Medicaid Managed Care Program Integrity Reviews

Matrix of Contract Obligations and Performance Standards

In accordance with New York State Social Services Law ("SSL") 364-j(36)(b), the New York State Office of the Medicaid Inspector General ("OMIG"), in consultation with the Department of Health, is required to publish on its website a list of those contractual obligations, including benchmarks, by which a Medicaid managed care plan's program integrity performance shall be evaluated. This Matrix pertains to the March 1, 2014, as amended October 1, 2015, Medicaid Managed Care/Family Health Plus/HIV Special Needs/Health and Recovery Plan Model Contract (the "Contract") and is valid for reviews conducted with a Review Period covering January 1, 2018 – December 31, 2018.

Pursuant to SSL 364-j(36)(c), where OMIG determines that a Managed Care Organization ("MCO") is not meeting its program integrity obligations under the Contract, OMIG may recover up to 2% of the administrative component of the Medicaid premium paid to the MCO for the period under review. OMIG shall evaluate MCO performance under each line of this Matrix and assess a score for that line (between 0% and 100%), and then take the average score for all Matrix Lines ("ML").

The recovery percentage shall be calculated based on the following ranges of the average score:

Average Score	**Recovery Percentage**
≤60%	2%
>60% and <90%	Between 1.93% and 0.067%*
≥90%	0%

*The range of percentages listed here are close approximations of the recovery percentage for the average scores listed.

This Matrix does not constitute rulemaking by OMIG and may not be relied on to create a substantive or procedural right or benefit enforceable, at law or in equity, by any person. Furthermore, nothing in this Matrix alters any statutory, regulatory, or contractual requirement and the absence of any contractual requirement from this Matrix does not preclude the State from evaluating or enforcing the requirement. In the event of a conflict between statements in this Matrix and either statutory, regulatory or contractual requirements, the requirements of the statutes, regulations and contracts shall govern. Furthermore, this Matrix does not limit or diminish OMIG's authority to recover improperly expended Medicaid funds and OMIG may amend this Matrix as necessary to address identified issues of non-compliance. Additional reasons for amending this Matrix include, but are not limited to, responding to a hearing decision, litigation decision, or statutory, regulatory or contractual change. Any amendment to this Matrix will be published on OMIG's website.

All terms and acronyms contained within this Matrix, unless otherwise noted, shall have the same meaning as defined in Section 1 and Appendix Q of the Contract.

ML	Obligation	Performance Standard	Measurement Assessment	Benchmark
Fraud and Abuse Prevention				
1	**SDOH Certification** Section 18.9(a)	The MCO certifies initially and upon changed circumstances that it does not knowingly have an individual who has been suspended or debarred by the federal or state government, or otherwise excluded from participating in procurement activities: (i) as a director, officer, partner or person with beneficial ownership of more than five percent (5%) of the MCO's equity; or (ii) as a party to an employment, consulting or other agreement with the MCO for the provision of items and services that are significant and material to the MCO's obligations in the MMC Program and/or the FHPlus Program, consistent with requirements of SSA § 1932 (d)(1).	MCO shall provide the last certification filed with SDOH, and OMIG shall review a list of individuals provided by the MCO to ensure that none of the individuals were debarred or suspended from participating in procurement activities during the Review Period.	The MCO has certified to SDOH that they do not have, and OMIG verifies that the MCO did not have a prohibited relationship.
2	**State and Federal Databases and Excluded Providers** Section 18.9(b) & (c), 21.5(a)	The MCO checks its employees, participating providers and non-participating providers against the Federal and State databases, at the frequency specified in the contract. The MCO takes appropriate action upon identification of an excluded individual or entity.	OMIG will review to determine if the MCO is performing the checks of the Federal and State databases identified in the contract, and at the frequency required. To determine if the MCO is meeting its obligation, OMIG will compare its results to the list of terminated provider agreements provided by the MCO.	The MCO performs all the required checks against all employees, participating providers and non-participating providers, and takes appropriate action.
3	**Participating Provider – Federal Database Checks** Section 18.9(d)	The MCO must confirm that providers have procedures to identify and determine the exclusion status of managing employees through routine checks of federal databases.	The MCO shall provide, and OMIG shall review, documentation demonstrating that the MCO confirms that providers have the procedures in place.	The MCO confirms that its providers have procedures in place.
4	**Report, Explain and Adjust** Section 21.5(c)	The MCO must report and explain within 60 days of identification of payments made to excluded providers and identify the date on which the encounter data is adjusted to reflect the recovery.	OMIG will review the corresponding encounter data to determine if the encounter data was adjusted.	All inappropriate payments are reported within 60 days and the encounter data is adjusted.

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5	**Administrative and Management Arrangements to Prevent Fraud and Abuse** Section 23.1(a) & (b)	The MCO has administrative and management arrangements, including a mandatory compliance plan, that are designed to prevent fraud and abuse. The MCO's administrative and management arrangements includes each of the seven (7) elements identified in 23.1(b).	The MCO shall provide evidence that it has administrative and management arrangements designed to prevent fraud and abuse, and OMIG shall review to determine that such arrangements meet the requirements of the contract.	OMIG determines that the MCO has administrative and management arrangements that are designed to prevent fraud and abuse, including: ▪ A compliance plan; and ▪ The seven elements identified in 23.1(b).
6	**Fraud and Abuse Prevention Plan and Special Investigation Units (SIU)** Section 23.2	If the MCO has more than 10,000 enrollees in the aggregate during the Review Period, the MCO is required to develop a Fraud and Abuse Prevention Plan, which includes the development of a SIU, and it must meet the requirements of the contract and DOH regulations.	The MCO shall provide its Fraud and Abuse Prevention Plan, and OMIG shall review to determine that the Fraud and Abuse Prevention Plan meets contractual, statutory and regulatory requirements.	OMIG determines that the MCO has a Fraud and Abuse Prevention Plan that meets contractual, statutory and regulatory requirements.
		If the MCO has fewer than 10,000 enrollees in the aggregate during the Review Period, it must submit an annual report of overpayments recovered to SDOH and OMIG.	The MCO provides a copy of its annual report of overpayment recoveries submitted to SDOH and OMIG during the review period.	MCO had fewer than 10,000 enrollees in the aggregate during the Review Period and annual report of overpayments recovered was submitted to SDOH and OMIG.
7	**Service Verification** Section 23.3	There is a service verification process in place to evaluate a statistically valid sample of the delivery of billed services.	The MCO shall provide a list of all verifications conducted during the Review Period.	OMIG determines that the MCO has established a process and the sample(s) used is statistically valid.
8	**Withholds for Credible Allegations of Fraud** Section 23.4	The MCO begins to withhold payments within five (5) business days from the date of notification from OMIG.	For the universe of directed withholds, compare the date of notification to the date the withhold was implemented.	All withholds were implemented within five (5) business days of OMIG notification.
9	**Restricted Recipient Program Review Team Composition** Appendix Q, section (1)(f)	The MCO is required to maintain a Restricted Recipient Program Review Team (RRPRT) comprised of at minimum: one (1) physician, one (1) registered nurse, and one (1) pharmacist.	The MCO must provide a list of the RRPRT members. The professional members of the RRPRT should be listed and their title must be included. OMIG will review the list provided by the MCO to ensure that the composition of the RRPRT meets the minimum contractual obligations.	The RRPRT must contain the minimum number of professional members, in each professional category.

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10	**Restricted Recipient Program Processes and Monitoring** Appendix Q, section (3)	The MCO is required to: ▪ have effective mechanisms to ensure new Enrollees who meet certain criteria are enrolled as Restricted Enrollees; ▪ have effective mechanisms to monitor the activity of all Restricted Enrollees; ▪ have effective mechanisms to identify Participating Providers who are able to function as Restricted Recipient Providers (RRP); ▪ have effective mechanisms for reviewing utilization data and other information to, at a minimum, identify Enrollee behaviors as described in Appendix Q(4)(i) that may indicate abusive practices or a pattern of misuse of services; and ▪ establish criteria for determining whether an Enrollee has engaged in Abusive Practices or demonstrated a pattern of misuse of Benefit Package services.	The MCO must provide documentation that it has effective mechanisms in place as required by Appendix Q, Sections (3)(a) – (3)(d) and that it has established criteria in accordance with Appendix Q, Section (3)(e).	OMIG determines that the MCO has effective mechanisms for enrolling Enrollees as Restricted Enrollees, where required by Appendix Q, section (3)(a).
				OMIG determines that the MCO has effective mechanisms to monitor Benefit Package services provided to the Restricted Enrollee, where required by Appendix Q, section (3)(b).
				OMIG determines that the MCO has effective mechanisms for identifying Participating Providers who can function as RRP pursuant to Appendix Q, section (3)(c)
				OMIG determines that the MCO has effective mechanisms for reviewing utilization data and other information to identify Enrollee behaviors that may indicate Abusive Practices or a pattern of misuse of services pursuant to Appendix Q, section (3)(d).
				OMIG determines that the MCO has established criteria for determining whether an Enrollee has engaged in Abusive Practices or demonstrated a pattern of misuse of Benefit Package services that is in accordance with 18 NYCRR 360-6.4 and consistent with criteria established by OMIG, pursuant to Appendix Q, section (3)(e).
11	**Restricted Recipient Program Document Retention** Appendix Q, section (7)	The MCO must maintain a file for each review conducted by the RRPRT and for each Restricted Recipient, and such records shall be readily available for review by SDOH and OMIG, on-site or off-site, upon request.	The MCO shall provide documentation demonstrating that it is in compliance with the requirements of Appendix Q, section (7).	OMIG determines that the MCO maintains a file for each review conducted by the RRPRT, and the records are readily available for review, and the file contains the required components pursuant to Appendix Q, section (7).

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Reporting Requirements				
12	**Reporting Cases of Fraud and Abuse** Contract Section(s) 18.5(a)(vii)(A)(I)-(VII), (B)	The MCO submits a timely report of reasonably suspected or confirmed fraud or abuse which contains all seven (7) components, including the certification signed by an executive officer of the MCO, and the report contains accurate information.	Each report submitted is reviewed by OMIG to determine completeness and accuracy. In determining completeness and accuracy, OMIG will consider MCO responsiveness in remediating deficiencies.	All reports submitted are determined by OMIG to be complete. All reports submitted are determined by OMIG to contain accurate information.
13	**Reporting Recipient Restrictions** Section 18.5(a)(xvi)(A), (B) Appendix Q- 4(h)(i)	The MCO has the obligation to report Enrollee Restriction(s) at the time they become effective, and any changes on a monthly basis (the reporting obligation applies to new and continued restrictions).	OMIG will compare the restriction date to the date the MCO reported the new and continued Enrollee Restriction(s), and whether the MCO reported, at least monthly, changes to existing restrictions.	New restrictions are reported at the time the restriction becomes effective. Continued restrictions are reported at the time the restriction becomes effective. Changes to existing restrictions are reported on a monthly basis.
14	**Deficit Reduction Act Certification** Section 18.5(a)(xxii)	The MCO is required to submit the certification to OMIG, using the Deficit Reduction Act (DRA) certification form on OMIG's website, that it is meeting the requirements of section 1902(a)(68) of the Social Security Act for each year of the Review Period.	OMIG will review to determine if the MCO filed the certification using the form on OMIG's website in December of each year of the Review Period.	Confirmation that the certification(s) was/were submitted timely using the DRA certification form on OMIG's website.
15	**Provider Investigative Report** Section 18.5(a)(xxiii)	The MCO timely submitted four (4) Provider Investigative Reports (PIR) during each calendar year of the Review Period, each report submitted conformed to the form and format requirements as specified by OMIG, settlement agreements were submitted where applicable, and the Chief Financial Officer (CFO) certified to the accuracy of the data for each report submitted.	OMIG will review the Provider Investigative Reports submitted by the MCO to ensure each submission includes a valid CFO certification, that the report conforms to form and format requirements, that settlement agreements have been submitted where applicable, and OMIG will review the content of the report for completeness and accuracy. In determining completeness and conformance to form and format standards, OMIG will consider MCO responsiveness in remediating deficiencies.	The MCO timely submitted (4) provider investigative reports during each calendar year of the Review Period. Each submission contained a valid certification by MCO's CFO. Each report was accurate based on OMIG's review of a subset of report fields.