Health Reform: Fraud and Abuse Workgroup
Thursday, January 27, 2011
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, Robert Blum, Cheryl Ann Mulloy-Villemagne, Rosalyn Pettyford, Sandee Resnick, Craig Umstead

Steering Committee Members: Conor Brockett, Clarence Ervin, Tracy Hayes

NCIOM Staff: Sharon Schiro, Rachel Williams

Other Interested Persons: Kathy Arney, Glenda Artis, Erica Bing, Heather Carter, Julie George, Kevin Hutchinson, Monica Jones, Johnny Loper, Ben Massey, Karen Matthew, Roger Purnell, Nancy Rogers, Rose Shattuck, Chris Skowronek

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, NC Department of Health and Human Services, Co-chair

Mr. Koehler welcomed everyone to the meeting.

Update on CMS Rules
Tara Larson

On January 24, the Centers for Medicare and Medicaid Services approved new rules, authorized by the ACA, to stop fraud and abuse. The final rules include a rigorous screening process and a new enrollment process for Medicaid and CHIP providers. The rules also stop enrollment or payment to providers suspected of fraud.[1]

Review of Legislation Recommendations

The workgroup reviewed a draft of the North Carolina Proposed Affordable Care Act Fraud and Abuse Legislation. Discussion points included the definition of health care provider, the amount in overpayments owed to Medicaid and/or Health Choice for a provider to be placed in the high-risk category, timelines to submit documentation for announced vs. unannounced audits, and meeting frequency for agencies to disseminate information.

[1] Source: www.hhs.gov/news/press/2011pres/01/20110124a.html.

The workgroup determined that for the purpose of this legislation, a health care provider is anyone who receives public dollars for the delivery of health care in North Carolina. This definition only applies to Medicare, Medicaid and Health Choice providers.

Under the proposed legislation, providers that owe an overpayment to Medicaid or Health Choice will be placed in the high-risk provider category. The workgroup discussed what the minimum overpayment amount owed should be for being placed in the high-risk category. Rather than dollar amounts, the workgroup decided the amount should be a percentage of annual billing. The workgroup also began discussions on how long that provider would be in the high-risk category, but did not come to a consensus.

Providers must submit requested documentation to the Department of Medical Assistance for announced and unannounced visits, audits, investigations, etc. The workgroup discussed having different timelines for submission for announced and unannounced visits. For announced visits, DMA expects to have the documentation before leaving the site. For documentation not originally requested for an announced visit or documentation requested at an unannounced visit providers should have enough time to retrieve the documentation but not time to make the document up. The workgroup suggested, but did not agree on, a 24-hour turn around for these scenarios. If no documentation is received then the provider will be expected to repay Medicaid and/or Health Choice in full. The workgroup also suggested giving providers in the limited-risk category more time to submit documentation than those in the high-risk category.

Selected questions and comments:

- Q: Why are physical therapists in the moderate risk category? A: Risk categories were something that the federal government and CMS decided on based on studies about fraud and abuse among various providers.
- Q: How would the risk categories apply to providers reimbursed by private insurers? A: The risk categories are only for Medicaid, Medicare and CHIP providers.
- Q: Is there an appeals process if an individual provider is put into one of these categories? A: An individual provider can appeal if they are denied enrollment.
- Q: Are payment suspensions public information? A: Yes, because we want to share that information with other payers as well, not just the public.

Next Meeting—February 17 at 1:00pm

For the next meeting, the workgroup will follow up on the revised draft legislation and Interim Health Reform Report, hear from Department of Social Services about recipient fraud, and will further discuss sharing information between interested agencies and boards. Participants were asked to submit changes to the Interim Health Reform Report and the draft legislation no later than 1 Feb 2011.

Public Comment Period

No further public comments were given.