

Health Reform: Fraud and Abuse Workgroup
Tuesday, March 15, 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, Conor Brockett, Clarence Ervin, Tracy Hayes, Jeff Horton, Cheryl Ann Mulloy-Villemagne, Rosalyn Pettyford, Doug Thoren, Craig Umstead

Steering Committee Members: Clarence Ervin, Tracy Hayes, Albert Koehler, Tara Larson, Doug Thoren

NCIOM Staff: Sharon Schiro, Rachel Williams

Other Interested Persons: Kathy Arney, Glenda Artis, Allyson Baxter, Melanie Bush, Heather Carter, Teresa Johnson, Monica Jones, Renee Montgomery, Sheila Platts, Roger Purnell, Amanda Ray, Nancy Rogers, Kathie Smith, Nancy Warren

Welcome and Introductions

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

Tracy Hayes, JD, Assistant Attorney General, NC Department of Justice

Recommendation Review

The workgroup reviewed a draft recommendation about proposed quarterly meetings between state agencies to discuss trends in fraud and abuse. These meetings would assist in early detection of payment errors, review procedures for incident reporting and response, and identification of problems within the system.

The workgroup agreed that the meetings should not be legally “required.” Also, the workgroup wanted to keep the list of parties involved as broad as possible and took out the listing of specific state agencies and licensing boards. The Division of Medical Assistance (DMA) agreed to take on the scheduling and initiation of the meetings. The initial meeting will address the scope and charge of the meetings including confidentiality.

A draft of the recommendation can be found here: [Draft Recommendation](#).

Legislation Overview

The workgroup reviewed draft legislation for special provisions not required by the ACA from DMA. The workgroup discussed logistics related to individual providers being labeled high-risk, overpayment determination, registration of billing agents, prepayment review, and investigations and audits. Chapter 108C(3)(f) gives DMA the authority adjust the risk level of individual providers when specific conditions occur. The workgroup felt this was a much better way of handling risk than placing entire provider groups into higher risk categories based on the actions of only a few individuals. However, the workgroup also felt there should be a form of due process such as competency requirements and/or time lines so that the risk adjustment is not permanent. If a provider does not meet the competency requirements or other criteria within the specified period of time then he/she should be terminated from the Medicaid program.

Some members of the workgroup expressed concern over the language of Chapter 108(4) regarding payment suspensions because payment can be suspended during the pending of an appeal. Suspensions during the period of appeal could put good providers out of business and also raised concerns over proper due process. DMA argued that it does not intend to suspend payments prior to proper review and will give the provider under investigation a 31-day notice prior to the beginning of the payment suspension. If an appeal is in the provider's favor, DMA will reimburse the provider for all clean claims suspended during the period of appeal.

DMA is waiting for more federal guidance on the registration of billing agents before moving forward with Chapter 108C(5). However, the workgroup expressed concern over this provision becoming effective upon enactment since it would not give billing agents enough time to register or know about registering before filing claims. The workgroup felt there should be an education piece for billing agents so that claims are not filed before agents are even aware of the law or a phase in process for this provision.

Provider associations felt the percentage in Chapter 108C(6)(d) should be based on objective published criteria rather than DMA's experience. Also, the associations felt it was important to state specific reasons or criteria to determine who gets sanctioned. Proper due process for providers was also a concern particularly based on the time periods listed in this section.

Chapter 108C(7) addresses cooperation with investigations and audits. Some concern was expressed that the broadness of the language regarding who could perform audits in this section could allow almost anyone to show up to perform an audit. Clarity was also suggested on whether or not agencies and licensing boards could only perform audits under this provision for Medicaid/Health Choice integrity or for all investigations.

Further discussion is needed on the details of background checks and employment (Section 2). The workgroup feels that the Florida legislation is too narrow for North Carolina's needs. This part of the proposed legislation does not have to be presented to the General Assembly until next year's session (2012).

Selected questions and comments:

- CMS held a conference on background checks recently and the overall message on fingerprinting is that CMS wants states to do fingerprints for all providers, regardless of a provider's time in the state. Also, CMS wants states to start retaining finger prints so that in 2014 a FBI database will be able to run through all fingerprints once periodically to find any hits.
 - We are waiting for final guidance from the federal government on the fingerprinting piece. The current proposed rules regarding the federal fingerprinting requirement only includes high-risk providers; but, this provision is currently up for comment and could still be changed to include all providers.
- Should the training provider representatives attend in order to enroll into Medicaid or Health Choice include education on audits (Chapter 108C(10)(c))?
 - There are currently many free computer-based trainings being rolled out. Auditing could be a topic for one of those modules.
- There should be a way to contact DMA to find out if there are any auditing issues or money owed by facilities about to be bought or sold (Chapter 108C(11)).
- Q: Who will introduce this legislation? A: The Governor's Office will as a part of the budget.

Recipient Fraud

The workgroup discussed how to create a system to deal with recipient fraud consistently across the state. The Department of Social Services (DSS) has a county-level fraud system, so dealing with fraud in each county is different. However, this system makes it difficult to deal with fraud and abuse consistently across the state.

The workgroup would like more information regarding recipient fraud for further discussion at future meetings. Suggestions included inviting a county DSS representative to discuss fraud and abuse, someone to discuss the financial and economic impact of recipient fraud, and someone to discuss overutilization, especially as it relates to substance abuse.

Selected questions and comments:

- One issue is getting prosecutors interested to take cases. Agencies should have a person that focuses on recipient and insurance fraud so he/she can help investigators by offering their experience and knowledge.
- New assistant DAs are used to murders, rapes, etc. When a white collar crime like fraud comes along, that case takes forever to get to court since the DA is inexperienced and uninterested. There needs to be education on insurance policies and other relevant topics so prosecutors are not overwhelmed in dealing with new concepts.
- There should be some discussion about modifying legislation to make it a requirement for banks to report suspicious activity to DSS.

Next Meeting—April 14 at 1:00pm

Public Comment Period

No further public comments were given.