

Health Reform: Fraud and Abuse Workgroup
Wednesday, October 20, 2010
North Carolina Institute of Medicine, Morrisville
9:00am-12:00pm
Meeting Summary

Workgroup Members: Tara Larson (co-chair), Amelia Bryant, Robert Blum, Connor Brockett, Kenneth Burgess, Jeff Horton, Cheryl Ann Mulloy-Villemagne, Rosalyn Pettyford, Sandee Resnick, Timothy Rogers

Steering Committee Members: Doug Thoren

NCIOM Staff: Sharon Schiro, Rachel Williams

Other Interested Persons: Kari Barsness, Roger Burnell, Peter Hans, Tracy Hayes, Harry Kaplan, Markita Keaton, Chris Skowronek, Franklin Walker

Welcome and Introductions

Tara Larson

Chief Clinical Operations Officer

Division of Medical Assistance

Co-Chair

Ms. Larson welcomed everyone and then those in attendance introduced themselves.

Description of Gap Analysis Document

Sharon Schiro

Vice President

NC Institute of Medicine

Dr. Schiro briefly described the structure of the gap analysis spreadsheet. The spreadsheet is broken down by provision, section of bill, entity, state action required, effective dates, current NC efforts, what gap exists, and what's needed. The spreadsheet can be found here: [Fraud and Abuse Task List](#).

Workgroup Discussion on Gap Analysis

Kenneth L. Burgess

Partner

Poyner Spruill LLP

Tracy Hayes
Assistant Attorney General
NC Department of Justice

Mr. Burgess and Ms. Hayes led the group through the spreadsheet and explained what each provision related to fraud and abuse requires the state to do, if anything. They also explained what the state currently has or is doing to address the new provisions and where gaps exist.

Selected questions/comments:

- Row 5
 - Comment: This provision will not require state action for anything other than what the DMA will do to make sure these programs are in place at the provider level.
 - Comment: We will probably have a state rule on requirements and what we intend to do for violating requirements.
- Row 10
 - Comment: The federal government will have a central database which states will dump data into to allow other states to see which providers have had license infractions.
 - Comment: The DMA wants providers to self-report, however there is not much incentive for them to since self-reporting does not always assure leniency in their punishment.
- Row 12
 - Comment: This provision is protection for providers that don't realize their billing agency is involved in fraud.
 - Q: What would be the consequences of failing to register or breaking the rules?
A: We are currently waiting for federal guidance on that.
- Row 24
 - Q: What does the expanded set of Medicaid data include? A: More program integrity data. One side is what capitation payments are going for and how often services are utilized. They want to make sure that the capitation payment is not so high that agencies reap all the benefits while recipients are not getting services. Another side is quality data.
 - Q: Will it apply to community care networks? A: Not in the sense of managed care, but it could. It depends on if the federal government defines provision only for at risk capitated programs or for managed care in the broader sense.
- Row 28
 - Q: What is the extent of access to the databases? A: All information is public from the state's perspective. However, information can be private if the provider

is currently under the investigation of the attorney general. All final actions are public.

- Row 38
 - Comment: This provision will put some wrinkles in NC's process of payment suspension in cases of fraud and therefore we will have to iron those out once we get more information from the federal government.
 - Comment: There is a difference between an isolated incident and systematic problems with an agency.
 - Q: How will "best interest of Medicaid" be interpreted?
 - Comment: Needs to be a discussion with private providers about disclosing suspension of payments from Medicaid because if they are not paying then private companies shouldn't be either.
- Comment: There is a disparity now in how each county deals with recipient fraud. There is an opportunity here for legislation to reduce these disparities.
 - Response: It doesn't make sense for a small county to operate the same way as a large county and therefore it doesn't make sense to have 1 person handle all 100 county cases of recipient fraud. DSS is talking about several options including regionalization, individual investigators, or contracting with a vendor.

Proposed Provider Enrollment Rule Changes

Tracy Hayes

Ms. Hayes reviewed the proposed rule changes as of September 23, 2010, for provider enrollment. A copy of the proposed rule changes can be found here: [Rule Changes](#).

Selected questions/comments:

- §455.412
 - Comment: Medicaid can deny verification for someone with restrictions on their license. Sometimes you find this in specialized therapies, but they are still employable. It depends on the facts of the case; not every criminal offense prevents someone from providing direct care.
 - Q: Does the CMC and DMA have communication with medical board now on revocations? A: Yes. We are supposed to hit their database up against every application that comes in.
 - Comment: The DMA is becoming more descriptive on what licensures and diplomas are being accepted. They are starting to require official transcripts for providers giving certain services.
- §455.416

- Q: How is “agent” defined here? A: There is a CFR earlier in the document defining agent; however, this section does not refer back to that definition. We will have to look into what “agent” means here.
- Comment: There should be a way that Medicaid can accept fingerprints from the licensing board instead of requiring providers to send in duplicates.
- Q: What is the definition of “high risk” in the state? A: The definition can be found in §455.450(c).
 - Comment: From the state’s perspective, we automatically put mental health providers and other specialties in high risk category because of a history of a lot of fraud in those disciplines. This is a place where the state rules will be stricter than the federal guidelines.
- Comment: We will have to have a discussion on when it is absolute that we NOT hire a person based on certain criminal charges.
 - Response: There is a law in Florida that we can base that on. It limits the number of citations and also has a way a person can seek an exemption.
 - Response: We want it to be prohibited to hire persons with certain classes of felonies.
 - Response: Hard and fast rules have benefits but also downfalls. There are people that rehabilitate and we don’t know what a person would require to show that they have rehabilitated.
 - Response: We could have time restrictions on certain felonies for hiring. It might also depend on what specialty that person is working in (i.e. a recovering drug addict working in a substance abuse clinic versus working in a nursing home with access to prescription drugs).