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DEPARTMENT

Presentation to Western Medicaid Pharmacy Administrators Association
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Medicaid Program Integrity Under the Mega-Rule
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A. Spending on Healthcare.

1. Projected to hit $3.1 trillion or $9,695 per person.
2. ACA increase of $8.4 million.
3. Anticipated growth of 5.8% per year between 2015 through 2024.
4. Drivers of healthcare costs:
   a) 12.6% prescription drugs;
   b) Growing older – every day for the nest 18 years 10,000 more will be over 65; and
   c) New technologies/services.

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B. Growth of Healthcare Fraud.

1. Fraud, Waste and Abuse amount to 10% of U.S. health expenditures.
2. Definitions:
   a) fraud is the intentional deception or misrepresentation made by a person with knowledge that the decision could result in some unauthorized benefit to him or her or some other person. It includes any act that constitutes fraud under applicable federal or state law. Examples:
      1) purposely billing for services that were never given;
      2) Billing for a service that has a higher reimbursement than the service rendered; and
      3) rounding up time.

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b) waste is the overutilization of services or other practices that result in unnecessary costs. Generally not considered to be criminally negligent actions, but rather a misuse of resources. Examples:

1) provider ordering excessive testing; and
2) recipient using excessive services.

c) abuse is provider practices that are inconsistent with sound fiscal, business, or clinical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement of services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. Examples:

1) services that are billed by mistake;
2) misusing codes – code on the claim does not comply with national or local coding guidelines; not billed as rendered; and
3) billing for non-covered services.

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C. New Healthcare Reform Laws.

1. ACA.
   a) requires more program oversight; and
   b) use of predictive modeling.
2. Small Business Jobs Act of 2010.
   a) $100 million to CMS to implement new program integrity strategies.

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D. CMS Program Integrity Requirements.

1. Overpayments.
   a) 60-day self-disclosure rule;
   b) whose money is it in a capitated environment; and
   c) use of statistical sampling/extrapolation.
2. Identification.
   a) earlier – move to analytics versus pay and chase;
   b) enhanced requirements on MCO SIU; and
   c) triggers the 60-day clock.
3. Mandatory reporting of potential fraud.
   a) credible allegations of fraud.
4. Mandatory reporting of identified or recovered overpayments.

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5. Verification that services were actually received by MCO recipients.
6. Background checks.
   a) High risk/moderate risk/limited risk;
   b) Utilization of vendors/MCOs; and
   c) High risk definitions include:
      1) Providers for which the state agency has imposed a payment suspension; and
      2) Excluded by the OIG or another state Medicaid program.
7. On-site visits required for high risk providers.
8. Required contractual provisions regarding MCO's recovery of overpayments.

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Questions?

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