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PAGE 14

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PAGE 4

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PAGE 44

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PAGE 32

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Behavioral health and the Medicaid Integrity Program

By Deborah Rubbens Hutchison, JD, LLM

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Recent changes in the regulatory and compliance environment require behavioral health providers to prepare for a dramatic change and increase in Medicaid enforcement.

For several years, the Office of Inspector General's (OIG) Annual Work Plan and the state Medicaid Fraud Control Units' (MFCU) annual reports paid little attention to behavioral health and substance abuse. However, in 2005 behavioral health, particularly services that are funded by Medicaid, once again became a hot topic. Both the OIG and the state MFCUs have since been involved in an increasing number of investigations and enforcement actions relating to mental health and substance abuse services covered by Medicaid.

Simultaneously, Congress passed the Deficit Reduction Act of 2005 (DRA), one of the most vital compliance laws. Among other things the DRA called for the establishment of the Medicaid Integrity Program (MIP). This program will increase the involvement of the federal government in the enforcement of Medicaid regulations. This in turn will pressure states to step it up and oblige providers to comply.

The focus on Medicaid-funded behavioral health is relatively new, but definitely justified. About 16% of adults and 8% of children who are covered by Medicaid benefit from mental health or substance abuse services.[1] State mental health systems count Medicaid as their largest source of income. Medicaid is, after all, the principal payment source for mental health care nationwide.

Considering that the Medicaid program is of such importance to the behavioral health of many Americans, it is important to take a closer look at the integrity issues that arise with the provision of behavioral health services, as well as the consequences the MIP has for behavioral health providers.

Areas of concern

A number of integrity issues have been identified with regard to the screening, treatment, and billing for behavioral health services. For demonstration purposes, the main areas of concern can be categorized into: (1) mental health services; (2) early periodic screening, diagnosis, and treatment services; (3) prescription drugs; and (4) managed care. Although these categories are not exhaustive, they do represent the areas considered most important and most problematic by the OIG and state MFCUs.

Mental health services. The OIG plans to examine nearly 100 issues in Medicaid for 2007. Mental health providers and behavioral health services are among the top areas under review. The following issues are under increased scrutiny:[2]

- States claiming excess federal financial participation
- Medicaid payments to community mental health centers
- Mental health payments to prepaid inpatient health plans
- Medicaid payments for outpatient mental health services
- Psychiatric residential treatment facilities for children that use restraints and seclusion
- Over-utilization of Medicaid outpatient mental health services

The state MFCUs also list a number of common fraud patterns under review, such as misrepresentation as a licensed psychologist, billing for counseling sessions not rendered, and charging Medicaid for individual therapy sessions when less expensive group therapy was provided.[3]

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). This program is designed to screen for, diagnose, and treat medical conditions that might otherwise go undetected or untreated in Medicaid-eligible individuals under the age of 21.

Through the EPSDT benefit, Medicaid provides coverage for children for a broad range of screening and treatment services, including mental health therapies. The OIG mentioned in its 2007 Work Plan that it would place particular emphasis on the methods used for screening and treatment of mental health issues. Managed care organizations are under increased scrutiny as well as providers who fail to identify and treat mental health and substance abuse problems in children. Particularly, children in foster care and out-of-home placements are vulnerable and are often left out.

Prescription drugs. Medicaid plays a fundamental role in the provision of prescription drugs, accounting for 19% of national spending for this service. Of the almost $41 billion the Medicaid program spent on prescription drugs, an estimated 20% are used for mental health services.

Continued on page 26

Behavioral health and the Medicaid Integrity Program

...continued from page 25

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Common fraud and abuse schemes, as identified by the OIG and state MFCUs, include:[4]

- Price manipulation
- Drug marketing
- Switching arrangements
- Deliberate miscalculations of the "best price" to participate in the Medicaid drug rebate program
- Illegal kickbacks
- Off-label promotion
- Charges for consulting and advisory payments
- Over-prescribed addictive anti-depressants and narcotic drugs

Managed Care. At present, more than half of the Medicaid beneficiaries are enrolled in managed care plans. The transition from Medicaid fee-for-service to managed care has raised numerous concerns about access to necessary mental health care as well as quality of care.

The implementation of managed care programs has increased access to primary care for most beneficiaries, but it has limited access to specialty care, such as behavioral health care.

Moreover, states have flexibility in determining their Medicaid managed care programs through the submission of waivers. As a result, mental health and substance abuse services, while covered under Medicaid, are often "carved out" and provided on a fee-for-service basis. This can lead to under-utilization of services and denial of access to certain populations. Many states have already been challenged for under-providing home and community-based psychological and behavioral services.

The Medicaid Integrity Program

In response to the DRA, the Centers for Medicare and Medicaid Services (CMS) developed a five-year comprehensive Medicaid Integrity Plan in July 2006. This plan outlines how CMS, under the leadership of the Center for Medicaid & State Operations, envisions the implementation of MIP and how it plans to use its new functions.[5]

MIP significantly increases CMS's capacity to prevent and detect fraud and abuse. Congress appropriated extra funds to CMS specifically for this program. The funds will reach approximately $75 million annually by fiscal year 2009 and each year thereafter. This significant investment represents the government's commitment to fight fraud and abuse in Medicaid.

MIP provides a first opportunity for a national approach to Medicaid integrity. It takes the state-federal partnership, under which Medicaid has been operating since the mid 1960s, to a new level. The states remain primarily responsible for policing fraud in the Medicaid program, but CMS now has the legal foundation to provide oversight and technical assistance to the state Medicaid agencies.

To achieve the two main goals of the MIP (i.e., conducting audits and supporting state program integrity efforts) CMS may use Medicaid Integrity Contractors (MICs) with extensive experience in healthcare auditing. The MICs will fulfill four fundamental activities defined in the DRA:

1. Reviewing the actions of providers seeking payment from Medicaid
2. Auditing claims for payment
3. Identifying overpayments
4. Educating providers and stakeholders on payment integrity and quality of care

The potential for conflicts with ongoing state or federal fraud investigation highlights the importance of collaboration. CMS will thus work closely with the state MFCUs, OIG, and the Department of Justice (DoJ) when identifying, investigating, and preventing fraud, waste, and abuse.

Impact on mental health providers

Mental health providers will be under increased scrutiny under the MIP. CMS now has increased resources and powers to fight known patterns and schemes of fraud, waste, and abuse. Moreover, through the new partnerships and tasks assigned to the MICs, new areas of concern are likely to emerge. Considering their more independent position between CMS and the MFCUs, the MICs are well positioned to audit and investigate any providers and issues where state involvement could involve a conflict of interest.

Historically, the responsibility for the implementation and enforcement of mental health and substance abuse-related issues was under government, rather than private, leadership. Consequently, many mental health institutions and rehabilitative hospitals are operated by the states. Community mental health centers (CMHCs), for example, are usually run by the state because they provide mental health services to economically disenfranchised and homeless people. Through EPSDT, children in foster care and state-run facilities can receive necessary health services that would not be accessible through the free market.

Given then, that a considerable portion of all mental health and substance abuse services are covered under the state-run Medicaid program and audited by the state MFCUs, conflicts of interests may arise. This problem will be resolved once the MICs are fully operational and able to audit these state-run facilities. Mental health providers thus face increased scrutiny under the MIP. ■

1 Buck, Jeffrey A. and Miller, Kay (2002). Mental Health and Substance Abuse Services in Medicaid. US Department of Health and Human Services (DHHS Publication Number (SMA) 02-3713).
2 Office of Inspector General, Work Plan 2007.
3 Office of Inspector General, State Medicaid Fraud Control Units Annual Report Fiscal Years 2004-2005; and 2006.
4 Testimony of Lewis Morris, Chief Counsel to the Inspector General U.S. Department of Health and Human Services, before the House Committee on Oversight and Government Reform on February 9, 2007; OIG, MFCU annual reports for fiscal years 2004, 2005, and 2006.
5 Center for Medicaid and State Operations, Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program FY 2006-2010, July 2006.

Compliance Today CEU Quiz Deadline

Compliance Today readers taking the CEU quiz have ONE YEAR from the published date of the CEU article to submit their completed quiz.

VOLUNTEER IN 2008 with HCCA's Compliance Caring for the Community!

Come to the Compliance Institute early and join us in a wonderful networking opportunity to help others! We will be volunteering with the New Orleans Area Habitat for Humanity (NOAHH) for our 2008 project on Saturday, April 12, 2008, in New Orleans, LA.

NOAHH volunteers work in partnership with staff, qualified homeowners, and sponsors to eliminate substandard housing in New Orleans. This partnership builds simple affordable homes that are sold to the homeowner with a long-term, interest-free mortgage.

At the worksite, we have experienced staff and volunteers to teach and guide our new volunteers. There are also a number of tasks that can be performed that do not require serious lifting, so everyone can participate! No experience is required. All the instruction that you need will be given on-site.

You will be able to register for this event on your 2008 Compliance Institute registration form. Please contact Jennifer Jansen at *jennifer.jansen@hcca-info.org* with any questions. ■