Multi-Engagement Audits: Advancing Program Integrity Across Fee for Service & Managed Care

NEW YORK STATE | Office of the Medicaid Inspector General

Multi Engagement Audits: Advancing Program Integrity Across Fee for Service & Managed Care

Review of FFS and MCO Payments of a Single Provider

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Agency Overview

- The Office of the Medicaid Inspector General (OMIG) is an independent entity created within the New York State Department of Health to promote and protect the integrity of the Medicaid program in New York State.
- In carrying out its mission, OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with laws and regulations.

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OMIG Mission

Our mission is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high-quality patient care.

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Guiding Principles

- Maximize Medicaid Program Integrity
- Improve Awareness and Stakeholder Relationships
- Strengthen Compliance and Encourage Self Disclosures
- Promote Quality of Care
- Preserve Medicaid Resources and Access to Care

NYS Medicaid Program Fact Sheet

2nd largest Medicaid program

Payments include both FFS and MC

62 counties

6.43 million Medicaid enrollees

- 56% NYC vs 44% rest of NYS

$115.6 billion (est.) Medicaid expenditures for SFY 2025

- Federal - $69.2 billion
- State & Local - $46.3 billion

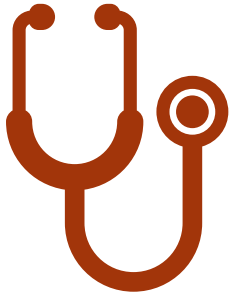
OMIG - 39 Provider Audit Protocols

- 3 provider audit types with multi-payor under review
  - Diagnostic & Treatment Centers, Hospital Outpatient Department, Office of Addiction Services and Support

Overview of Payor Sources

Fee-for-Service

The state pays providers directly for each service; enrollees may see any Medicaid-accepting provider.



Managed Care

Most enrollees must join a health plan that coordinates care and uses a defined provider network.

Emphasis on preventive care and chronic disease management.

Multi-Engagement Audits

What?

- Managed Care (MC) Encounters & Fee-for-Service (FFS) Claims billed for an audit program by a single provider

How?

- Conduct audits simultaneously of both MC encounters and FFS claims of a single provider

Why?

- Increase audit reach to identify potential waste or abuse in the NYS Medicaid program.
- Isolate MCO encounter data to resolve the difficulty of trying to allocate findings across mixed MCO encounter samples.
- Review audit results to compare Federal PERM FFS error rate to MCO error rates
- Ensure program integrity confirming provider is compliant regardless of payor source

How Multi-Engagement Audits Expand Coverage

Single Payor	vs	Multi-Payor
• Review either FFS Claims **OR** MCO encounters • Narrowed audit scope • One audit universe and sample • One audit project • Partial view of the providers Medicaid activity		• Review FFS claims **AND** MCO encounters • Broader scope across payor sources • Separate universes and samples for each engagement • Multiple audit projects (2 or more) • Expanded view of billing and potential risk areas

Benefits

- Smaller Providers
  - Less intrusive process as we would engage them only once and not repetitively for each MCO.
- Larger Providers
  - Less intrusive, but larger audit scope review
  - We can compare a large provider's FFS error rate against their reporting for MCO's.
- Eliminates redundant documentation requests and reduces the administrative burden on the provider.
- Increase the total universe dollars and claims/encounters under review.
- Mirrors single payor audits but all payor sources are reviewed for audit program of single provider.

Methodology

Fee-for-Service

- We use our standard sampling methodology to establish a baseline of the data for traditional payments.

Managed Care

- We obtain data for all MCO encounters by Plan ID and identify comparable data to the FFS universe.
- Each MCO has its own defined universe and sample.

Pre-Audit Phase

- Select program area where claims $ = encounters $
- Conduct datamining to identify provider(s) including FFS and Encounter $ Shared Trend Analysis
- Narrow down 1-3 providers to audit
  - Conduct five-points check to determine audit viability
  - Medicaid Data Warehouse (MDW) universe summary query
  - Review data to select viable year(s) based on universe totals, rate, or procedure codes
- Confirm rate and procedure codes as well as exclusions
- Multi-sample single Provider ID audit request

Pre-Audit Phase: 5 Points Check

- Is the provider still in business?
- Is the provider actively billing Medicaid?
- Is the provider under audit or investigation by OMIG or another state agency?
- Is the provider on the abeyance list (MFCU)?
- Has the audit program for the provider been audited within the past 5 years?

MCO Plan Selection

PLAN_ID	PLAN_NAME	CLAIM_CT	MC_RPT_PLAN_PD_AMT
9	METROPLUS HEALTH PLAN INC	9,419	$1,323,205.89
0	HEALTH FIRST PHSP INC	7,121	$965,230.20
6	FIDELIS CARE	5,957	$815,235.51
6	HEALTHFIRST PHSP PERS WELLNESS PLAN	2,419	$324,405.69
6	MOLINA HEALTHCARE OF NEW YORK INC	1,574	$217,390.10
4	ANTHEM HP LLC	1,551	$205,999.87
6	UNITED HEALTHCARE OF NY INC	1,386	$185,153.98
9	HLTH INSURANCE PLAN OF GTR NY	1,316	$178,273.91
1	METROPLUS HEALTH PLAN INC	1,209	$171,625.03
6	FIDELIS CARE	970	$133,120.40
7	ANTHEM HP LLC	750	$102,452.94
7	MOLINA HEALTHCARE OF NEW YORK, INC	464	$63,271.77
3	HEALTH INSURANCE PLAN OF GREATER NE	338	$46,977.21
1	UNITEDHEALTHCARE OF NEW YORK	363	$46,456.58
2	AMIDA CARE INC	342	$44,898.60
4	MOLINA HEALTHCARE OF NEW YORK INC	341	$42,105.02
1	VNS CHOICE SELECT HEALTH SNP	167	$24,871.04
0	FIDELIS CARE	101	$14,989.33
2	METROPLUS PARTNERSHIP CARE SNP	92	$14,580.64
2	MOLINA HEALTHCARE OF NEW YORK INC	62	$8,664.84
8	HEALTHFIRST HEALTH PLAN, INC	41	$0.00

MCO Universe Review and Validation

Receive universe data for the selected MCO plan(s) and plan IDs

Review MCO Universe Data to verify:

Plan(s) and Plan IDs	DOS for audit year(s)	Encounter Counts and Total Reported Dollars reconcile to MCO Summary	COS, rate codes, procedure codes includes all requested information	Flag overlapping recipient/DOS combinations for further review

Example of Audit Statistics

Payor Source	Provider Type	Universe Dollars	Universe Service Size
Fee-for-Service	Office of Addiction Services and Support (OASAS)	$901,166.61	6,924
Managed Care	Office of Addiction Services and Support (OASAS)	$1,323,205.89	13,627
Totals		**$2,224,372.50**	**20,551**

Payor Source	Provider Type	Universe Dollars	Universe Service Size
Fee-for-Service	Diagnostic And Treatment Center (DTC)	$1,804,581.55	21,122
Managed Care	Diagnostic And Treatment Center (DTC)	$10,470,738.01	201,212
Totals		**$12,275,319.56**	**222,334**

Scope and Stratification

Office of Addiction Services and Support (OASAS)

Scope

Period – 1/1/2021 – 12/31/2021

Simple sample due to consistent services & payment amounts

Plan Paid Claim Stratum	Claim Count	Total Plan Paid Amt
$10 and less	1	$5.03
$10 to $20	2	$37.36
$20 to $30	3	$71.93
$40 to $50	9	$420.30
$50 to $60	18,172	$952,880.32
$60 to $70	363	$22,502.99
$70 to $80	1	$73.72
$80 to $90	23	$1,968.47
$90 to $100	252	$24,960.79
$100 to $200	27,299	$3,457,460.89
$200 to $300	5	$1,188.13

Diagnostic and Treatment Center (DTC)

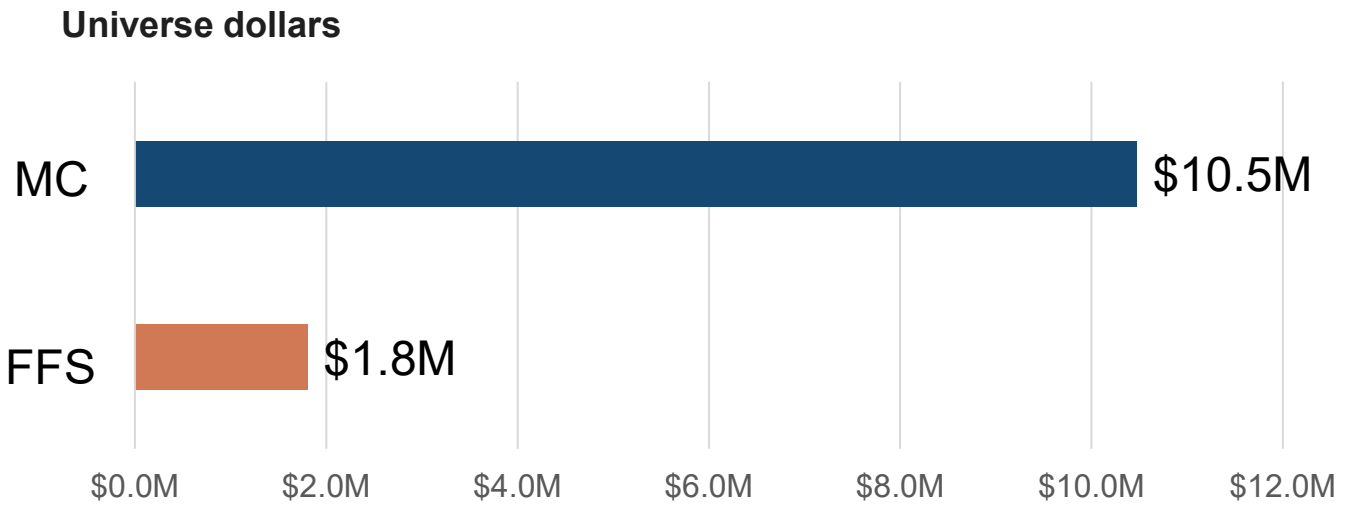
Scope

Period – 1/1/2021 – 12/31/2022

Stratified sample due to diversity of services rendered

Paid Claim Stratum	Claim Count	Total Paid Amt
$10 and less	2,813	$11,713.51
$10 to $20	3,685	$65,075.44
$20 to $30	2,859	$66,935.74
$30 to $40	3,784	$139,525.85
$40 to $50	15,239	$630,301.70
$50 to $60	1,202	$65,153.54
$60 to $70	879	$56,983.29
$70 to $80	2,748	$206,697.38
$80 to $90	1,911	$159,331.37
$90 to $100	426	$41,201.31
$100 to $200	126,661	$15,352,939.11
$200 to $300	4,053	$976,110.44
$300 to $400	618	$210,471.29
$400 to $500	182	$80,156.93
$500 to $600	57	$30,740.26
$600 to $700	31	$20,089.65
$700 to $800	16	$11,916.99
$800 to $900	6	$5,073.81
$900 to $1,000	2	$1,883.44
$1,000 to $2,000	12	$14,160.34

Why the Managed Care Engagement Matters



85% of combined universe dollars are in managed care

90% of combined services and encounters are in managed care

$12.3M combined • 222,334 services and encounters

Sample comparison	Fee-For-Service	Managed Care
Sample size	250	250
Universe Service Size	21,122	201,212
Sample dollars	$54,303.67	$174,099.27
Share of universe	1.2% services • 3.0% dollars	0.12% encounters • 1.7% dollars

Key Issues Identified

Examples from prior non-multi-provider engagement audits
Current multi-engagement audits are ongoing

- Inaccurate Servicing Provider on claim
- No Explanation of Benefits (EOB)/Documentation
- No Explanations of Benefits (EOB) for Third Party Health Insurance (TPHI) Covered Service (Excluding Medicare)
- Missing Documentation of Service

Pre-Entrance Checklists

- ✓ Notice of Intent Letters issued to each MCO and include all Plan IDs
- ✓ Review sampling data
- ✓ Load data into internal program(s)
- ✓ Issue Audit Notification Letter
  - Separate Audit Notification Letters for FFS and MCO per audit # (Plan Name and Plan ID) with coversheet informing provider of multiple audit projects
- ✓ Identify duplicate patients across samples

Provider Contact

- “Nobody likes being audited.”
- Multiple Samples = Multiple Reports, LCLs, Midpoints
- Important to explain the “multi-engagement” audit process to ensure maximum cooperation
- Explain the process at the Entrance Conference and offer flexible options to the provider for information requests

Entrance Conference

- Prepare and review Entrance Conference Outlines
  - Per audit #, Plan Name, Plan ID, audit statistics
  - Include specific Plan Name & ID

SCOPE:

OMIG will review a sample of reported encounters for OASAS Substance Use Disorder Outpatient Program (COS 0160) services for the audit period of January 1, 2021, through December 31, 2021. MetroPlus Health Plan, Inc. (Plan ID 12345678) reported $1,323,205.89 was paid for 13,627 distinct recipient date of service combinations (encounters) during that time period to ABC, LLC (Provider ID #898765432). The OMIG review will involve a random sample of 100 of these encounters for which $13,858.69 was reported paid MetroPlus Health Plan, Inc. (Plan ID 12345678).

Information Requests

- Prepare Information Requests
  - Include a note, additional page, etc. to inform provider of patients listed in multiple samples
  - Explain to provider that each record is only required to be submitted once

Please note the chart below includes seven patients that will be listed across requests #25-1000, #25-1001, #25-1002, #25-1003 for different service months; however, only one record is required to be submitted and include all service months requested. We have condensed the information into one chart with all months required as well as indicated in the following pages (3-6) the patients, sample numbers and months specific to each audit number for reference.

AUDIT #s	CIN #	PATIENT NAME	DOB	SERVICE MONTH(S)
#25-1000, #25-1001	AB12345Z	DOE, JANE	10/31/1983	JUNE & AUGUST
#25-1000, #25-1002	BC12345X	EARHART, AMELIA	1/25/1976	SEPTEMBER & DECEMBER
#25-1000, #25-1003	CD12345Y	JACKSON, JERMAINE	11/9/1987	AUGUST & SEPTEMBER
#25-1002, #25-1003	DE12345U	MARLEY, ROBERT	5/19/2000	MAY & SEPTEMBER
#25-1001, #25-1002	EF12345W	MORGAN, GARRETT,	5/25/1970	JUNE, SEPTEMBER & NOVEMBER
#25-1000, #25-1001	FG12345T	ROOSEVELT, THEODORE.	3/3/1954	JUNE & OCTOBER
#25-1000, # 25-1003	GH12345S	WADE, DWAYNE	12/19/1960	MARCH & JULY

Things to Note…

	When contacting the provider to schedule the Entrance Conference (and at the Entrance Conference itself), expect there will be more questions than usual.
	Multi-engagement audits = “**One review with multiple components**”. This a more palatable description of the process than “multiple audits at once”.
	A positive aspect of multi-engagement audits is the audit period can vary due to the increased audit scope with one, two, or three-year periods.
	Request records by client name, as there will likely be some crossover between audit samples.
	Be prepared to allow additional time for records retrieval and submission.

Challenges

- Method for requesting the audit samples
- Isolating data to separate payor source for the same provider
- Additional parameters to include when data mining
- Duplicative lines for the same DOS and patient in sample

Current Status

- 3 Audit Programs:
  - Diagnostic & Treatment Centers
    - 5 Providers
  - Hospital Outpatient Department
    - 4 Providers
  - OASAS Substance Use Disorder Outpatient Program
    - 1 Provider

Findings Analysis

Analyze findings throughout audit to ensure information is not missed in submissions due to misunderstandings

Pre-Exit, Exit, DAR, and FAR offer opportunities for provider to submit additional information

Analyze findings, if any, prior to FAR issuance to include in memo:

- Are findings based on provider discrepancies or MCOs?
- Compare FFS to MCO and MCO to MCO
- Are corrective actions required for MCO?
- Does the overarching agency need to issue additional guidance to MCOs, or providers based on findings identified?

Contact Information

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Questions & Answers

Thank You!