

State of Vermont
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston VT 05495-2807
dvha.vermont.gov

Agency of Human Services

[Phone] 802-879-5900
[Fax] 802-879-5651

TO: Rep. Martha Heath, Chair, House Appropriations Committee
Sen. Jane Kitchel, Chair, Senate Appropriations Committee

CC: Rep. Mark Larson, Chair, House Health Care Committee
Sen. Claire Ayer, Chair, Senate Health and Welfare Committee

FROM: Susan Besio, PhD, Commissioner, Department of Vermont Health access

DATE: January 21, 2011

RE: Legislative report: 2010 Act 156 Sec. 306(b); Program Integrity Measures

During the SFY 2011 legislative session, the Department of Vermont Health Access (DVHA) proposed adding three (3) additional full-time positions to its Program Integrity (PI) unit to maximize efforts to control fraud, waste, and abuse in the Medicaid system. Ultimately, the legislature approved six (6) new full-time positions to expand the program integrity efforts, with the expectation of saving the State of Vermont a total of \$2.3 million (gross) in SFY 2011 from PI activities.

The DVHA has now hired the six additional staff and, as required per Section E 306(b) of Act 156 (2010), has developed measures to evaluate the success of these new positions. Included in this summary report are the evaluation activities developed to measure the projected savings for SFY 2011. The PI unit is confident of realizing the savings expectations.

To date, the PI unit has saved \$1.3 million (gross). The majority of savings has been achieved through two sources: direct reporting of potential fraud, waste and abuse to the PI unit from other state departments, providers, and beneficiaries; and DVHA's partnership with the Medicaid Fraud and Residential Abuse Unit (MFRAU). Additional savings have been achieved through data mining activities conducted in collaboration with DVHA's contractor, Ingenix, to identify potential overpayments in the following areas:

- *Pharmacy Kits.* Some pharmacy medications are sold in kits containing multiple units; units in kits are less expensive than when sold individually. Instead of billing for the kit, some pharmacies have continued to bill for the number of individual units in the kit (e.g., Imitrex, a migraine medication, is packaged in quantities of two (2) syringes; some pharmacies continue to bill for each of the two syringes instead of for the kit).
- *Pharmacy Billing Codes.* Some drugs require Prior Authorization (PA) from the primary insurer, such as the Medicare Part D Plan (PDP). However, rather than obtaining a PA from the primary insurer, pharmacies sometimes put an override code into the system which allows the claim to be paid through Medicaid as the primary. As a result, Medicaid pays significantly more than the portion it would have paid if the primary insurer had authorized and paid its portion of the costs first.

- *Therapy Services (Physical, Occupational, and Speech)*. Some providers have not adhered to Medicaid Prior Authorization requirements for these services.
- *Non-Emergency Transportation Services*. Some beneficiaries may attempt to use transportation services to access non-medical services, which are not covered through the Medicaid program.

In addition, DVHA is reviewing the following areas and expects them to yield an additional \$1 million savings in SFY 2011:

- *Correct Coding Initiative*. Identifying defined code pairs that should never be billed together (e.g., removal of a benign lesion and destruction of a lesion should not be billed together).
- *Ambulance Transport for Inpatient Beneficiaries*. Identifying inappropriately billed ambulance transports during an inpatient hospital stay.
- *Rounding Errors*. Drug packages may contain units in a size other than a whole number. When pharmacies round the unit size up to the next whole number before multiplying by the number of units in the package, Medicaid is billed for more of the drug than is actually dispensed. (e.g., nebulizer solutions, vaccines, and other solutions that are packaged in decimal quantities such as 2.5ml which are then rounded up to 3ml, or 8 oz bottles that are rounded up from 237ml to 240ml).
- *Unreasonable Medication Quantities*. Identifying drugs that are billed in quantities that are not clinically indicated or appropriate.
- *Team Care*. Reducing prescription drug abuse by restricting certain beneficiaries to one pharmacy and/or one provider will result in savings through reduced drug diversion and improved coordination of care.
- *Behavioral Health Codes*. Reviewing medical necessity and appropriate billing of certain behavioral health codes (e.g., group therapy billed for excessive units or excessive visits).
- *Credit Balances*. Creating a procedure similar to Medicare's in which providers are requested to return any known credit balances and/or attest none exists.
- *Pharmacy Reimbursement for Renal Dialysis*. Identifying when pharmacy services billed by dialysis providers are paid a percent of charges instead of at the fee schedule rate, resulting in overpayments.
- *Physician Assistant Reimbursement Logic*. Identifying when physician assistants are reimbursed at the MD level instead of at 90% of the MD level.

It also is important to note that of the \$2.3 million expected (gross) savings from PI activities in 2011, \$1 million of the savings will be a one time recoupment and \$1.3 million saved in 2011 will generate ongoing cost-avoidance savings. However, we anticipate that our on-going work in SFY 12 will generate savings to continue the \$1 million so it can be considered an on-going (i.e., base) savings into the future.

If you have any questions regarding this report, please contact Ron Clark, Director of Program Integrity, at (802) 879-5652.