

**FRAUD AND ABUSE LEGISLATIVE OUTLINE**  
**February 28, 2011**

This document includes a list of the 19-item punch list developed by the Division of Medical Assistance of the North Carolina Department of Health and Human Services through the North Carolina Institute of Medicine Workgroup on Fraud and Abuse. Various provider associations attended the Workgroup meetings and participated in vigorous discussions over the outlined issues. After receiving the Department’s revised draft legislation on February 18, 2011, the providers worked together to draft alternative legislation. Because the Workgroup was created to address North Carolina’s compliance with the Patient Protection and Affordable Care Act (“PPACA”) and because PPACA compliance is the impetus behind the tight timeframe to develop the legislation, the providers have drafted two bills. The first bill includes all legislation necessary to ensure North Carolina’s compliance with PPACA. Also, in a good-faith effort to address the other concerns raised but not resolved through the Workgroup process, the providers have drafted additional legislation that encompasses the Workgroup list. Below is a table that includes cross-references to the providers’ drafts and, where appropriate, comments on the provisions.

**Key**

R = Legislation Required by PPACA

A= Additional Recommended Legislation

#	Item	Cross-reference	Comments
1	Define high risk categories in addition to proposed 455.416 (behavioral health? Home care including adult care homes?)	108C-3 (R)	The providers’ draft differs from the Department’s draft in that its categorization of provider types more closely resembles the way in which CMS categorized Medicare providers. Also, the providers’ draft includes screening requirements, which the Department’s draft fails to include. The providers’ draft also includes other PPACA requirements that the Department’s draft does not include.
2	Define criteria for individual providers to be placed in high risk categories (newly enrolled, questionable background hits that do not disqualify but warrant further scrutiny, overutilization).	108C-3 (R)	
3	Requirement for providers to conduct background screening of hires in provider categories where workers come into direct contact with patients – lifetime exclusion of individuals with violent crime history, sexual predators, etc. Model after FL statute. Incident reporting? Where do incidents get reported and	108C-3A (R)	The providers’ draft requires background screenings (including fingerprints) for high-risk providers and also permits such screening for employees involved in direct patient care on behalf of a high-risk provider.

	<p>how does it get used?  Substantiation? Threshold for temporary exclusion?  Different time limit for different types of crimes?  Exception/ waiver criteria.  Attestation?</p>		
4	<p>Authorize DMA to engage in payment suspension against providers with outstanding amounts owed to state/ define parameters/ define “indicia of reliability.”</p>	108C-4 (R, A)	<p>The providers’ draft of legislation required by PPACA includes the authority to suspend payments in accordance with the federal rule. The providers’ draft of additional recommended legislation also permits payment suspension for providers who owe a final overpayment, assessment or fine or have had their participation suspended or terminated.</p>
5	<p>Authorize prepayment review/ define parameters.</p>	108C-7 (A)	<p>The providers’ draft includes parameters for when the Department may implement prepayment review and also includes specific timelines to ensure prompt payment of claims.</p>
6	<p>Establish threshold dollar amount (\$100?) requirement for recovery – right now DMA must recover every dollar.</p>		<p>The providers’ drafts do not include any sections regarding this recommendation. The providers are satisfied that the Department is considering a threshold to ensure appropriate use of limited Department and provider resources.</p>
7	<p>Establish permanent performance bond statute?</p>		<p>No instrument exists in the market that would permit a provider to meet any performance bond requirement. Additionally, any financial obligations for providers are currently being addressed through rulemaking, so statutory changes are unnecessary.</p>
8	<p>Successor liability statute that extends beyond nursing homes.</p>	108C-8 (R)	<p>The providers’ draft adopts the federal CHOW rule.</p>
9	<p>State law prohibiting the sale of PHI (currently a federal law but no state).</p>		<p>This statement is not entirely accurate. HITECH does include such a prohibition, but it has not been implemented through federal rulemaking. Given the complexity of HIPAA compliance, the providers recommend that North Carolina not adopt any rule that might conflict with the federal rule.</p>
10	<p>Require all state regulatory agencies to meet regularly and share information</p>		<p>This provision is not required by PPACA, nor would State legislation be helpful at this stage. The providers would, however,</p>

	regarding fraud and abuse with providers. Legislation to create study of procedures by Boards etc. for incident reporting/ fraud, abuse, neglect, exploitation/ ramifications? Avoid creation of huge bureaucratic nightmare that accomplishes next to nothing. Quarterly association meetings?		ask to be involved in any meetings or process.
11	Require insurers to share information regarding providers with DMA.		This provision is not required by PPACA.
12	Create civil penalties/ exclusion for abandonment of records.		This provision is not required by PPACA, and no statutory change is necessary.
13	Requirement to notify TPR in all settlement and estate actions.		This provision is not required by PPACA.
14	Authority to repeal, propose and/or revise any and all NCDHHS rules governing Medicaid providers to bring up to date in expedited fashion. Rules review? Association group?		Special rulemaking authority is not necessary to comply with PPACA, and the providers oppose giving the Department such authority.
15	Require providers to undergo certain required training before allowed to enroll. Require attestation that provider has minimum business requirements to enroll – means, resources, assets, training/ education. Authority to terminate providers who don't meet minimum business requirements. Threshold enrollment requirements?	108C-3B, 108C-6(R)	The providers' draft includes provision on provider training and attestation requirements.
16	Penalties/ exclusions for making false statements in enrollment application.		Existing statutes at G.S. § 108A-63 fully prohibit, and provide appropriate sanctions for any provider which knowingly and willfully makes or causes to be made any false statement or representation of a material fact in connection with an application for enrollment in Medicaid or continuing entitlement to payment by the

			Medicaid program, making such actions a Class I Felony.
17	Require enrollment of all individual providers in accordance with proposed 455.410 (individual pharmacists, physician extenders).	108C-3B (R)	
18	Establish statutory time limits for submission of documents during appeal process. Create preliminary steps prior to issuing overpayment findings? RAC-style limits based on billing for how many documents can be requested at one time? Duplicate Medicare appeal timelines?		Such a provision is not required by PPACA. The providers would be happy to work with the Department on a fair and efficient audit process in a less condensed timeframe.
19	Establish billing agent registry and requirements.	108C-5 (A)	