

HEALTH CARE FRAUD AND ABUSE TASK FORCE
LEGISLATIVE TOPICS UNDER DISCUSSION

1. Define high risk categories in addition to proposed 455.416 (behavioral health? Home care including adult care homes?)
2. Define criteria for individual providers to be placed in high risk categories (newly enrolled, questionable background hits that do not disqualify but warrant further scrutiny, overutilization).
3. Requirement for providers to conduct background screening of hires in provider categories where workers come into direct contact with patients – lifetime exclusion of individuals with violent crime history, sexual predators, etc. Model after FL statute. Incident reporting? Where do incidents get reported and how does it get used? Substantiation? Threshold for temporary exclusion? Different time limit for different types of crimes? Exception/ waiver criteria. Attestation?
4. Authorize DMA to engage in payment suspension against providers with outstanding amounts owed to state/ define parameters/ define “indicia of reliability.”
5. Authorize prepayment review/ define parameters.
6. Establish threshold dollar amount (\$100?) requirement for recovery – right now DMA must recover every dollar.
7. Establish permanent performance bond statute?
8. Successor liability statute that extends beyond nursing homes.
9. State law prohibiting the sale of PHI (currently a federal law but no state).
10. Require all state regulatory agencies to meet regularly and share information regarding fraud and abuse with providers. Legislation to create study of procedures by Boards etc. for incident reporting/ fraud, abuse, neglect, exploitation/ ramifications? Avoid creation of huge bureaucratic nightmare that accomplishes next to nothing. Quarterly association meetings?
11. Require insurers to share information regarding providers with DMA.
12. Create civil penalties/ exclusion for abandonment of records.
13. Requirement to notify TPR in all settlement and estate actions.

14. Authority to repeal, propose and/or revise any and all NCDHHS rules governing Medicaid providers to bring up to date in expedited fashion. Rules review? Association group?
15. Require providers to undergo certain required training before allowed to enroll. Require attestation that provider has minimum business requirements to enroll – means, resources, assets, training/ education. Authority to terminate providers who don't meet minimum business requirements. Threshold enrollment requirements?
16. Penalties/ exclusions for making false statements in enrollment application.
17. Require enrollment of all individual providers in accordance with proposed 455.410 (individual pharmacists, physician extenders).
18. Establish statutory time limits for submission of documents during appeal process. Create preliminary steps prior to issuing overpayment findings? RAC-style limits based on billing for how many documents can be requested at one time? Duplicate Medicare appeal timelines?
19. Establish billing agent registry and requirements.