



Making a World of  
*Difference*

## Deficit Reduction Act and Medicaid Managed Care Plans

Implementing the  
compliance-related requirements.



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### **Medicaid Overview**

- Originated in 1965 to ensure health coverage for low-income and financially needed people.
- In 2004, it provided health care coverage for over 56 million low-income individuals including children and the aged, blind and disabled.
- It is funded by Federal and State dollars.
- In fiscal year 2004, benefit payments totaled \$287 billion, of which the federal share was about \$168 billion.

## Overview

- Oversight for the Medicaid program is with CMS.
- However, CMS focused on Medicare (fully funded by the Federal government).
- CMS allowed the States to monitor the Medicaid Programs.

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## Deficit Reduction Act of 2005

- Signed into law by President Bush on February 8, 2006.
- There are many requirements with various effective dates (depending upon the provision):
  - Changes in Prescription Drugs
  - Asset Transfers
  - Proof of Citizenship for Medicaid
  - Cost Sharing Provisions
  - Benefits – mandatory vs. optional, benchmark
  - Fraud, Waste, and Abuse
  - Many Others

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## DRA ...

- Today's focus is on the Fraud, Waste, and Abuse Chapter, specifically, the compliance aspects of:
  - Employee Education about False Claims Act, and
  - Medicaid Integrity Program
- Effective 1/1/2007, entities that receive at least \$5 million in annual Medicaid payments, the Deficit Reduction Act requires – as a condition of receiving Medicaid payments – that certain requirements are met
- Failure to comply may disqualify Providers from receiving Medicaid reimbursement for the period of non-compliance.

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## Some Important Definitions

- Entity includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangements by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State plan approved under title XIX or under any waiver of such plan, totaling at least \$5,000,000 annually.

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## Definitions ...

- Employee includes any officer or employee of the entity.
- Contractor or agent includes any contractor, subcontractor, agent, or other person which or who on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity.

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## Who's Who?

- Entity – As Health Plans, we qualify as an entity. Do you meet the \$5 million threshold?
- If so, all employees in your plan are affected.
- So are your Contractors or agents:
  - In-network providers of service
  - Third party vendors, e.g., PBMs, Behavioral Health Vendors, Dental Vendors, etc.
  - Vendors to assist in coding and monitoring, e.g., DRG Validation vendors

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## **Employees Education About False Claims Act**

- Effective 1/1/2007 (or as soon after that the State adopts the necessary State Medicaid Plan amendments), Health Plans (entities) must:
  - Adopt written policies and procedures that provide detailed information about the federal False Claims Act (the FCA) and any comparable state laws, including the remedies and whistleblower protections

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## **Employees Education ...**

- Include in their written policies detailed provisions regarding provisions regarding the way in which the Plan detects and prevents fraud, waste, and abuse,
- Incorporate into their employee handbook provisions governing the FCA, including its whistleblower and non-retaliation provisions, and
- Educate employees and contractors about the FCA and the organization policies for detecting and preventing fraud, waste, and abuse.

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## **Affinity's Actions**

- Created a new P&P and revised an existing P&P
- Distributed the P&P to all employees (no requirement for specific training)
- Developed a letter for all contractors and agents with summary information and updated our Provider Policy and Procedure Manual
- Updated our employee on-line "handbook" with information about the FCA
- Copies are available for your information

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## **Medicaid Integrity Plan (MIP)**

- MIP represents CMS's first national strategy to detect and prevent Medicaid fraud and abuse in the program's history.
- Responsibilities
  - Review the actions of those providing Medicaid services.
  - Provide support and assistance to the States to combat Medicaid fraud, waste, and abuse.

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## MIP ...

- Dramatically increases CMS' obligations and resources to combat fraud and abuse
- 5 million in 2006
- 50 million in 2007 and 2008
- 75 million in 2009
- Requires CMS to hire 100 new FTEs "whose duties consist solely of protecting the integrity of the Medicaid program."

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## MIP ...

- CMS created the Medicaid Integrity Group
- Four major functions
  - Create the ***Comprehensive Medicaid Integrity Plan*** (CMIP) – current version released in July, 2006
  - Procure and provide oversight of ***Medicaid Integrity Contractors*** (MICs) who will conduct reviews, audits, and education
  - ***Field Operations*** will provide state program integrity oversight review and provide support, e.g., technical assistance and fraud and abuse training to States
  - ***Fraud Research & Detection*** will provide statistical and data support, identify emerging fraud trends

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## What Does It Mean For Health Plans?

- Although there is some uncertainty as to exactly what it means, there will be much more focus on Medicaid as a whole and specifically Medicaid managed care plans!
- CMS is currently developing meaningful measures (early stages)
- Focus is on Payment Error Rate Measurement (PERM)
- CMS expect to have its first PERM results in 2008

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## What Does It Mean For Health Plans?

- Review a 3 year pilot called PAM... to analyze the accuracy in paying Medicaid claims.
- CMS has also identified several specific issues to initially target:
  - Nursing and personal care such as fraud related to long term,
  - The provisions of prescription drugs to beneficiaries and the underlying costs of those drugs,
  - Durable medical equipment and other medical suppliers, and
  - Improper claims for payment from hospitals and individual practitioners.

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## Affinity's Actions

- Review existing PAM Report to identify opportunities for improvements.
- Audit targeted areas such as:
  - Nursing homes
  - PBM activities
  - DME and medical supplier claims
  - Claims submitted by hospital and physicians
    - DRG Validation - vendors
    - Upcoding/Unbundling - software
    - Subrogation – vendors

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## References

- US Government Accountability Office – Medicaid Integrity – Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud, Waste, and Abuse dated March 28, 2006
- Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program – FY 2006-2010 dated July 2006
- CMS State Medicaid Director letter dated December 13, 2006
- Individual State Plans found on the CMS website (only 4 are available at this time)
- You may email your questions to:  
[Medicaid\\_integrityprogram @cms.hhs.gov](mailto:Medicaid_integrityprogram@cms.hhs.gov).

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## **Any Questions?**

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