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Managing Medicaid Managed Care

Lance Plunkett JD, LLM
NYSDA, lplunkett@nysdental.org

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There is a system in place to ensure Medicaid managed care organizations operate properly. Be prepared for a lot of paperwork.

Lance Plunkett, J.D., LL.M.

Members often question what, if any, controls there are on Medicaid managed care organizations. They may be surprised to learn there is an extensive system requiring these programs to deal with fraudulent behaviors that waste Medicaid dollars and divert them from patient care. How effective these controls are is a different issue, but the controls are supposed to work as outlined below.

All Medicaid managed care organizations (MMCOs) are required to adopt and implement programs to detect and prevent fraud, waste and abuse in the Medicaid program. Regulations in Sections 521-2.1 through 521-2.4 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (18 NYCRR) set forth the standards for managed care fraud, waste and abuse prevention programs. It should be noted that Title 18 contains the regulations of the old New York State Department of Social Services, but now these regulations are maintained by the New York State Department of Health. New York eliminated the Department of Social Services and made the Department of Health the single state agency running the Medicaid program. The definitions of fraud and abuse are defined in each Medicaid Managed Care Contract. The definition of waste is the overutilization of services or other practices that directly or indirectly result in unnecessary cost to the Medicaid program.

The Title 18 regulations require that MMCOs adopt and implement policies and procedures designed to detect and prevent fraud, waste and abuse. The MMCO's fraud, waste and abuse prevention program may be a component of a more comprehensive effort by the organization but must meet the requirements outlined in Section 521-2.4 of Title 18, which requires that the Medicaid fraud, waste and abuse prevention program be incorporated into the Medicaid Compliance Program.

In addition to general MMCO record-retention requirements in the regulations, Section 521-2.3 specifically requires any MMCO and its subcontractors to provide the New York State Office of the Medicaid Inspector General (OMIG), the Department of Health, or any of their authorized representatives, and the New York State Medicaid Fraud Control Unit (MFCU) of the New York State Attorney General's Office all records and information requested, in the form re-

quested, and to allow access to their facilities at any time. The MMCO and its subcontractor must permit private interviews of MMCO personnel, its subcontractors and their personnel, as requested.

OMIG is the entity that will issue written requests for records or other information needed. The requests will be delivered via email to the MMCO Government Liaison, Compliance Officer, Special Investigative Unit (SIU) Director and/or other designee. The requests will include submission instructions and identify a due date.

Full Disclosure

MMCOs must specify within their contracts with contractors, agents, subcontractors, independent contractors and participating providers that they are subject to audit, investigation or review under the MMCO's fraud, waste and abuse prevention program. OMIG may request the MMCO to provide a copy of its contract to demonstrate compliance with this requirement. The MMCO is responsible for ensuring that the requirements of its fraud, waste and abuse prevention program are incorporated into its overall Medicaid compliance program. If the MMCO has an enrolled population of 1,000 or more persons in the aggregate in any given year, the MMCO must establish a full-time Special Investigation Unit (SIU) to identify risk and to detect and investigate cases of potential fraud, waste and abuse. If the total enrollment during any month of the calendar year is 1,000 or more, the requirement to establish a full-time SIU is prompted and remains in effect for the duration of that calendar year.

To assist MMCOs in determining the number of enrollees, plans may reference the New York State Department of Health (DOH) Medicaid Managed Care Enrollment Reports. The reports can be found at: https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/. MMCOs must monitor their enrollment levels to determine when the SIU staffing requirements may be triggered. MMCOs may consider the Medicaid Managed Care Enrollment Reports to assist them with monitoring enrollment. SIU staffing will only be prompted when the enrollment thresholds are met and not at intermediate points.

The MMCO is required to explain how the MMCO determined the SIU staff and resources dedicated to the SIU were sufficient. OMIG recommends that the MMCO consider how it determines sufficient staffing levels for commercial lines on business and take an equitable approach to dedicating staffing and resources to the Medicaid line of business. One full-time lead investigator and one SIU director are required to be based in New York State and be responsible for communicating and coordinating with OMIG or MFCU on reports of fraud, waste and abuse. An in-state presence is designed to enhance the efficiency of the SIU to conduct any necessary fieldwork and more readily obtain/access records needed for the MMCO to determine if an allegation is potentially fraudulent, wasteful or abusive, thereby requiring referral to OMIG.

Exceptions to the Rule

In recognition of the different business models and activities conducted by the SIUs, OMIG allows the MMCOs flexibility to determine any proposed alternate staffing levels that are as effective as the regulatorily defined staffing requirements. It is the responsibility of the MMCO to demonstrate and communicate this determination. Requests for exceptions to the regulatorily defined requirement must be submitted to: bmfa.mco@omig.ny.gov. SIU investigators must have:

1. A minimum of five years in the healthcare field working in fraud, waste and abuse investigations and audits; or five years of insurance claims investigation experience or professional investigation experience with law enforcement agencies; or seven years of professional investigation experience involving economic or insurance-related matters.
2. An associate's or bachelor's degree in criminal justice or a related field; or employment as an investigator in the MMCO's SIU on or before the effective date of the regulations. The MMCO will need to make available, upon request, employment information, including the date of employment and assignment date to SIU, for any investigator who cannot demonstrate in a resume or other documentation that they meet the credentials required of investigators to be in compliance with the regulations.

Annual Plan

The SIU must prepare a work plan no less frequently than annually. In developing this plan, the SIU must consider the MMCO's risk areas, as well as current trends related to fraud, waste and abuse. Consideration of risk areas and fraud, waste and abuse trends is designed to help ensure that the MMCO is conducting audits and investigations appropriate to preventing and detecting fraud, waste and abusive practices. The work plan, at a minimum, must identify provider name and/or provider types to be audited or investigated and include the intended scope and review period of the planned audit or investigation, along with the rationale for conducting the planned audit or investigation. The MMCO may delegate all or part of the functions of the SIU. If the MMCO decides to delegate management authority, such contract shall be subject to review and approval by the Department of Health. If the MMCO delegates all

or part of its SIU function, the contract shall be submitted to OMIG for informational purposes only. The submission to OMIG does not constitute approval of the contract. SIU contract submissions made to OMIG must be submitted via e-mail to: bmfa.mco@omig.ny.gov or via OMIG's MCO Reporting Unit shared mailbox on the New York State Health Commerce System (HCS) at https://commerce.health.state.ny.us. All electronic files must be submitted in a file format that is searchable.

The MMCO must audit, investigate or review cases of fraud, waste or abuse specific to its participation in the Medicaid program, and the risk areas identified by the SIU in its Work Plan. These audits, investigations and reviews shall be conducted in accordance with the regulatory requirements and contracts between the MMCO and Department of Health. If applicable, the SIU will be primarily responsible for performing this work or collaborating and overseeing the individuals performing these activities. The SIU will also coordinate with the MMCO's overall compliance officer. Section 521-2.4(c)(2) of Title 18 requires the audits, investigations and reviews involve at least one percent or more of the aggregate of Medicaid claims. "Aggregate" means total number of Medicaid claims paid.

Audits, investigations and/or reviews must include pre/post-payment review of Medicaid claims, patient records, orders and any other supporting documentation to substantiate claim submissions. Examples of audits, investigations and/or reviews that are acceptable include, but are not limited to: 1) SIU investigations into allegations of fraud, waste or abuse identified through data analysis or referrals received; 2) vendor investigations into fraud, waste or abuse, including Pharmacy Benefit Managers, dental benefits, mental health or substance abuse services; and 3) either the MMCO or subcontractor audits of Medicaid claims through data analysis typically to capture issues like duplicate claims, third-party liability, retroactive disenrollment, modifier misuse, or Diagnostic Related Grouping (DRG) overpayments. Questions on these items may be directed to mmcoreporting@omig.ny.gov.

The MMCO and its subcontractors shall report all cases of potential fraud, waste and abuse to OMIG. "Potential" means having or showing the capacity to become or develop into fraud, waste or abuse in the future. The MMCO must take reasonable steps to establish the potential for fraud, waste or abuse prior to reporting. This may be done by reviewing data and/or patient records or conducting other investigative activities to determine the allegation or complaint is potentially substantiated. OMIG has its own referral form that an MMCO must use. If an MMCO has its own investigative summary report that it would like to at-

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tach to OMIG's referral form, the MMCO may submit a written request and sample report to bmfa.mco@omig.ny.gov seeking OMIG's review and approval. The request should clearly describe or identify how the MMCO's investigative report form includes all the information outlined in OMIG's Investigative Summary Report.

MMCO investigative summary reports shall not be considered acceptable unless and until written approval from OMIG is received. Any filing must report the specific Medicaid program statutes, rules, regulations and/or policies violated. If the report alleges violation of an MMCO policy, a copy of the policy must be included with the referral. Copies of the investigation file and related material must be submitted as part of all referrals. The investigative file means any and all information maintained in the MMCO SIU's records relative to the matter reported. The reports must be reviewed and signed by an executive officer of the MMCO responsible for the operations of the SIU. A report is considered "signed" by a unique signature either by hand or electronic means. All reports must be submitted via e-mail to: bmfa.mco@omig.ny.gov or via the HCS through the Secure File Transfer to OMIG's MCO Reporting Unit shared mailbox or the upload link on the MCO Reports to DOH/OMIG Uploads Application at https://commerce.health.state.ny.us. All electronic files attached to the report must be submitted in a file format that is searchable.

Reporting criminal activity relates to the commission of a crime, which is different from the standard reporting obligations related to potential fraud, waste and abuse. Therefore, in reporting suspected criminal activity, OMIG's Medicaid Managed Care, Potential Fraud, Waste and Abuse Referral form should not be utilized. A description of the suspected criminal activity with all relevant information must be reported to OMIG at bmfa.mco@omig.ny.gov and MFCU at MFCUReferrals@ag.ny.gov.

Identifying and Disclosing Overpayments

OMIG's Self-Disclosure Guidance serves as the primary guidance to report, return and explain Medicaid overpayments that have been identified. To comply with Section 521-2.4(f) of Title 18, the MMCO must develop a process for healthcare providers to report, return and explain any identified overpayments within 60 days of identification. In accordance with Section 521-2(h) of Title 18, the procedure for healthcare providers to self-disclose must be published on the MMCO website. Any reported self-disclosures an MMCO receives from a healthcare provider must be reported on the MMCO's Medicaid Managed Care Operating Report and monthly Provider Investigative Report, conforming with the requirements for each report.

An MMCO must develop a fraud, waste and abuse detection procedures manual for use by officers, directors, managers, personnel and subcontractors performing claims underwriting, member services, utilization management, complaint, investigative and/or SIU services. The fraud, waste and abuse detection procedures manual is incorporated into the MMCO's Medicaid compliance program, and the manual must be reviewed and updated at least annually. Training on the fraud, waste and abuse detection procedures manual may also be incorporated into the general MMCO training and education requirements set forth in Section 521-1.4(d)(1)(ii) of Title 18.

The MMCO must also develop a fraud, waste and abuse public awareness program focused on the cost and frequency of Medicaid program fraud, and the methods by which the MMCO's enrollees, providers and other contractors, agents, subcontractors or independent contractors can prevent it. The MMCO must make information regarding the public awareness program available on the MMCO website.

A summary of the MMCOs fraud and abuse prevention activities for the past year, including their public awareness campaign, is required to be included in the "Annual SIU Report for Managed Care Organizations" pursuant to the Department of Health Guidance and Instructions, accessible through the HCS MCO Reports to DOH/OMIG Uploads Application.

The MMCO must also develop a fraud, waste, and abuse prevention plan. The MMCO shall be responsible for ensuring that the requirements of its fraud, waste and abuse prevention program are incorporated into its overall Medicaid compliance program. MMCOs must submit the fraud, waste and abuse prevention plan to OMIG within 90 calendar days of the effective date of the regulations and within 90 calendar days of signing a new MMCO contract with the Department of Health. The MMCO must review and update such plan no less frequently than annually. All such plans must be submitted via email to: bmfa.mco@omig.ny.gov or via the HCS through the Secure File Transfer to OMIG's MCO Reporting Unit shared mailbox or the upload link on the MCO Reports to DOH/OMIG Uploads Application at https://commerce.health.state.ny.us. All electronic files attached to the report must be submitted in a file format that is searchable.

OMIG has developed a Managed Care Plan Annual Report form, accessible through the HCS MCO Reports to DOH/OMIG Uploads Application, which includes fields for all information required to be reported. Managed Care Plan Annual Reports must be submitted between Feb. 1-28 each year via e-mail to: bmfa.mco@omig.ny.gov or via the HCS through the Secure File Transfer to OMIG's MCO Reporting

Unit shared mailbox or the upload link on the MCO Reports to DOH/OMIG Uploads Application at https://commerce.health.state.ny.us. All electronic files attached to the report must be submitted in a file format that is searchable. The first annual report was required to be submitted in February 2024.

Bottom Line

The bottom line is that MMCOs must adopt and implement policies and procedures designed to detect and prevent fraud, waste and abuse and these requirements include but are not limited to the establishment of special investigation units (SIU), minimum staffing requirements, the obligation to prepare an SIU work plan, requirements related to delegation of the MMCO's SIU function, and minimum standards for conducting audits and investigations.

Does any of this work to control bad behaviors of MMCOs? It is all designed to provide data and access to OMIG, the Department of Health and MFCUs to help them combat misspending Medicaid managed care monies and benefit patients. Or it's a massive amount of paperwork that sounds comprehensive but is paperwork only. It isn't clear that any of it has improved Medicaid managed care interactions with healthcare providers.

A lot of thought went into the Title 18 regulations governing Medicaid managed care, but it may be that a lot of paperwork is what has come out of it.

The material contained in this column is informational only and does not constitute legal advice. For specific questions, dentists should contact their own attorney.