NEW RULES TO PREVENT FRAUD & STRENGTHEN MEDICARE, MEDICAID, CHIP SUMMARY

On February 2, 2011, CMS published the final rule in the Federal Register that addresses program integrity changes mandated by the Affordable Care Act. The final rule affects **42 CFR Parts: 405, 447, 455, 457, 498, and 1007**. This summary is limited to the change impact to the Medicaid program.

I. Background Screening of Medicare, Medicaid, and CHIP Providers

- The final rule creates procedures for screening, and requires the HHS Secretary, in consultation with the OIG, to determine a level of screening based on the risk of fraud, waste and abuse presented by each type of provider or supplier.

- Screening must include a licensure check, and, based on provider/supplier risk, may entail additional measures (e.g. criminal background check, fingerprinting, site visits, interstate database checks).

- States may rely on the results of the Medicare screening process for Medicare providers/suppliers also enrolled in Medicaid and CHIP. However, they have the option to adjust the risk category if they want to impose more (not less) stringent requirements. States must use the screening process mandated by the HHS Secretary for non-Medicare providers enrolled in Medicaid or CHIP.

- CMS will assign providers/suppliers to one of three risk categories (i.e. Limited, Moderate, High). The specific category will dictate the screening measures used (Attachment A). Additional "triggers" can move providers/suppliers to a category of higher risk. Note that the implementation of "Fingerprints and Background checks" is delayed until 60 days after the final rule is posted specific to fingerprints and background checks. Accordingly, CMS will continue to seek comment limited to the implementation of the fingerprinting provisions contained in § 424.518 and § 455.434 of this rule by April 1, 2011.

- The rationale for assigning a provider/supplier type to a given risk category is based, in large part, on existing scrutiny (e.g. state licensure process), dependence on federal health care programs for generation of revenue, and sheer volume of services and associated billing.

- Individual states must assign a risk category to provider types that are not included on the Medicare list.

- New screening procedures would take effect on March 23, 2011 per the rule. Providers must re-validate their enrollment every five years. State Medicaid Agencies should complete the first revalidation cycle by 2015, with 20% of providers being re-validated each year beginning 2011. State Agencies have discretion in determining which provider types to re-validate first. The Agency is in the process of identifying and completing needed system changes as it works towards implementation.

II. Application Fee

- To cover the cost of background screening and other program integrity activities, PPACA requires the HHS Secretary to impose an application fee on each institutional provider/supplier (excludes eligible professionals, such as physicians and nurse practitioners).

- The fee applies to all institutional providers/suppliers billing Medicare as well as institutional entities billing Medicaid or CHIP on a fee-for-service basis (e.g. personal care agencies, non-emergency transportation providers, residential treatment centers).

- The fee does **not** apply to: individual physicians or non- physician practitioners such as nurse practitioners, CRNAs, OT, PT or Speech therapists, audiologists, psychologists, other behavioral therapists

- The fee of $500 is adjustable each year based on the Consumer Price Index. The application fee is non-refundable.

- The HHS Secretary may waive the application fee if payment would create a hardship or compromise access to care for Medicaid beneficiaries in a particular state (e.g. When a provider enrolls to furnish services because of a public health emergency).

- A Medicaid Agency will not review an enrollment application or re-validation unless it is accompanied by either an application fee or a hardship request. When the Provider is both Medicare/Medicaid, s/he will be required to show proof of the fee payment to Medicare.

- Because CMS would allow state Medicaid programs to rely on results of the Medicare screening process, Medicare providers/suppliers also enrolled in Medicaid or CHIP would pay only the Medicare application fee. The state must collect the fee from non-Medicare Institutional providers/suppliers (excludes eligible professionals, such as physicians and nurse practitioners) to offset the cost of Medicaid and CHIP screening.

- Screening is required every five years. It is estimated that 80% of Medicaid providers also participate in Medicare and, therefore, would be screened by Medicare contractors. State Medicaid agencies would be required to screen ≤20% re-enrolling Medicaid-only providers each year.

- The application fee will take effect concurrent with the new screening procedures, and would apply to all newly enrolling providers/suppliers as well as those re-enrolling and revalidating Medicare enrollment.

III. Temporary Moratoria on Enrollment

- The HHS Secretary has discretion to impose temporary moratoria on the enrollment of new Medicare, Medicaid, or CHIP providers/suppliers in order to allow for review of programs and regulations and, if necessary, implement necessary changes.

- CMS could impose moratoria, in six-month increments, on providers/suppliers or in specific geographical areas.

- Moratoria would not apply to existing providers/suppliers or in cases involving ownership change, merger, or consolidation.

- Before imposing a temporary moratorium, CMS would identify data that indicate a high risk of fraud, waste, or abuse (e.g. disproportion number in a category of suppliers/providers relative to number of beneficiaries; sudden increase in enrollment applications within a specific category or geographic area).

- State Medicaid agencies would comply with any temporary moratorium imposed by CMS, unless the moratorium would negatively affect access to care for beneficiaries. If that were the case, the state would be required to provide CMS with a written explanation and formally seek an exception to the moratorium.

- Currently states have authority to impose moratoria, volume caps, or other limits on providers identified by the HHS Secretary as high risk for fraud, waste, or abuse. The rule would require states to seek agreement for a proposed moratorium from CMS in the form of a written justification that indicates anticipated duration and identifies the way in which a moratorium would reduce the risk of fraud.

- Per the preamble, HHS will be issuing subregulatory guidance to assist States with the operational impact of implementing this provision in the near future.

IV. Suspension of Payments

Re: Medicaid

- The final rule expands CMS's authority to suspend payments based on a "credible allegation of fraud," which includes allegations from any source (e.g. civil false claims cases, law enforcement investigations). Suspension of payment would end when there is resolution to the investigation (i.e. by settlement, judgment, dismissal, or closure because of insufficient evidence).

- Current regulations allow Medicaid agencies to withhold payments when there is "reliable evidence" of fraud or willful misrepresentation. The final rule would replace the word "withhold" with the word "suspend," and require suspensions during a pending investigation of "credible allegation." The definition of "credible allegation" is the same as that for Medicare.

- State agency investigations are "adequate vehicles" for determining a "credible allegation" of fraud.

- CMS recognizes that the threshold for payment suspension is a lesser threshold than in current regulation, but does not expect that it will be used more frequently.

- The final rule mandates that the state agency notify the provider of payment suspension within five days of taking action except in cases where law enforcement provides a written request to delay 30 days (may be renewed twice).

- The provision requires a state initiating a payment suspension to forward a written fraud referral to its Medicaid Fraud Control Unit (MFCU) or the appropriate law enforcement agency, and request quarterly reports as the investigation continues.

- Like the Medicare regulations, the final Medicaid regulations include "good cause" exceptions to payment suspensions (e.g. when suspension is not in best interest of Medicaid program).

- The final rule adds reporting and document retention requirements (e.g. states must maintain suspension notices and referrals to MFCU for a minimum of five years). It is expected that these provisions will be accomplished primarily through measures such as State Program Integrity reviews conducted by CMS. When reviews indicate lack of compliance, FFP will be deferred or disallowed.