Fraud Chapter

Overview of problem

The ACA includes funding to support more aggressive efforts to eliminate fraud and abuse, and to recover overpayments in Medicare, Medicaid, and CHIP. These new efforts are expected to yield $6 billion in savings to the federal government over the next 10 years (and a corresponding reduction in costs to the state for the Medicaid and CHIP programs). Many of these requirements will require the state to implement new enforcement procedures.

Unlike many of the other ACA provisions, most of the fraud and abuse provisions went in to effect in 2010 or 2011. The ACA increases funding to the Healthcare Fraud and Abuse Control Program by $350 million over the next decade. These funds can be used for fraud and abuse control and for the Medicare Integrity Program.[1]

The ACA also includes new or enhanced program requirements for Medicare, Medicaid and CHIP, including new provider requirements to participate in these programs. States are required to apply these new rules and requirements to Medicaid and CHIP:

- *Provider screening*. States must screen all providers and suppliers of services through Medicaid and CHIP as part of enrollment and re-enrollment in these programs.[2] A period of enhanced oversight also is required for newly enrolled providers and suppliers. Providers and suppliers must disclose any past affiliation with a provider who has had their Medicare, Medicaid, or CHIP payments suspended or excluded from participation.[3]

- *Terminating or excluding providers who have been terminated from other public programs*. States must terminate providers from participation in Medicaid who have been terminated from participation in Medicare or CHIP. [4] Similarly, states must exclude providers from participating if they are owned by individuals or entities who 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 (effective January 2011).[5, 6]

- *Creation of risk categories*. The ACA requires the state Medicaid agency to create limited, moderate, and high risk categories for provider specialty types, and to impose different screening and monitoring standards and requirements upon the different

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[1] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§6402, 1303.
[2] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§6401, 10603.
[3] DMA already requires providers and suppliers to disclose if they, or any affiliated provider, have had their Medicare, Medicaid or CHIP payments suspended or if they have been excluded from participation. Tara Larson, Chief Clinical Operations Officer, DMA, NCDHHS, electronic communication, January 10, 2011.
[4] Patient Protection and Affordable Care Act, Pub L No. 111-148, §6501.
[5] Patient Protection and Affordable Care Act, Pub L No. 111-148, §6502.
[6] DMA already excludes providers from participating for these reasons. Tara Larson, Chief Clinical Operations Officer, DMA, NCDHHS, electronic communication, January 10, 2011.

categories. Home health and durable medical equipment providers are identified in the ACA as high risk. The proposed federal regulations have created corresponding risk categories for Medicare.

- *Payment suspension.* The state Medicaid agency must suspend all Medicaid payments to a health care professional or entity when there is a pending investigation of a credible Medicaid fraud allegation.

- *Provider registration and identification numbers.* Groups submitting claims on behalf of providers must register with the state and CMS.[7] Providers and suppliers of services are also required to include their National Provider Identifier on all enrollment applications and claims submissions through Medicare, Medicaid, and CHIP (effective January 1, 2011).[8, 9]

- *Expanded data reporting and matching activities to identify fraud and abuse*. States and Medicaid managed care organizations must submit an expanded set of Medicaid data elements (effective for data submitted on or after January 1, 2010).[10] For example, states are required to report all final actions including revocation or suspension of licenses, reprimands, probation, dismissal, loss of license or the right to apply for or renew a license, or other negative action. To ensure that these data elements can be shared with the federal government, state Medicaid information systems must be compatible with the National Correct Coding Initiative (effective March 2011).[11] The federal government will establish a National Health Care Fraud and Abuse Data Collection Program to report all final actions against health care providers, suppliers, and practitioners (effective one year after enactment or when regulations are published, whichever is later).[12]

- *Penalties and federal powers to investigate fraud and abuse are enhanced.* Penalties include those for persons who make false statements when making claims, involuntarily enroll or transfer enrollees, or do not provide timely access to information for audits, investigations, evaluations, or other statutory functions.[13]

- *Overpayments.* The state has an expanded period to recover overpayments (effective March 2010).[14] Individuals who receive overpayments through Medicare, Medicaid, and CHIP are required to report and return the overpayment within 60 days.[15] In addition, states must establish a Recovery Audit Contractor (RAC) program to identify underpayments and overpayments and recoup overpayments under Medicaid. The RAC

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[7] Patient Protection and Affordable Care Act, Pub L No. 111-148, §6503.
[8] Patient Protection and Affordable Care Act, Pub L No. 111-148, §6402.
[9] DMA already implemented this registration requirement. Tara Larson, Chief Clinical Operations Officer, DMA, NCDHHS, electronic communication, January 10, 2011.
[10] Patient Protection and Affordable Care Act, Pub L No. 111-148, §6504.
[11] Patient Protection and Affordable Care Act, Pub L No. 111-148, §6507.
[12] Patient Protection and Affordable Care Act, Pub L No. 111-148, §6403.
[13] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§6402, 6408, 10606.
[14] Patient Protection and Affordable Care Act, Pub L No. 111-148, §6506.
[15] Patient Protection and Affordable Care Act, Pub L No. 111-148, §6402.

program is expanded to include Medicare Advantage plans and Medicare Part D (effective December 31, 2010).[16, 17]

- *Medicaid payments outside the US*. States are prohibited from providing Medicaid payment for services to entities outside the US (effective January 2011).[18]

- *Home health and suppliers of durable medical equipment (DME)*. The ACA included several new provisions to prevent fraud and abuse in home health and DME. For example, a face-to-face encounter with the recipient is required before home health services can be certified or authorized under Medicare and Medicaid and before payment can be made for DME under Medicare (effective January 1, 2010).[19] Providers and suppliers in Medicare are required to supply documentation about referrals, 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, 2010).[20] The ACA also required the surety bonds for DME and home health agencies be adjusted by billing volume.[21] Payments to DME suppliers can be withheld for 90 days if there is a significant risk for fraud (effective January 2011).[22] In addition, physicians or eligible professionals who are not enrolled in Medicare are prohibited from ordering home health services or DME for Medicare enrollees (effective July 2010).[23]

- *Provider anti-fraud and abuse compliance programs:* The ACA mandates that providers and suppliers establish anti-fraud and abuse compliance programs.[24] Core program elements and the required implementation date are to be determined by the Secretary.

North Carolina response

Many requirements of the ACA provisions were already being addressed in NC including implementation of vendor enrollment and oversight software, provision of compliance programs, provider education, and prepayment review. Specific examples include:

- *Provider enrollment and oversight:* CSC is the agent contracted by NC-DHHS to perform Medicaid provider enrollment, verification, and credentialing (EVC) activities as well as provider file maintenance. HP Enterprise Services is the fiscal agent contracted by DMA to process claims for Medicaid enrolled providers.

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[16] Patient Protection and Affordable Care Act, Pub L No. 111-148, §6411.
[17] DMA submitted a State Plan Amendment as required, and has a RAC in place. The state is waiting for further guidance on underpayments, but is currently in compliance with the federal requirements to collect overpayments. Tara Larson, Chief Clinical Operations Officer, DMA, NCDHHS, electronic communication, January 10, 2011.
[18] Patient Protection and Affordable Care Act, Pub L No. 111-148, §6505.
[19] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§6407, 10605.
[20] Patient Protection and Affordable Care Act, Pub L No. 111-148, §6406.
[21] Patient Protection and Affordable Care Act, Pub L No. 111-148, §6402.
[22] Patient Protection and Affordable Care Act, Pub L No. 111-148, §1304.
[23] Patient Protection and Affordable Care Act, Pub L No. 111-148, §6405.
[24] Patient Protection and Affordable Care Act, Pub L No. 111-148, §§6401, 10603.

- *Provider education:* Information on changes to provider requirements and processes is provided through the DMA website through Medicaid Bulletins. Topics include enrollment, audits and post-payment reviews, claim submission, and identification of fraud. Providers also may sign up for email alerts for information that is not covered by the Bulletins.
- *Pre-payment review:* DMA contracts with The Carolinas Center for Medical Excellence (CCME) for pre-payment review of Medicaid claims. The recent audit by CMS indicates that NC is in full compliance for it's pre-payment review process.
- *National Provider Identifier:* Providers and suppliers of services in NC are already required to include their National Provider Identifier on all enrollment applications and claims submissions for Medicaid and CHIP.
- *Performance statistics:* The DMA Program Integrity Unit tracks performance statistics on fraud and abuse investigations.

Task Force work

The Fraud and Abuse Workgroup conducted a gap analysis, breaking down the requirements of each provision, then identified ongoing efforts to address these requirements, the gaps between what is currently underway in North Carolina and the new requirements, and required changes and/or legislation to fully implement the ACA provisions. A copy of the Gap Analysis is available at http://www.nciom.org/wp-content/uploads/2010/10/GapAnalysis.pdf. The workgroup used the gap analysis to develop a 19-item legislation concept list [see Appendix xx] representing the guiding principles for legislation. The workgroup also helped draft proposed legislation to address ACA implementation requirements. DMA used this proposed legislation, along with the concept list, to draft its recommended fraud and abuse legislation. DMA's proposals were introduced into the 2011 Session (Senate Bill 496), and were ultimately enacted as Session Law 2011-399. The legislation included provisions addressing the following topics:

- Medicaid and Health Choice provider screening
- Criminal history record checks for certain providers
- Payment suspension and audits utilizing extrapolation
- Registration of agents, clearinghouses, and alternative payees
- Prepayment claims review
- Threshold recovery amount
- Provider enrollment criteria
- Change of ownership and successor liability
- Cooperation with investigations and audits
- Appeals by Medicaid providers and applicants
- Procedures for changing medical policy

A copy of the legislation is available at:
http://www.ncleg.net/Sessions/2011/Bills/Senate/PDF/S496v5.pdf.

Though this legislation covers the requirements of most of the ACA Fraud and Abuse provisions, DMA continues to work on rules to address some of the remaining requirements, such as provider compliance programs, fingerprinting as part of provider screening, registration of groups submitting claims on behalf of providers, face-to-face requirement for certification for home health services, surety bond size adjustment for DME and home health agencies, and withholding of payment for DME suppliers with significant fraud risk. In addition, final federal rules for the RAC program were released in Sep 2011, so the state now will issue a request-for-proposal (RFP) for a RAC contractor. The state plan amendment has been approved, and an interim contractor is in place, which puts the state in compliance with the RAC program requirement. Two additional provisions regarding submission of Medicaid encounter data (Secs 6402 & 6504) require further information from the Federal government before the State can respond.

Appendix

Legislation Concepts

1. Define high risk categories in addition to proposed 455.416.
2. Define criteria for individual providers to be placed in high risk categories (e.g., newly enrolled, questionable background hits that do not disqualify but warrant further scrutiny, overutilization).
3. Require providers to conduct background screening of hires in provider categories where workers come in direct contact with patients. Implement a life-time exclusion of individuals with a violent crime history or who are sexual predators. Considerations:
    a. Determine how and where incidents are reported, and how this information will be used.
    b. Are individuals to be excluded based on accusations – or only if convicted? How are accusations to be substantiated?
    c. Is there a threshold for a temporary exclusion, i.e., should there be different exclusion periods for different crimes?
    d. What will the process be for exceptions or waivers?
    e. Consider modeling this legislation on Florida's statute.
4. Authorize DMA to engage in payment suspension against providers with outstanding amounts owed to the state. Define parameters and "indicia of reliability".
5. Authorize pre-payment review and define parameters.
6. Establish a threshold amount requirement for recovery, to eliminate the requirement that DMA recover every dollar, regardless of the cost of recovery.
7. Establish a permanent performance bond statute.
8. Define a successor liability statute that extends beyond nursing homes.
9. Prohibit sale of personal health information (PHI).

10. Require all state regulatory agencies to meet regularly and share information regarding fraud and abuse with providers. Develop legislation to create study of procedures by Boards etc. for incident reporting/ fraud, abuse, neglect, and exploitation/ ramifications. Goal is to create an opportunity for productive, open sharing of information without creating a large bureaucracy.
11. Require insurers to share information regarding providers with DMA.
12. Create civil penalties for abandonment of records.
13. Establish requirement to notify Third Party Recovery (TPR) of all settlements and estate actions.
14. Establish authority to repeal, propose, and/or revise any and all NCDHHS rules governing Medicaid providers to bring up to date in expedited fashion.
15. Require providers to undergo training before enrollment with Medicaid. Require attestation that provider meets minimum business requirements to enroll (e.g., means, resources, assets, training/education). Provide DMA with the authority to terminate providers who don't meet the minimum business requirements. Define threshold business requirements.
16. Establish penalties or exclusions for making false statements on the enrollment application.
17. Require enrollment of all individual providers in accordance with proposed 455.410 (individual pharmacists, physician extenders).
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?
19. Establish a billing agent registry and guidelines.