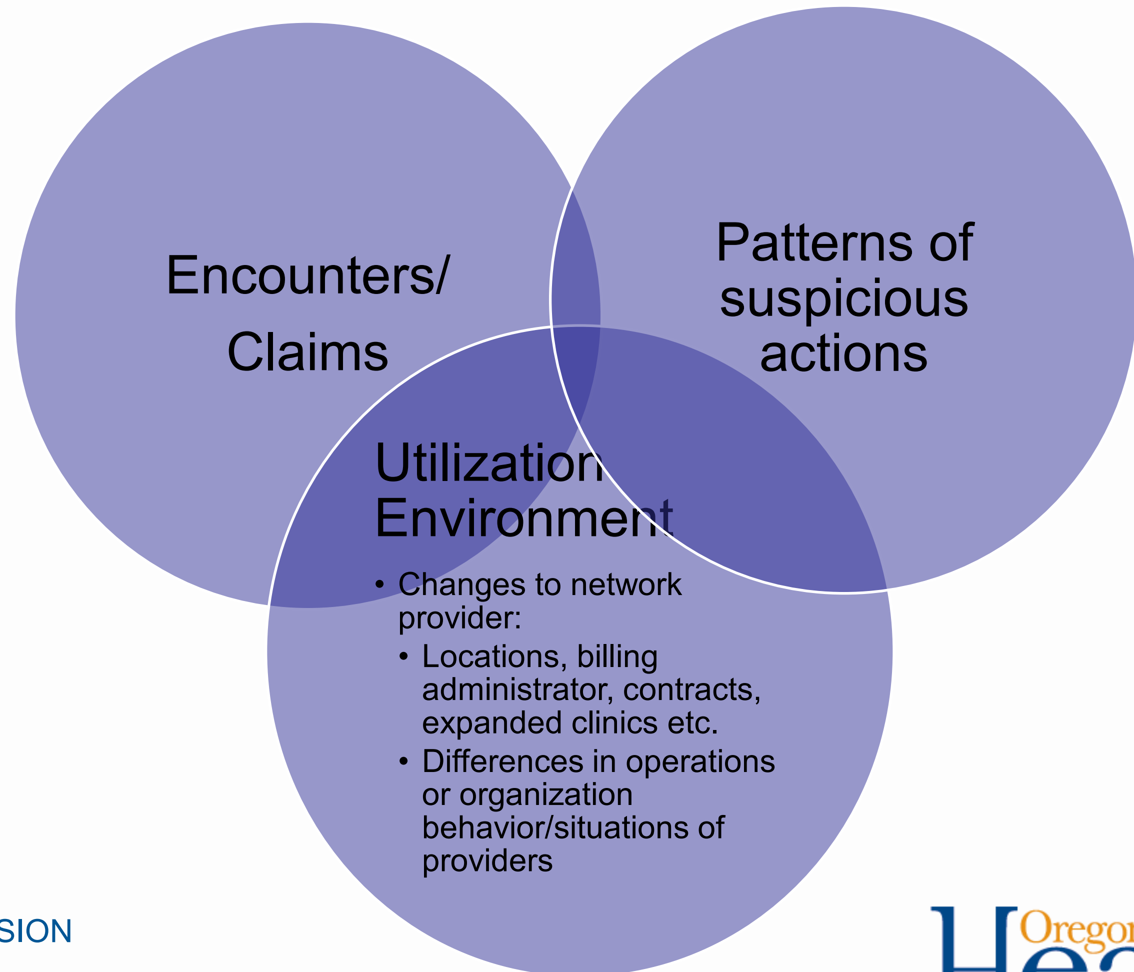
Data, data, data

- Data is an essential element before, during and after any investigation.
- Reports:



Recordkeeping best practices

- The next slide offers tips and general best practices for documenting your investigation work.
- Medicaid can and will audit up to 10 years after a date of service.
- Certified Fraud Examiner training or other high-quality training will ensure you are covering all your bases and avoid re-work.
- Any piece of material that may be directly or indirectly used to support or refute allegations must be documented.

Recordkeeping best practices

Decide early how you will document your investigations:

- Electronic vs. paper
- Record retention and secure storage
- Monitoring and tracking – do you have a case management system?

Be specific and factual:

- Record a date, time and source for all information gathered or received
- Avoid conclusions in your documentation (especially early in the investigation)
- Don't make any inflammatory comments (avoid bias)
- Do not leave out exculpatory evidence (you're the investigator, not a judge or jury)
- Ethics matter.

For data analysis/mining:

- Save all queries. You must be able to replicate any results (a defense expert will also want to)
- Always preserve the raw data. Articulate any changes you made to copies of working data
- Document what your data mining universe was (i.e. what you 'mined') Keep the universe.

Gather the facts of the case:

- Regardless of where or how you got the case, document it:
  - Who it came from and how to contact them again
  - What was their complaint or allegation
  - How and when did you receive it and what time period is involved
- Research
  - Laws
  - Rules/regulation
  - Utilization policies or clinical guidelines

How to collect information

- Consider what the relationship between the provider or subcontractor and your MCE looks like.
- Standard terms and conditions in both contracts and provider agreements provide for:
  - Audits and investigation and
  - Required cooperation by provider/contractor.

Collecting records and documents

- Prepare for the appeal now – Anything used in court must be lawfully obtained
- Ask for information and records – consent is best
- Remind provider of contractual obligations

Interviews

Internet research

Correspondence with state or federal agencies

Traditional sources of provider information

- When looking into a provider, also consider:
  - Who, in addition to the provider, is potentially part of the allegation?
  - Other departments or units in your MCE that oversee services, providers, contractors/vendors?
- Gather facts about each person using existing resources available to you.
- Sources may be external or internal:

Background checks

Provider agreements/contracts

State/federal data

- OIG List of Excluded Individuals/Entities
- Federal System for Award Management
- Medicaid Management Information System
- Licensing/certification boards
- Oregon License Directory (Secretary of State License Directory)
- Oregon Business Registry (Secretary of State Business Registry)
- Provider licensing board (e.g. the Oregon Medical Board license verification)

Complaints

- Hotline, customer service calls
- Other non-compliance or quality issues
- Other units within your organization

Less-traditional sources of provider information

- If you are doing research on the internet:
  - Make copies of everything you find
  - Include the date/time you made the copy
- The internet is not static; what was there today could be gone tomorrow
- Source may be:

Social media

- Facebook
- Twitter
- LinkedIn

Google

Other

- Online forums
- Reviews (e.g., Yelp, WebMD)

Best practices for working with providers

- If you are investigating a provider:
  - Prepare for the appeal now
    - Anything used in court must be lawfully obtained

Contract or provider agreement

- Remind provider of contractual obligations

Ask for information and records

- Consent is best

Correspondence

- From MCE or subcontractor to the provider
- From federal or state agencies

Wrapping up investigations

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Next steps

- What is the data telling you about the incident/allegation?
  - Analysis
  - Trends
  - Root-cause
- Document:
  - Conclusions and findings
  - Decisions
  - Resolution or approach to correcting issues identified
  - Date of any referrals

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Investigation and referrals

- MCEs often ask when to make referrals during an investigation
- The answer is any time that:
  - You suspect possible FWA or
  - You find an issue with one or more of the FWA characteristics listed in Section 16, Exhibit B, Part 9
- The timeline for referral is within 7 days of discovery

When should MCEs refer FWA to the state?

- Promptly but in no event more than seven (7) days after becoming aware of the suspicious case.

What should be reported?

- All suspected cases of FWA, including suspected Fraud committed by employees, Participating Providers, Subcontractors, Members, or any other third parties.
- Regardless of MCE's suspicions or lack thereof, incidents with any of the characteristics listed in Section16 of Exhibit B, Part 9.

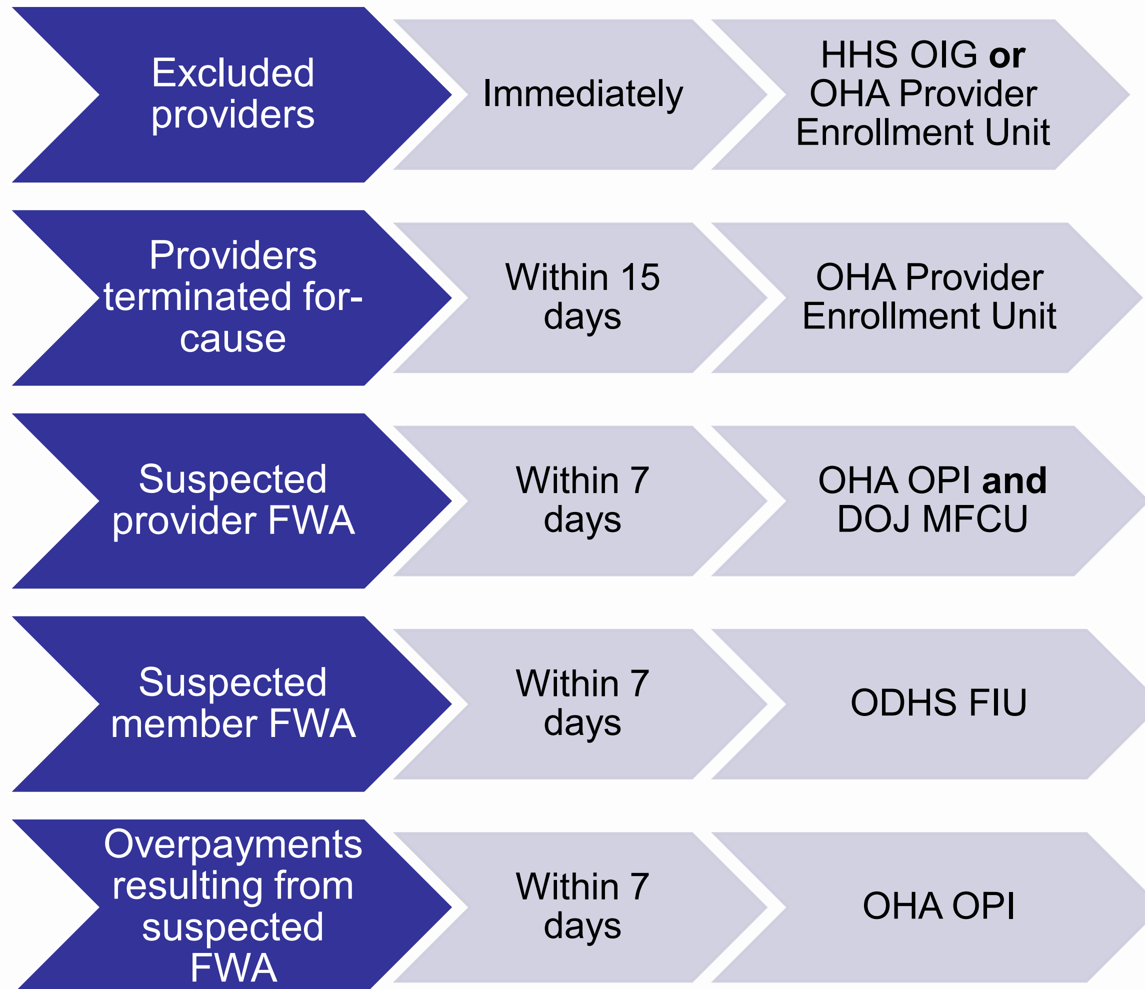
MCE responsibilities

- The contract does not delegate to MCEs the decision of whether an allegation of FWA is credible.
  - Only OHA and MFCU make this decision.

**Exhibit B, Part 9, Section 17
Contractor's Obligations to Report FWA**

- d. In addition to the annual and quarterly summary of FWA Referrals and Investigations, Contractor shall report all suspected cases of Fraud, Waste, and Abuse, including suspected Fraud committed by its employees, Participating Providers, Subcontractors, Members, or any other third parties to OPI and DOJ's MFCU. **Reporting must be made promptly but in no event more than seven (7) days after Contractor is initially made aware of the suspicious case.** All reporting must be made as set forth below in Paragraphs. h. and i below, of this Section 17, Exhibit B, Part 9.
- e. In addition to the annual and quarterly summary of FWA Referrals and Investigations, Contractor shall report, regardless of its own suspicions or lack thereof, to the MFCU an incident with any of the characteristics listed in Section 16, of this Exhibit B, Part 9. All reporting must be made as set forth below in Paragraphs. h. and i. below, of this Sec. 17, Exhibit B, Part 9.

Required referrals and timeframes



State responsibilities

- OHA is required to refer cases of suspected provider fraud or abuse to MFCU.
- The MFCU:
  - Works cases from suspected/possible fraud to credible fraud
  - All the way through prosecution and settlement or sentencing

42 CFR § 455.15

- Full investigation. If the findings of a preliminary investigation give the [State Medicaid] agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the agency must take the following action, as appropriate:
- (a) If a provider is suspected of fraud or abuse, the agency must—
- (1) In States with a State Medicaid fraud control unit certified under subpart C of part 1002 of this title, refer the case to the unit under the terms of its agreement with the unit entered into under §1002.309 of this title; or

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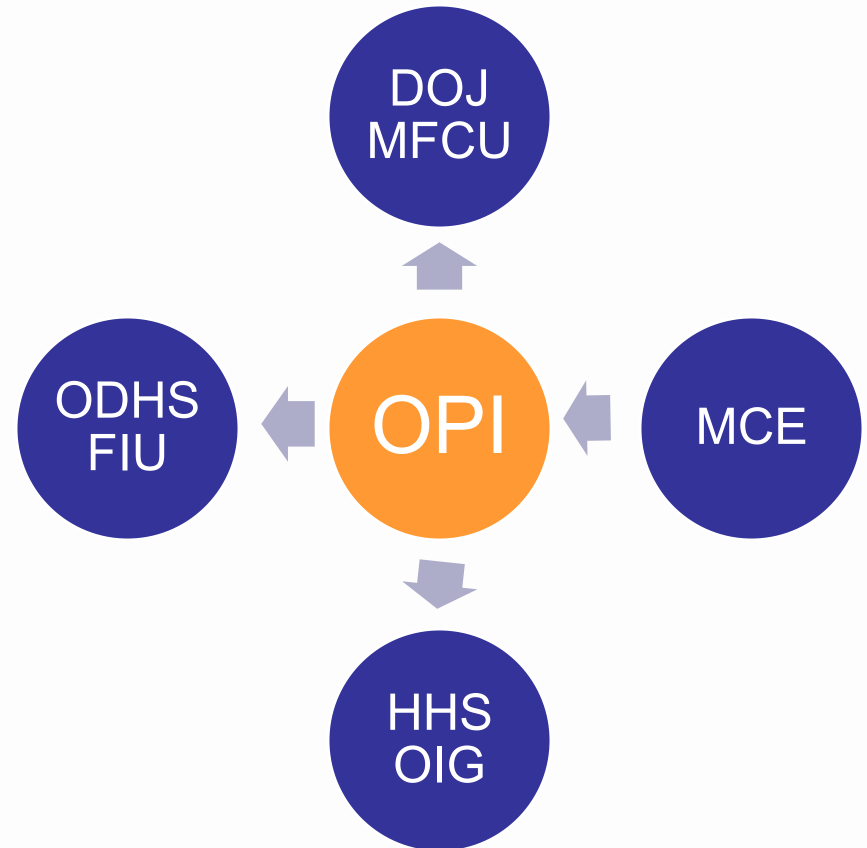
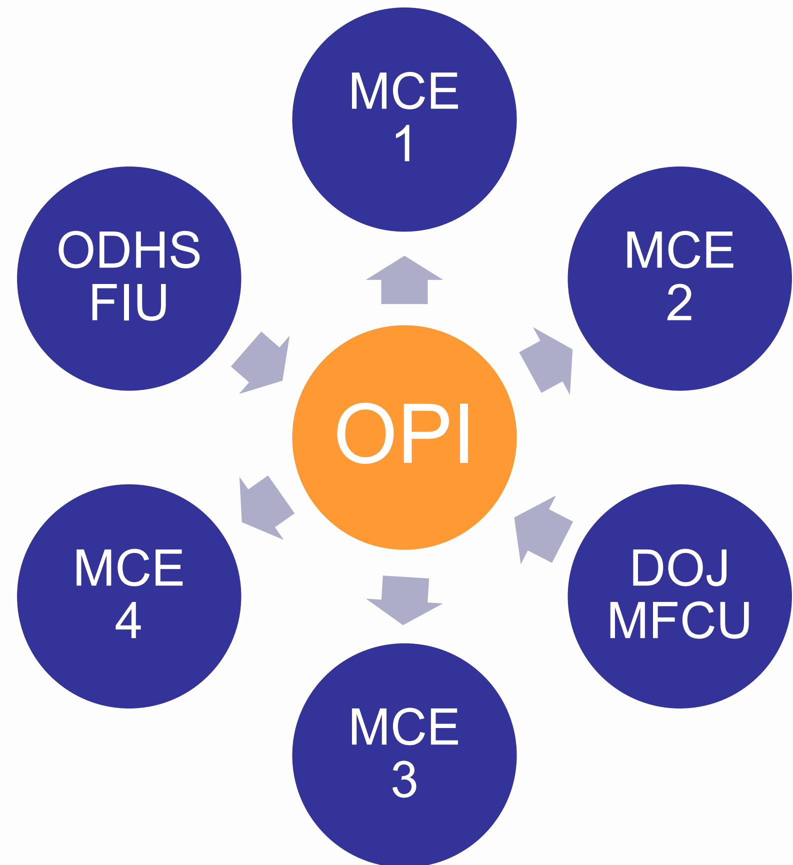
OHA’s process

- For each referral from your MCE, OPI:
  - Looks into the issue
  - Validates the provider is a Medicaid provider
  - Reviews recent MMIS claims/encounters for managed care and FFS
  - Reviews known fraud schemes and bad actors
  - Confirms whether the issue may overlap with any open OPI, ODHS or MFCU case



OHA's process

- If there is overlap with an open case, OPI will:
  - Consult with MFCU and
  - Respond to the MCE about whether or how to proceed with its investigation
- If the issue may impact other MCEs, OPI will notify them.
- If the issue may impact FFS:
  - OPI will review internally
  - This may or may not include an audit



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MFCU responsibilities

- Investigate and prosecute health care provider fraud in the Medicaid program.
- Identify overpayments made by the program to Medicaid providers and attempt to collect overpayments or refer for collection.
- Review complaints about:
  - Resident abuse or neglect in health care facilities
  - The misappropriation of resident's private funds in facilities

What MFCU looks for

- These are some examples of the types of issues referred to MFCU.

Definitions of fraud and abuse

- The primary difference between fraud and abuse is intention
- Not every issue will rise to the level of fraud

Fraud

- When someone intentionally deceives or makes misrepresentations to obtain money or property of any health care benefit program

Abuse

- When health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any health care benefit program

Know your audience

- MFCU looks for civilly or criminally prosecutable health care fraud.
- What may be incorrect or improper may not necessarily be criminal.
- While you are not responsible for investigating provider fraud to the extent of determining criminal activity, there are some common-sense, preliminary guidelines for FWA referrals.

What to include in referrals

- These are some examples of the information to include in referrals to MFCU and OPI:

Subject and all information on the subject

- Provider’s name, tax ID, NPI, Medicaid ID
- Member’s name, member ID #, Phone number or address
- Complainant information

Source of the issue or allegation

- Dates when the issue happened
- When you discovered the issue
- How you discovered the issue

Description of the misconduct

- Provider details, category of service, factual explanation of allegation (specific claims)
- Amount paid to provider for last 3 years or period of alleged misconduct
- Specific rule(s) violated and why conduct violates rules
- Any communication between MCE and provider regarding alleged misconduct (e.g., preapproval issues)
- Contact information for everyone involved in the investigation from the MCE thus far

When is it referral viable?

Operable referrals	Less operable referrals

• Crime
• Loss
  • One instance, or broad impact
• Clear violation of regulations/program rules
• Evidence (direct or circumstantial)
• Pattern of bad conduct
  • Historical or comprehensive
• Provider has been warned about the behavior
  • Clear prior communications from OHA
  • Clear prior communications from MCE
• Greed
	• Generally, quality of care concerns are not fraud.
	  • Rude behavior
	  • Poor service or communication
	  • Disagreements between providers and members
	  • Medication errors (can refer for Medicare Drug Integrity Contractor intervention)
	  • Unnecessary, inappropriate or inadequate or untimely treatment
	  • Inadequate instructions
	• Allegations that are:
	  • Stale
	  • Vague
	  • Biased
	  • Fishing
	  • Retaliatory

Making a viable referral

- Be sure to communicate:
  - A clear definition of loss to your program
  - The methodology used to identify the loss
  - Your understanding of your MCE's exposure (based on the information you gathered)
  - Your understanding of the scope of the issue (one provider or many?)

Making a viable referral to MFCU

- While a referral may indicate fraud, the prosecutable act needs to be apparent to all parties in the process*:
  - MFCU investigators
  - Prosecutors
  - Defense attorneys
  - Jurors
  - Media
- Find the criminal element and use whatever means available to "drive the point home."
- There is a difference between "wrong" and "jail wrong." That difference isn't the same for every state or even for every prosecutor.

* to learn more about MFCUs

Reporting excluded and terminated providers

- In addition to referrals of suspected FWA, you need to report the following information if it pertains to providers you investigate.
- Details about where to send reports are included in your MCE contract.

Exclusions

- If the provider or any managing employee is found to be an excluded provider you must report this immediately.
- Contact:
  - OIG, or
  - OHA Provider Enrollment Unit

For-cause terminations

- If the MCE terminates a provider entity or individual for-cause, you must report the provider within 15 days of termination.
- Contact: OHA Provider Enrollment Unit

Reporting excluded providers

HHS Office of the Inspector General (OIG)

- Electronic report:
  - https://oig.hhs.gov/compliance/self-disclosure-info/index.asp
- Report by mail:
  - Chief of the Administrative and Civil Remedies Branch
    Office of Counsel to the Inspector General, Office of Inspector General
    Department of Health and Human Services
    330 Independence Avenue, SW Cohen Building, Room 5527
    Washington, DC 20201
  - **OIG guidance for healthcare providers**

OHA Provider Enrollment Unit

- Email: oha.provider.review@dhsoha.state.or.us