**Health Reform: Fraud and Abuse Workgroup Meeting**
**Monday, December 13, 2010**
**North Carolina Institute of Medicine, Morrisville**
**9:00am-12:00pm**
**Meeting Summary**

**Attendees:**
*Workgroup Members:* Albert Koehler (co-chair), Tara Larson (co-chair), Amelia Bryant, Conor Brockett, Tracy Hayes, Jeff Horton, Cheryl Anne Mulloy-Villemagne, Rosalyn Pettyford, Roger Purnell, Timothy Rogers, Craig Umstead

*Steering Committee Members:* Albert Koehler, Tara Larson

*NCIOM Staff:* Sharon Schiro, Rachel Williams

*Other Interested Persons:* Thomas Aldridge, Glenda Artis, Heather Carter, Mary Edwards, Geneva Fearrington, Kevin Hutchinson, Markita Keaton, Rose Shattuck, Chris Skowronek, Curtis Venable, Jim Waldinger, Franklin Walker

**Welcome and Introductions**
*Albert P. Koehler, Deputy Commissioner/Director, Criminal Investigations Division, NC Department of Insurance, Co-chair*

*Tara Larson, MAEd, Chief Clinical Operations Officer, Division of Medical Assistance, Co-chair*

Ms. Larson welcomed everyone to the meeting and asked everyone to introduce themselves.

**Current Status of Gap Analysis Document**
*Tracey Hayes, JD, Assistant Attorney General, NC Department of Justice*

Ms. Hayes gave an update on the gap analysis. The largest gap North Carolina has is the registration of billing agents with Medicaid since the ACA requires this registration (Sec. 6503) and North Carolina has not required it before. Progress for new legislation has been put on hold since the final federal rules have not been released yet; however, it is expected that the final rules will be similar to the proposed rules. The most recent gap analysis document can be found here: Gap Analysis 12/13/2010.

**Billing Agents**
*Rose Shattuck, CPC, CCP, CHBME, PCS, CEO, Physician Billing Solutions, LLC*

Ms. Shattuck presented information on the challenges billing companies could face due to the upcoming registration requirement by the ACA (Sec. 6503). A copy of her presentation can be found here: Billing Agents.

Selected questions and comments:

- Section 6503 only seems to capture entities that actually send payment to the Division of Medical Assistance (DMA). It might not catch intermediaries.
- Q: Are billers currently required to register in each state they have clients in? A: The only state that requires registration currently is New Jersey. New Jersey has a list of requirements and the list can be overwhelming, especially to small billing entities. New York tried to require registration but found it to be too hard to define "billing entity."
- What constitutes a billing agent? Are the following included: agencies with dual billing licenses (billing plus collections), "scrubbing" companies, coders (who code the information for billing, but don't submit the bills)?
- Options for North Carolina registration requirements include billing entities having: a business license, liability insurance, basic contact information, compliance plans, and education minimums, and providing client lists.
    - Requiring liability insurance could run smaller billing entities out of business and push billing companies to be larger. It will also increase costs which will eventually be passed on to the consumer.
    - There should be notification to other interested parties if a billing entity is being investigated by some other entity.
        - Should billers that use these billing companies under investigation be categorized as high risk?
- Cons for implementing registration:
    - Will providers stop billing Medicaid? Rule only requires for Medicaid – not Medicare. Will this ultimately affect all insurance companies? Or all state agencies (Blind Commission, Crippled Children, Workers Comp)?
    - Billing agents will charge more to cover the registration costs.
- We need an update on guidance for the registry. Geneva and Clarence will provide this information at the next meeting.

**Workgroup Discussion**

The workgroup discussed the status of workgroup recommendations/proposed legislation and how the public system impacts private payors. The workgroup currently has 19 areas of proposed legislation addressing the identification of high risk providers, compliance programs,

automatic communication between interested parties (i.e. payors, licensing boards and provider associations), and criminal background checks for direct health care workers.
A summary of the legislative proposals can be found here: Proposed Legislation Outline.

Selected questions and comments:

- The administrative burden on providers to file billing claims correctly drives up the cost and creates less time for patients. It also creates a higher risk of making an error.
    - There should be one universal billing set. Different entities have different nuances of information they want. It costs more money to do that because providers have to treat everyone coming in with the most stringent rules.
    - Legislation requiring communication between payors would be a step forward.
- What happens to a person who commits a crime, is charged with a crime, or commits a substantiated abuse only after being employed? We wouldn't want that person jumping to another agency. A central database would help employers communicate information related to abuse or crimes committed by employees.
    - Q: What would have to be reported? A: There are systems out there that could be an example we could base a database off of.
    - Legislation to do a pilot study on incident reporting and/or procedures done by professionals to address abuse/neglect with the licensing boards is a good idea. We need to know what the impact and ramifications of this system would be.
- High risk categories:
    - DMA must define what constitutes a high-risk category. New high risk groups discussed include:
        - Behavioral health.
        - Newly enrolled with a questionable, but non-disqualifying background hit (e.g., a hit that's just outside of the disqualifying time frame).
        - Providers who overutilize services (e.g., imaging)
        - Home health, including home care, PCS
    - Need to define rules for adding individual providers to high-risk categories (based on individual behaviors vs provider-wide behaviors).
- Background checks:
    - Need to establish a state law for provider categories that directly touch patients, and specify what background information would disqualify the person for employment across all of these categories of provider.
    - Recommendation: Follow Florida's law.
    - Comment: What about the person with no criminal record who is currently employed who then commits a crime.
        - Who should this be reported to? If the person is a licensed professional, would the professional board be responsible for investigating? If so, how

and to whom should what information be shared? How is sharing operationalized?
        - What existing systems record incidents?
        - What types of incidents should be reported?
        - What is the person is not charged, but there is substantiated abuse? How do we balance protection against due process?
        - Will a provider become high-risk if individuals they employ commit a crime? Do we require an attestation that people in their employ meet certain criteria?
    - If there is a registry, how do we educate providers so they know to check the registry before hiring?
    - Need to have licensing boards involved in this discussion, and need legislation to study this issue.
        - Licensing boards need to define what's significant for each profession.
        - Need legislation to provide for inter-agency communication without creating a huge bureaucracy.
- Payment suspensions:
    - Comments:
        - Need better pre-payment review parameters.
        - Performance bond statute: may be problematic for PCS and PDNA agencies.
        - 2009 change to HIPAA: Federal crime to sell PHI. Trying to sell client caseload as they go out of business (this isn't the purchase of business).
    - Recommendations:
        - Change threshold $ amount for program integrity to recover. Currently have to recover every $, even if it costs more to recover that amount to be recovered.
        - Successor liability – currently limited to nursing homes. Make statuatory vs rule. If purchase a nursing home, then you're liable for their debts. Expand to assisted living, ICF-MRs.
        - Requiring state regulatory agencies to meet regularly and share info on F&A. DOI, DOL,
        - Requiring health insurers to share information on providers with DMA.
        - Abandonment of records – a growing problem with economy. Some of records are combination of Medicaid and private insurers.
          **Recommendation:** Need to create civil penalties.
        - Require providers to undergo training prior to enrollment in Medicaid. Require attestation that they have minimum business requirements to enroll. Need consistency between DMA and DSHR.

        - Cons: some of small providers won't be able to get in business and there may be a delay in billing.
        - Need licensure training and enrollment assessment.
        - Create penalties and temporary/permanent exclusions for false statements.
        - Proposed 455-410 rule: enroll pharmacists (not just pharmacies).
        - Establishing statutory time limits for submitting of documents for appeals: adopting CMS rules.
            - Pro: standardization. Common rules would help with education.
            - Cons:
            - Very strict guidelines.
            - Require auditor to communicate with provider being audited – to let them know what's missing.
            - Should there be a limit on # of records requested, as will be occurring for RAC program? Until fraud is substantiated? Based on # of patients served – statistical sample.
        - Establish statutory authority to revise program integrity rule.
            - Should rules governing provider issues could go through PAG? Concerns: Not every provider type has a representative on that group, so a large number of provider groups will object, because of lack of diversity of representation. Good concept (clinical expertise), but still need openness of rule-making. Alternative: Create something similar to PAG using representatives from all provider groups? Concern: How is DMA going to accomplish implementation?
- Recipient fraud
    - Issues
        - Problems with prosecution of fraud:
            - Understaffing of DAs office
            - Low priority as compared to rape or murder cases
        - Failure to report assets that would result in change in eligibility.
            - Data "clouds" should reduce this failure to report assets, since reporting will be automated.
                - Need standards for those doing presumptive eligibility work, to ensure accuracy – even with the cloud.
                - Hospitals may need protection, especially if they're using an independent eligibility firm, because they won't know that the eligibility firm didn't do the job correctly.
        - Use of another person's Medicaid card. Need education of providers on requiring card and verification of eligibility.
        - Drug abuse and prescription fraud

**Next Meeting—January 27 at 9am**

For the next meeting, the workgroup discussed hearing a presentation from county-level Department of Social Services (DSS) on recipient fraud, reaching out to licensing boards to get them more involved, and talking about the actual text of the legislation.

**Public Comment Period**

- We need to have a stronger effort to include licensing boards in our discussions.