

Business & Labor Committee
HB 496 Hearing
February 7, 2005

Big Sky AMES response to the Medicaid assumptions concerning HB 496.

DPHHS and SLTC assumptions:

1. **Retroactive collection due to provider error will not be allowed under the provisions of this bill.**
 - a. This bill does not prevent the Department from retroactively collecting payments for any item that is not medically necessary or fraudulently billed as outline in 42 CFR 433.304.
2. **Currently the Senior and Long Term Care (SLTC) Division collects approximately \$250,000 annually due to incorrect billing from Medicaid providers.**
 - a. Under the current system the department treats a simple error the same as fraud and abuse.
 - b. 42 CFR 433.304 requires Medicaid programs to recoup payments made due to fraud, abuse or overpayment. Overpayment is further defined to be an amount greater than the allowable.
 - c. If a medically necessary item, ordered by a qualified healthcare professional is provided to an eligible Medicaid recipient and the amount billed is not in excess of the allowable it does meet the criteria for repayment. Currently Medicaid is recouping payment for any error.
3. **The federal fund portions of these collections are repaid to the federal government. The state fund portion of these recoveries, are deposited to the general fund.**
 - a. This will not change.
4. **Federal Medical Assistance Participation (FMAP) rates are 70.71 percent federal funds and 29.29 percent state funds in FY 2006 and 70.08 percent federal funds and 29.92 percent state funds in FY 2007.**
 - a. This does will not change
5. **It is estimated that lost revenues to the general fund as a result of this bill would be \$73,225 in FY 2006 and \$74,800 in FY 2007.**
 - a. This estimate is based on the assumption that all repayments are based on fraud, abuse or overpayment as defined by 42 CFR 433.304.
 - b. Given that this assumption the Department will still be able to recoup these payments Under HB496

Operations and Technology Division assumptions:

6. It is estimated to take approximately 1,000 programming hours to the Medicaid Management Information System (MMIS) to evaluate the claims payment edits currently in place to create new edits to address the provisions in this bill.
 - a. There are no new edits required under this bill. They would proceed as they do now.
7. Programming is billed by Affiliated Computer Services, Inc. (ACS), The MMIS Fiscal Agent at \$100 per hour for a total of \$110,000 for FY2006.
 - a. Again there are no computer system changes. The existing system for auditing claims would continue. .
8. It is assumed that these cost are funded at the Medicaid Administrative rate of 25 percent general funds and 75 percent federal funds.
 - a. HB 496 does not change to the auditing system.

Quality Assurance Division Assumptions:

9. States are required to have a post-payment review process for Medicaid paid claims (42 CFR 456). DPHHS has a Surveillance/Utilization Review Section (SURS) within the Quality Assurance Division. SURS carries out the federally mandated program that performs retrospective reviews of paid claims. SURS is required to safeguard against unnecessary and inappropriate use of Medicaid service and against excess payments.
 - a. This bill does not prevent the Department from having a Surveillance/Utilization Review Section (SURS) or performing retrospective reviews as required by 42 CFR 456.
10. States are required by law to refund the federal share of Medicaid overpayments to providers (42 CFR 433). In accordance with Title XIX of the Social Security Act, as outlined inn 42 CFR 433, a state has 60 days from discovery of an overpayment for Medicaid service to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the state is made. That adjustment must be made at the end of the 60 days, whether or not recovery is made. The only exception is if a state is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectible.
 - a. 42 CFR 433.304 states The following:
 1. "Abuse (in accordance with Sec. 455.2) means provider practices that are inconsistent with sound fiscal, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
 2. Fraud (in accordance with Sec. 455.2) means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
 3. Overpayment means the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for

services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act.

- b. HB496 does not stop the Department from collecting under these circumstances.
 - c. HB496 brings the department in line with 42 CFR 433.304
11. Federal Law, 42 CFR 447, requires states to pay providers in a timely fashion. Specifically:
- a. The agency (DPHHS) must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt (of a claim).
 - b. The agency (DPHHS) must pay 99 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt (of a claim).
 1. HB 496 Does not change this. The Department will continue to pay claims as they do now and review them in a post payment audit system.
12. Montana Medicaid paid approximately 6,667,205 claims to 12, 851 providers in FY 2004 through our fiscal agent, Affiliated Computer Services, Inc. (ACA). The computerized system used to pay Medicaid claims has a number of edits "built into" the system to prevent improper payments (such as duplicate payments, age and sex edits, provider type matches service performed, etc.) No automated system, however, is capable of identifying all possible overpayments or underpayments.
- a. HB496 does not change the Department's current system.
13. It is assumed that und this bill DPHHS will be required to pay the federal government their share of the amount that would have been recovered from the provider using general funds. For SURS recoveries alone, the general fund cost for this payback would have been \$1,175,351 in FY 2002; \$1,174,194 in FY 2003; and \$978,893 in FY 2004.
- a. This is simply not accurate. It assumes that all collections were for non-medically necessary or fraudulently provided items.
 - b. If the above figures were for non-medically necessary or fraudulently provided items, HB 496 would not prevent their collection and there would be no financial cost to this bill.
14. Additional cost for automatic mass adjustments that are made through the payment system were \$418,010 in FY 2002; \$19,966 in FY 2003; and \$28,316 in FY 2004.
- a. This bill would not affect these mass adjustments if they were made accordance with 42 CFR 433.
15. It is estimated that the federal portion for repayment on SURS recoveries and mass adjustments would be \$1,264,909 in FY 2006 and \$1,264,909 in FY 2007.
- a. This assumes all collections were for non-medically necessary or fraudulently billed items. HB496 does not stop the Department from making such collections.

Technical Notes:

1. Recoveries for provider billing errors is required by Federal Medicaid law. Provisions of this bill are in violation with those Federal Medicaid statutes.

- a. 42 CFR 433.304 requires recoveries for fraud, abuse or overpayment (defined as an amounts billed over the allowable by the Act).
 - b. 42 CFR 433.304 does not mandate a recovery unless the error meets one of the above descriptions.
 - c. HB 496 brings the Department in line with Federal Medicaid law.
2. **An alternative to utilizing a post payment review process would be to review all claims prior to payment. There is no automated medical claims payment systems (private or public) that perform this function. It would require significant increase in manual claims review to attempt to tie 6,667,205 claims per year to a medical record. ACS (the state's fiscal agent for claims payment) estimates 240 FTE at \$30,000 each per year to manually process the claims or \$7,200,000/year.**
 - a. HB 496 does not require the Department to review all claims prior to payment.
 - b. HB 496 does increase or decrease the amount of post payment audits.
 - c. There is no additional cost to the department because no changes are made to the Departments current system.
3. **It is unknown if und this bill the DPHHS would be in compliance with the Health Insurance Portability and Accountability Act (HIPPA) with which all medical payment systems must comply.**
 - a. HB 496 does not change the way health information is collected, processed or shared. This bill does not affect the current rules.
4. **General fund impact may be understated because it is unknown how many overpayments providers return to the department on their own.**
 - a. HB 496 does not stop the Department from recovering payments made in violation to 42 CFR 433.
 - b. Current Department policies are not consistent with 42 CFR 433 and are negatively affecting the Department's funding.
 - c. The improper interpretation of 42 CFR 433 is costing the Federal dollars and State general fund dollars by processing inappropriate collections.
5. **DPHHS have discussed with the CMS regional auditor whether the federal government would require payback of the federal portion of what should have been recovered from a provider(s) if this bill passes. Specifically, would the prohibition on provider recoveries under stat law be considered uncollectible under the federal statute at 42 CFR 433? The auditor indicated, and state staff agrees based on their research, that the state would need to pay back the federal portion regardless of whether it was collected from the provider(s).**
 - a. 42 CFR 433.304 requires recoveries for fraud, abuse or overpayment (defined as an amount billed over the allowable by the Act). HB 496 does not prevent the Department from recovering any payments made under the definitions provided in 42 CFR 433.304.