

Health Reform Fraud/Abuse Task List

Row	Task(s)	Section of Bill	Entity	State Action - Required, Optional, N/A	Effective Date(s)
1	Apply new screening, oversight, disclosures, and compliance rules in Medicaid and CHIP	6401	State	Required	TBD
2	Educate providers on new screening requirements, including licensure check,	6401, 10603	Provider		
3	Develop mechanism to inform new providers and suppliers of services that they are subject to a period of enhanced oversight after enrollment. May include prepayment review and prepayment caps.	6401	Provider		March 2012
4	Educate providers and suppliers that they are required to disclose any past affiliation with a provider who has been subject to payment suspension, excluded from participation, or has had their billing privileges denied or revoked (Sec. 6401, 10603)	6401, 10603	Provider		
5	Providers and suppliers will be required to establish an anti-fraud and abuse compliance program (Sec. 6401, 10603)	6401, 10603	Provider		
6	States are required to apply the new screening, oversight, disclosure and compliance rules in Medicaid and CHIP (Sec. 6401, 10603)	6401, 10603	State	Required	

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Row	Task(s)	Section of Bill	Entity	State Action - Required, Optional, N/A	Effective Date(s)
7	Simplifies procedures to initiate prepayment review for fraud and abuse (Sec. 1302 of Reconciliation)	1302		FYI	
8	Community Mental Health Centers must provide at least 40% of partial hospitalization services to individuals not eligible for Medicare (Sec. 1301 of Reconciliation)	1301	CMHC	Required	
9	Prohibits Community Mental Health Centers from providing partial hospitalization services in an individual's home or in an inpatient or residential setting (Sec. 1301 of Reconciliation)	1301	CMHC	Required	
10	States must terminate providers from participation in Medicaid who have been terminated from participation in Medicare or CHIP (Effective: Jan. 1, 2011; Sec. 6501) (CMS will inform states of providers who have been terminated from participation in Medicare (Sec. 6401, 10603))	6501, 6401, 10603	State	Required	40544
11	Excludes providers and suppliers if they are owned by, or own, individuals or entities that: - have not repaid overpayments; - are suspended or excluded from participation in Medicaid; or - are affiliated with an individual or entity that has been suspended, excluded or terminated from participation	6502	State	Required	40544
12	Groups submitting claims on behalf of providers must register with the state and CMS	6503	State, Provider	Required	40544
13	Expands the period, from 60 days to one year, states have to recover overpayments (Effective: Upon enactment; Sec. 6506)		State	FYI	
14	Prohibits states from providing payment for services under Medicaid to entities outside the U.S. (Effective: Jan. 1, 2011; Sec. 6505)		State	Required	40544

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15	States must establish a RAC program to identify underpayments and overpayments and recoup overpayments under Medicaid (Effective Dec. 31, 2010; Sec. 6411) Payments to RAC contractors will come from amounts recovered, a portion of the recovered overpayments will be used to identify underpayments, and states must establish an appeals process.	6411	State	Required	40543
16	Expands the RAC program to Medicare Advantage Plans and Medicare Part D (Sec. 6411)	6411			
17	Requires a face-to-face encounter before certification for home health services under Medicare and Medicaid, and payment for DME under Medicare (Effective: Jan. 1, 2010; Sec 6407, 10605) Encounters can be with: a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife or physician assistant	6407, 10605	State, Provider	Required	40179
18	Providers and suppliers in Medicare are required access to documentation about referrals to, orders for DME, and certification for home health services to entities at a high risk for fraud and abuse (Effective: for orders, certification, or referrals on or after Jan. 1, 2010; Sec 6406) upon demand by secretary.	6406	Provider	Required	40179
19	Requires adjusting the size of surety bonds for DME and home health agencies by billing volume (Sec. 6402)	6402		Required	
20	Withholds payment to DME suppliers for 90 days if there is a significant risk for fraud (Effective Jan. 1, 2011; Sec. 1304 of Reconciliation)	R1304, 6401	Provider		40544
21	Prohibits physicians, or eligible professionals, not enrolled in Medicare from ordering home health services or DME for Medicare beneficiaries (Effective: July 1, 2010; Sec. 6405)	6405	Provider		40360
22	Individuals who receive overpayments through Medicare, Medicaid and CHIP are required to report and return the overpayment within 60 days (Sec. 6402)		Provider		Need to figure out.
23	Providers and suppliers of services are required to include their National Provider Identifier on all enrollment applications and claims submissions through Medicare, Medicaid and CHIP (Effective Jan. 1, 2011; Sec. 6402)	6402	Provider		40544
24	States and Medicaid managed care organizations must submit an expanded set of Medicaid data elements (Effective: for data submitted on or after January 1, 2010; Sec. 6504)		State	Required	40179

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Row	Task(s)	Section of Bill	Entity	State Action - Required, Optional, N/A	Effective Date(s)
25	State Medicaid information systems must be compatible with the National Coding Initiative (Effective: October 1, 2010; Sec. 6507)		State	Required	40179
26	Requires the Integrated Data Repository (IDR) of CMS to include claims and payment data from Medicare, Medicaid, CHIP, the Dept. of Veterans Affairs, the Dept. of Defense, the Social Security Administration, and the Indian Health Services (Sec. 6402) Data in the IDR will be matched to identify fraud and abuse in Medicare and Medicaid				
27	Establishes a National Health Care Fraud and Abuse Data Collection Program for the reporting of all final actions against health care providers, suppliers, and practitioners (Effective: whichever is later, one year after enactment or when regulations are published; Sec. 6403)	6403			One year post enactment or when regs published
28	States are required to report all final actions, which include: Revocation or suspension of licenses, reprimands, or probation Dismissal or closer of fraud and abuse proceedings Any other lost of license, or the right to apply for or renew a license, or other negative action	6403	State	Required	
29	State licensing, law, or fraud enforcement agencies will report any corrections to reported information	6403	State	Required	
30	Withholding of federal matching payments for states that fail to report enrollee encounter data in the Medicaid Statistical Information System.	6403	State	Required	
31	To prevent fraud and abuse in the new state insurance exchanges: (Sec 1313) The Secretary may investigate the exchanges for fraud and abuse and if there is serious misconduct the Secretary may reduce payments due to states by, at maximum, 1% until changes are made Individuals who commit fraud and abuse can be subject to federal prosecution if payments received through the Exchanges involved federal money		HIE (State)	Required	
32	Co-Ops and multi-state health insurance plans are required to comply with all the same federal and state laws as private health insurance issuers (Sec. 1324, 10404)		HIE (State)	Required	

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Row	Task(s)	Section of Bill	Entity	State Action - Required, Optional, N/A	Effective Date(s)
33	MEWAs are subject to state anti-fraud and abuse laws and regulations (Sec. 6604)				
34	Employees of MEWAs who make false statements concerning the financial condition or solvency, benefits, or regulatory status of the plan are subject to civil penalties (Sec. 6601)				
35	Enables the Sec. of Labor to issue cease and desist orders, if there is evidence of fraud and abuse, to temporarily shut down MEWAs (Sec. 6605) Allows the Sec. of Labor to seize the MEWAs' assets if it is in a financially hazardous condition				
36	Allows the Sec. of Labor to seize the MEWAs' assets if it is in a financially hazardous condition				
37	In order to prevent and fraud and abuse in CLASS (The Community Living Assistance Services and Supports Program): (Sec. 8002) Establishes procedures to allow authorized representatives access to a beneficiaries' benefits that prevent fraud and abuse CLASS regulations will include provisions to prevent fraud and abuse				
38	Payments, under Medicare and Medicaid, to providers can be suspended during investigations of fraud and abuse (Sec. 6402) Allows the Secretary to suspend the federal portion of payments, for services under Medicaid, to providers who are under investigation for fraud and abuse if the state does not suspend payments	6402			
39	Medicare, Medicaid and CHIP beneficiaries who participate in fraud and abuse can be subject to administrative penalties (Sec. 6402)				
40	Providers can be excluded from participation in Medicare, Medicaid, and CHIP if they make false statements when applying for, or making, claims and bids and can be subject to civil penalties up to \$50,000 per false claim (Sec. 6402, 6408)	6402			
41	Also subject to civil penalties are Medicare Advantage or Part D plans that involuntarily enroll beneficiaries, transfer individuals between plans to earn commissions, do not comply with marketing regulations, or contract with individuals that engage in these activities (Sec. 6408)	6408			

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Row	Task(s)	Section of Bill	Entity	State Action - Required, Optional, N/A	Effective Date(s)
42	Changes the federal sentencing guidelines to raise the penalties for convictions of federal health care offenses (with a net loss over \$1M) (Sec. 10606)	10606			
43	Persons who do not provide timely access to information for audits, investigations, evaluations, or other statutory functions can be subject to monetary penalties of \$15,000 per day (Sec. 6408)	6408			
44	Changes the intent requirement for health care fraud so that individuals do not need to know that their actions are fraudulent in order to be prosecuted for fraud and abuse (Sec. 10606)	10606			
45	Permits, in exclusion-only cases, Inspector General of DHHS to issue subpoenas and require the production of evidence and testimonials related to the investigation (Sec. 6402)	6402			
46	Grants the Inspector General of DHHS access to data from any individual (including beneficiaries) in order to investigate fraud and abuse (Sec. 6402)	6402			
47	Organizations that investigate fraud and abuse, under the Medicare and Medicaid Integrity Programs, are required to provide performance statistics (Sec. 6402). Such as: the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities	6402			
48	Creates evidentiary privilege for confidential communication between state and federal agencies that is related to investigations into fraud and abuse (Sec. 6607) Included state and federal agencies: state insurance departments, state attorney generals, the National Association of Insurance Commissioners, the Dept. of Labor, the Dept. of the Treasury, the Dept. of Justice, and the Dept. of Health and Human Services	6607			
49	Directs the National Association of Insurance Commissioners to develop a uniform reporting form that private health insurance issuers will submit to state insurance departments in to report suspected fraud or abuse for investigation (Sec. 6603)				
50	Withhold of FFP for states that withhold enrollee encounter data				

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Row	Current NC Efforts	Gap	What's needed? (Legislation, DHHS rules, etc)
1	<p>DMA engaged CSC (Computer Sciences Corporation) about 18 months ago to do reverification and reenrollment of all Medicaid providers.</p> <p>Issue - states may not be able to have stricter enforcement than Feds. NC has negotiated new Medicaid enrollment agreement, and has agreement with the NC Hospital Association, NC medical society, and others, but not home health agencies.</p> <p>Federal requirements will be 3 years re-enrollment cycle for DME & a 5 year cycle for all other providers. Any service delivered outside of a facility is high risk. CSC will be the MMIS contractor, as well as provider enrollment processing contractor (see DMA website). Some providers didn't have contracts because they were grandfathered in, but now they are having to enroll and create contracts</p>	On hold pending Federal rules	Rules
2	<p>Medicaid provider enrollment rules are in existence in draft form, but waiting for Fed rules to complete the process.</p>	On hold pending Federal rules	Rules
3		On hold pending Federal rules. Due date has changed to March 2012 due to need to wait for Federal rules.	Rules
4	<p>DMA is already doing this.</p>	None	Rules
5	<p>OIG has been putting out compliance programs since 2000 for hospitals, nursing homes, and home health to help employees and companies comply with federal laws. These have been voluntary for some providers, but now they will be mandatory.</p>	<p>1) Attestation that providers are in compliance.</p> <p>2) Provide on provider requirements. Do we want to a subgroup to develop this? What stakeholders should be a part of this group? Do we want someone from DMH to participate?</p> <p>3) Employee education</p> <p>4) Ensure that Medicaid requirements match Medicare requirements.</p>	Rules
6		On hold pending Federal rules	Rules

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7	DMA currently has contractor engaged for pre-payment review (CCME). It's not a sanction, but is one more utilization review procedure. If at high-risk of submitting improper claims, you're placed on pre-payment review. So – all backup documentation must be submitted to CCME with claim. CCME staff reviews documentation prior to payment.	Education of providers. Working on three sets of rules 22F(integrity) (not reviewed yet), 22J (audit) (haven't started revisions), 22N enrollment rules.	Rules
8		Questions: Interaction with CABA? Redirect to Medicaid WG (DMA/Clinical policy group).	n/a
9		Redirect to Medicaid WG (DMA/Clinical policy group)	n/a
10	Will be covered by 22N and 22F rule revisions.	Potential rule/rule revisions	Rules/Rule revisions
11	Will be covered by 22N and 22F rule revisions. Overpayment issue is not new to DMA. "Affiliation" still needs to be defined.	Potential rule/rule revisions	Rules/Rule revisions
12	Totally new for NC Assuming that this will impact hospitals, nursing homes, clinical labs, hospice, home health.	Waiting for Fed rule.	On-hold
13	Controller's office is aware and working on this.	f/u with OSC to be sure it's implemented.	
14		CSC issue - to be sure banks are in US or reject claim. Be sure that Dan Stewart (DHHS Assistant Secretary for Finance) and Steve Owen (OSC) are aware of this requirement.	

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15	Underway through Program Integrity Section, DMA. State plan due 12/31 to CMS.	None	n/a
16	n/a - not a state requirement.	None	n/a
17	Good for home health.	Need to expand template to DME.	Requires clinical policy change through Physician's Advisory Group (PAG)
18	This is a federal statute, not a state action. The State will enforce this as program integrity audits.	Would like to have this as an in-state rule, but not required.	Optional rule
19	Already exists as federal reg for home health agencies, but not implemented in NC.	Wait to see what Fed rule says. Will require revisions to DMA current bond rules. 22P?	Rule revisions
20		Wait for fed rule.	On-hold
21	Medicare, so n/a - Federal.	n/a - Fed	n/a
22	DHHS currently does federal and state tax intercepts for food stamps, workforce, overpayments.	Rule. Will require notice to public, education of recipients.	Rule
23	Already required in NC	None	n/a
24		Wait for feds to define elements.	On-hold

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25	In process (HP contracted with Bloodhound)	None	n/a
26	CMS is building the national repository.	None	n/a
27	CMS is building the national repository.	None	n/a
28		No rule or law required. Requires that someone at DMA-provider enrollment is responsible. Requires state coordination between integrity, provider enrollment, audit.	
29			
30			
31	Federal	None	n/a
32		Send to HBE group.	n/a

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33		Wait for feds.	On hold
34		Wait for feds.	On hold
35		Wait for feds.	On hold
36		Wait for feds.	On hold
37	Not funded. Federal	None	n/a
38		Will require revisions to DMA procedures and policies, and will require rule change.	Rule revision
39		Take opportunity to make some corrections.	Rule revision
40		Question for MIU - will we need to change false claims statute? Not approved by Feds.	Statute change?
41	Feds	None	n/a

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42	n/a - not a state requirement.	None	n/a
43		Have to wait for Feds to define "reasonable request". Then will have to change our rules.	Rule revision
44	Changes standard of proof.	Changes standard of proof.	
45	Fed	None	n/a
46	Fed	None	n/a
47	DMA Program Integrity DMA is already tracking this.	None	n/a
48	Federal rule	None	n/a
49			
50		Will require internal DMA change.	