

Patient Protection and Affordable Care Act Requirement	Effective Date	Current NC Efforts	Gap (if any)
Apply new screening, oversight, disclosures, and compliance rules in Medicaid and CHIP	March 2011? On hold pending final federal rules.	Currently underway by DMA's enrollment vendor CSC – final implementation on hold pending final CMS rules	Revisions to 10A NCAC 22F. Legislation giving DHHS special rulemaking authority/ implement new statutory screening requirements for Medicaid providers/ creation of risk categories and criteria.
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.	March 2011?	None	Revisions to 10A NCAC 22F. Legislation giving DHHS special rulemaking authority/ enhanced oversight requirements for newly-enrolled Medicaid providers.
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)	1/1/2011	DMA began this process with its vendor CSC in early 2010; it is currently part of DMA provider application process.	None
Providers and suppliers will be required to establish an anti-fraud and abuse compliance program (Sec. 6401, 10603)	TBD?	None (may be similar to anti-kickback requirements). OIG has been putting out compliance programs since 2000 for hospitals, nursing homes, and home health to help employees and companies comply	1) Attestation that providers are in compliance. 2) Should NCDHHS participate in developing model compliance programs? Should NCDHHS approve provider's compliance

Patient Protection and Affordable Care Act Requirement	Effective Date	Current NC Efforts	Gap (if any)
		with federal laws. These have been voluntary for some providers, but now they will be mandatory.	program? 3) Employee education 4) Ensure that Medicaid requirements match Medicare requirements.
Simplifies procedures to initiate prepayment review for fraud and abuse (Sec. 1302 of Reconciliation)	1/1/2011	DMA currently has contractor engaged for pre-payment review (CCME). DMA considers it to be a preventive measure, not a sanction, but this position is currently being challenged in court.	Rules/ Legislation
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))	1/1/2011	Already in effect in DMA to the extent it has access to this information.	Feds creating central sanction database. Final implementation dependent on CMS.
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	1/1/2011	Already in effect in DMA to the extent it has access to this information.	Feds creating central sanction database. Final implementation dependent on CMS.

Patient Protection and Affordable Care Act Requirement	Effective Date	Current NC Efforts	Gap (if any)
Groups submitting claims on behalf of providers must register with the state and CMS	1/1/2011	New to NC	Legislation. Business license? Liability insurance? Mandated education/ training?
Expands the period, from 60 days to one year, states have to recover overpayments (Effective: Upon enactment; Sec. 6506)	Effective date of PPACA	Implemented	None
Prohibits states from providing payment for services under Medicaid to entities outside the U.S. (Effective: Jan. 1, 2011; Sec. 6505)	1/1/2011	In process of implementation at NCDHHS Controller's Office	None
Requires a face-to-face encounter before certification for home health services under Medicare and Medicaid, and payment for DME under Medicare (Sec 6407, 10605) Encounters can be with: a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife or physician assistant	1/1/2011	Already required for PCS	Will need to be implemented for rest of home health and DMA. Will require Clinical Coverage Policy changes through Physicians Advisory Group (PAG) pursuant to 108A-54.2
Providers and supplier are required to provide 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, 2011; Sec 6406) upon demand by secretary.	1/1/2011	None	Federal requirement only/ no state action necessary
Requires adjusting the size of surety bonds for DME and home health agencies by billing volume (Sec. 6402)	1/1/2011	Provider Performance Bond Rules in process	Revise performance bond rules

Patient Protection and Affordable Care Act Requirement	Effective Date	Current NC Efforts	Gap (if any)
Withholds payment to DME suppliers for 90 days if there is a significant risk for fraud (Effective Jan. 1, 2011; Sec. 1304 of Reconciliation)	1/1/2011	None other than current withhold requirements at 42 CFR 455.23	Waiting for federal rule
Individuals who receive overpayments through Medicare, Medicaid and CHIP are required to report and return the overpayment within 60 days (Sec. 6402)	1/1/2011	Currently in provider participation agreement. DHHS currently does federal and state tax intercepts for food stamps, workforce, overpayments.	22F Rule revision for providers. DSS education to recipients/ potential legislative change.
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)	1/1/2011	Already required	None (possible 22N rule revision)
States and Medicaid managed care organizations must submit an expanded set of Medicaid data elements (Effective: for data submitted on or after January 1, 2011; Sec. 6504)	1/1/2011	None	Waiting for CMS to define data elements in rule or transmittals
State Medicaid information systems must be compatible with the National Coding Initiative (Effective: October 1, 2010; Sec. 6507)	10/1/2010	In process (HP contracted with Bloodhound)	None

Patient Protection and Affordable Care Act Requirement	Effective Date	Current NC Efforts	Gap (if any)
<p>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)</p> <p>Data in the IDR will be matched to identify fraud and abuse in Medicare and Medicaid</p>	TBD?	CMS is building the national repository.	None
<p>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)</p>	TBD?	CMS is building the national repository.	None
<p>States are required to report all final actions, which include:</p> <p>Revocation or suspension of licenses, reprimands, or probation</p> <p>Dismissal or closer of fraud and abuse proceedings</p> <p>Any other loss of license, or the right to apply for or renew a license, or other negative action</p> <p>State licensing, law, or fraud enforcement agencies will report any corrections to reported information</p>	1/1/2011	DMA already reporting certain actions	No rule or law required. Requires that someone at DMA-provider enrollment is responsible. Requires state coordination between integrity, provider enrollment, audit.
<p>Withholding of federal matching payments for states that fail to report enrollee encounter data in the Medicaid Statistical Information System.</p>	1/1/2011	N/A	Ensure reporting of enrollee encounter data/ coordinate with DSS

Patient Protection and Affordable Care Act Requirement	Effective Date	Current NC Efforts	Gap (if any)
<p>MEWAs are subject to state anti-fraud and abuse laws and regulations (Sec. 6604)</p> <p>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)</p> <p>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)</p> <p>Allows the Sec. of Labor to seize the MEWAs' assets if it is in a financially hazardous condition</p>	1/1/2011	None	Waiting for federal guidance
<p>In order to prevent and fraud and abuse in CLASS (The Community Living Assistance Services and Supports Program): (Sec. 8002)</p> <p>Establishes procedures to allow authorized representatives access to a beneficiaries' benefits that prevent fraud and abuse</p> <p>CLASS regulations will include provisions to prevent fraud and abuse</p>	1/1/2011	Not funded. Federal only.	None.
<p>Payments, under Medicare and Medicaid, to providers can be suspended during investigations of fraud and abuse (Sec. 6402)</p> <p>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</p>	1/1/2011	DMA already suspending payments 30 days after notice of overpayment becomes final.	Legislation to specify NC payment suspension.

Patient Protection and Affordable Care Act Requirement	Effective Date	Current NC Efforts	Gap (if any)
Medicare, Medicaid and CHIP beneficiaries who participate in fraud and abuse can be subject to administrative penalties (Sec. 6402)	1/1/2011	Federal	Waiting for guidance/ will ultimately need to coordinate with DSS/ potential legislation.
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)	1/1/2011	Federal/ OIG	None?
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)	1/1/2011	Federal/ OIG	HBE group?
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)	1/1/2011	Federal requirement	Legislation for similar state requirement? Have to wait for Feds to define "reasonable request."
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)	1/1/2011	Federal change	None.

Patient Protection and Affordable Care Act Requirement	Effective Date	Current NC Efforts	Gap (if any)
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	1/1/2011	Check with MIU	Not sure
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)	1/1/2011	None	Refer to HBE group?