Oklahoma Health Care Authority
Annual Board Retreat
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Program Integrity Mandates From The Affordable Care Act

Payment Suspension
Recover Audit Contractors
Contract Termination

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Section 6402(h)(2) Payment Suspension

- Provides that Federal Financial Participation (FFP) in the Medicaid Program shall not be made with respect to any amount expended for items or services (other than an emergency item or service) furnished by an individual or entity to whom a State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud.

Payment Suspension

- Good Cause Exceptions do Exist
  - Specific requests by law enforcement
  - State determines that a different action more effectively and/or quickly protects Medicaid funds
  - Provider furnishes written evidence that persuades the State suspension should be terminated or imposed only in part
  - Recipient access to items or services would be jeopardized
  - Law enforcement declines to cooperate in certifying a matter continues to be under investigation
  - State determines suspension is not in the best interest of the Medicaid program
  - State determines that a suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid (specific type of claim or business unit)

Payment Suspension

- CMS provisions on a “credible allegation of fraud”
  - Defines it as an allegation that has been verified by a state and has indicia of reliability from any source;
  - States should have flexibility in determining what constitutes a credible allegation;
  - Medicaid agency must conduct a preliminary investigation under 42 CFR 455.14;

Payment Suspension

- CMS provisions on a "credible allegation of fraud"
  - If a "credible allegation" exists, States must:
    - Refer the suspected fraud to its MFCU
    - Suspend payments to such provider unless the State has good cause not to suspend

Section 6411
Recovery Audit Contractors

- States are required to contract with one or more Medicaid RACs for the purpose of identifying underpayments and overpayments and recouping overpayments.
- Payments are on a contingency basis; payments will be made only from amounts recovered.
- State Plan Amendment has been submitted.
- Implementation date of April 1, 2011 has pushed back.
- Final rule should be published by September 30, 2011.

Section 6501 Contract Terminations

- Effective Jan. 1, 2011, States are required to terminate from participation in Medicaid any provider that has been terminated from the Medicare program or State Medicaid or CHIP program.
- Termination(s) must;
  - Be for cause – fraud, integrity, or quality.
  - Provider has exhausted all applicable appeal rights or the timeline for appeal has expired.
- Terminations must be reported;
  - States are required to report all providers terminated effective on or after Jan. 1, 2011.
  - CMS has developed a secure web-based portal for states to report their terminated providers and to access information reported by Medicare and other State programs.