Proposed Fraud & Abuse Rule
Implementing ACA Provisions

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Comments

Due November 16, 2010
To submit:
Refer to: CMS-6028-P
http://www.regulations.gov
What’s in the rule?

• Screening
• Application fee
• Temporary enrollment moratoria
• Payment suspension
• Effect of Medicare termination on Medicaid and CHIP

• Request for comments on compliance and ethics
  • Source: §6102 and §6401 of the ACA
Current Screening: Limited

1. Monthly review by Medicare contractors of state licensing board data
2. For Medicaid most states do “some” checking of in-state provider licenses
3. Some site visits for DMEPOS suppliers; some pre-enrollment visits to IDTFs; some pre and post enrollment site visits to Medicare providers/suppliers
4. Database checks as part of enrollment process
5. Monthly review of Exclusions database by Medicare contractors
Current screening ‘cont

6. Comparison of death information and information in NPIs
## Future Screening: Risk-based

<table>
<thead>
<tr>
<th>Risk</th>
<th>Examples</th>
<th>Screening Procedures</th>
</tr>
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</table>
| Limited  | Physicians, NPPs, medical clinics, group practices, hospitals, ASCs, ESRD facilities, FQHCs, SNFs, RHCs                                                 | 1. Verify Medicare /State requirements  
2. License verifications  
3. Database checks (pre and post enrollment) |
| Moderate | Comm mental health ctrs, comprehensive outpatient rehab facilities, nonpublic, government owned ambulance services suppliers, CMHCS, CORFs, hospice orgs, IDTFs, independent labs, HHAs, suppliers of DMEPOS | 4. Unscheduled pre and post-enrollment site visits                                    |
| High     | Newly enrolled HHAs and DMEPOS suppliers                                                                                                                | 5. Criminal background check  
6. Fingerprinting                                                                            |
Comments requested on:

1. Appropriateness of using criminal background checks in provider enrollment process

2. Use of fingerprinting as a screening measure
Effective dates

March 23, 2011 for newly enrolling providers and suppliers and those Medicare, Medicaid and CHIP providers and suppliers currently enrolled who revalidate their enrollment information between 3/23/2011 and 3/23/2012

March 23, 2012 for those currently enrolled in Medicare, Medicaid and CHIP
General Screening: Medicaid/CHIP

All screening, application and moratorium regulations apply to Medicaid and CHIP.

State Medicaid agencies screen Medicaid-only providers.

States may rely on results of screening by a Medicare contractor for Medicaid and CHIP.
State Requirements

- Refer to chart for Medicare
- All providers must undergo screening at least every 5 years, consistent with current Medicare requirements for revalidation.
Criminal Background Checks

Robust criminal background check, includes but not limited to:

1. Conducting national and state criminal record checks and

2. Requiring submission of fingerprints to be used for conducting criminal records check and verification of identity
Deactivation/Re-activation

Medicaid and CHIP

• Any Medicaid provider who hasn’t submitted a claim or made a referral that resulted in a claim for 12 consecutive months must have Medicaid enrollment deactivated

  • Reinstatement requires undergoing all disclosures and screening required of any other applicant

  • **Issue:** What about residents?
NPI for Ordering/Referring

For Medicaid and CHIP:

• All ordering/referring providers must be enrolled as participating providers by the State in the Medicaid program

• All claims must include NPI of ordering/referring physician or professional
Application fee

Medicare, Medicaid, CHIP

• No fee for eligible professionals

• Fee only for *institutional providers*—any health care provider that bills Medicare, Medicaid or CHIP on FFS basis, *except* Part B medical groups or clinics and physicians and NPPs who submit the CMS 855I to enroll in Medicare

• **$500 in 2011**; amount adjusted by CPI-U in subsequent years
Institutional Provider

Examples include, but not limited to:

- Ambulance service suppliers, ASCs, CMHCs, CORFs, DMEPOS suppliers, ESRD facilities, FQHCs, HHAs, hospices, hospitals, inpatient rehabilitation facilities, IDTFs, mammography centers, outpatient physical therapy/occupational therapy/speech pathology services, SNFs

- State may impose fee of any institutional entity that bills the State Medicaid program or CHIP on FFS basis
Paying The Fee

• March 23, 2011: start date

• Fee to accompany certification statement mailed to Medicare contractor if use PECOS, or sent with paper CMS-855 if enroll or revalidate by paper

• If no fee or request for hardship exception, application will be rejected and billing privileges will be revoked

• If enroll in more than one program (Medicare, Medicaid and/or CHIP) only submit one fee
Limitations on enrollment
Enrollment moratoria will be limited to:
1. Newly enrolling providers and suppliers and
2. Establishment of new practice locations
Moratoria could be imposed in 6-month increments if:

1. Review of existing data, without limitation, identifies a **trend** that appears to be associated with high risk of fraud, waste or abuse

2. **A state has imposed a moratorium on** enrollment in particular geographic area or on particular provider or supplier type

3. **CMS, in consultation with OIG or DOJ, identifies type of provider or geographic area** with significant potential for fraud, waste, or abuse in Medicare
Medicaid and CHIP Moratoria

States have authority to impose moratoria, numerical caps and other limits for providers that are identified by the Secretary as being at “high” risk for fraud, waste and abuse

• State must seek CMS concurrence with that determination

• For 6 months and may be extended in 6 month increments
Payment Suspension: Medicare

ACA allows for payment suspension if there is a credible allegation of fraud

“Credible allegation of fraud” to include an allegation from any source, including:

- Fraud hot lines
- Claims data mining
- Patterns identified through provider audits
- Civil false claims cases
- Law enforcement investigations
What’s “credible”?

“Allegations are considered to be credible when they have an *indicia of reliability*”

- Not defined in regulation; to be determined on case-by-case basis

Suspension requires consultation with OIG and possibly DOJ
When does suspension end?

An investigation has concluded when legal action is terminated by settlement, judgment, or dismissal or when case is closed or dropped because of insufficient evidence and the basis for suspension of payments will no longer exist.
Good cause exceptions

Examples of reasons not to suspend payments:

• Don’t want to alert potential perpetrator to an investigation

• Might jeopardize a provider’s ability to continue rendering services to Medicare beneficiaries

• If other available remedies more effectively or quickly protect Medicare funds
Payment Suspension: Medicaid

Payment suspensions will be mandatory if there’s a credible allegation of fraud

- Includes investigation by state Medicaid agency program integrity unit based on tips alleging fraud and proactive investigations based on internal data analyses and other fraud detection techniques
Termination

Termination = revocation of billing privileges for cause

• It’s NOT termination if it’s based on a failure to submit claims or any other voluntary action taken by provider (except if voluntary action is taken to avoid a sanction)

ACA adds requirement to terminate under Medicaid if a provider has been terminated under Medicare or another state’s Medicaid program

• Effective 1/1/11
Compliance: §6102 of ACA

Calls for compliance and ethics program for nursing homes and SNFs that is effective in preventing and detecting criminal, civil and administrative violations and in promoting quality of care

May include a model compliance program

Not later than 3 years after effective date of regulations effective: evaluation of the programs to determine if they led to changes in deficiency citations, changes in quality performance, or changes in the quality of resident care
Compliance: §6401(a) of ACA

Calls for compliance program as condition of enrollment under Medicare or Medicaid

• Core elements to be established by the Secretary in consultation with OIG

• Timelines for core elements and implementation date to be determined, taking into account extent of adoption of compliance programs in a particular industry sector
Core Elements

Comments requested on:

Use of the 7 elements in Federal Sentencing Guidelines

Also requests comments on:

1. Extent to which 7 elements are already incorporated in compliance programs

2. Suggestions for other compliance elements, including whether external and/or internal quality monitoring should be required for hospitals and LTC facilities
Core Elements ‘cont

3. Systems necessary for effective compliance and costs. CMS anticipates evaluation of effectiveness using electronic data

4. Existence and experience with state or other compliance requirements

5. Criteria to divide providers and suppliers into groups that would be subject to similar compliance requirements; should requirements be different for individuals and corporations

6. Research and experience about current rate of adoption and level of sophistication of compliance programs
Comments also requested on

7. How effective have compliance programs been and how the level of effectiveness was measured

8. Extent to which third party resources are used (consultants, auditors)

9. Reasonable timeline for establishment of required compliance programs

10. Any other information
Resource: Regulatory Cites

42 CFR

§405: Suspension of Payment, Recover of Overpayments, and Repayments of Scholarships and Loans

§424: Conditions for Medicare Payment (application fee, screening, denial of enrollment, revocation of enrollment, moratoria on enrollment)

§447: Payment for Services (pending investigations of credible allegations of Fraud: Medicaid)

§455: Program Integrity, Medicaid