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ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

DATE: December 16, 2011

TO: Stakeholders

FROM: AHCCCS, Office of the Inspector General

SUBJECT: Provider Integrity Changes Mandated By The Affordable Care Act Of 2010

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.

Beginning January 1, 2012, AHCCCS will be implementing program integrity changes related to: 1) Provider Registration and 2) Suspension of Provider Payment based on a Credible Allegation of Fraud. These changes will be implemented through the AHCCCS Office of the Inspector General. Although the rule addresses both Medicare and Medicaid, this correspondence is limited to the changes for Providers in the Medicaid Program.

Provider Registration

The first set of regulations involves enhancements to background screening and an enrollment fee for some provider groups. The enrollment fee does **NOT** apply to individual physicians or non-physician practitioners.

- **Background Screening**

The final rule creates procedures for screening with enhanced processes regarding how AHCCCS registers new and existing providers. This includes current practices such as licensure verification, National Provider ID Number verifications (NPI's), address verifications, and additional procedures utilizing national databases. For certain types of providers, additional measures may be required such as on-site visits.

All current AHCCCS providers will be required to re-enroll with AHCCCS using its new processes. CMS has given Medicaid Agencies a five year timeframe within which to complete the re-enrollment process for existing providers. AHCCCS will notify existing providers when their re-enrollment is due. Once re-enrolled, the existing providers will revalidate every five years. Newly enrolling providers will be required to revalidate their enrollment every five years.

- **Enrollment Fee**

In accordance with the Affordable Care Act, Section 6401 and 42 CFR Subpart E, institutional and other designated providers are required to submit an enrollment fee (\$523 beginning January 1, 2012) at the time of application. The enrollment fee is determined annually by CMS.

For purposes of the enrollment fee, institutional and other designated providers includes, but is not limited to: the range of ambulance service suppliers; ASCs; CMHCs; CORFs; DMEPOS suppliers; ESRD facilities; FQHCs; histocompatibility laboratories; HHAs; hospices; hospitals, including but not limited to acute inpatient facilities, inpatient psychiatric facilities (IPFs), inpatient rehabilitation facilities (IRFs), and physician-owned specialty hospitals; CAHs; independent clinical laboratories; IDTFs; mammography centers; mass immunizers (roster billers); OPOs; outpatient physical therapy/occupational therapy/speech pathology services, portable x-ray suppliers; SNFs; radiation therapy centers; RNHCIs; and RHCs. In addition to the providers and suppliers listed previously, other agencies such as Personal care agencies, non-emergency transportation providers, and residential treatment centers will be included.

Provider types requiring an enrollment fee can be found on the AHCCCS website www.ahcccs.gov. Providers will be instructed during the registration process regarding payment submission requirements.

Note: If a provider appropriately validates that the fee has previously been paid to Medicare or another Medicaid State Agency, the fee for Arizona may be waived.

Suspension Of Provider Payments (42 C.F.R. §455.23)

The second set of regulations requires AHCCCS to suspend payments to a provider if AHCCCS determines that there is a “credible allegation of fraud” against the Medicaid Program. A “credible allegation of fraud” is defined as an allegation which has been verified by the State from any source, including but not limited to: (1) fraud hotline complaints (2) claims data mining and (3) patterns identified through provider audits, civil false claims cases and law enforcement investigations. Allegations are considered credible when they have indicia of reliability and the State Medicaid Agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.

Prior to the Affordable Care Act, suspending payment to a provider for alleged fraud was discretionary with the Agency. Now, it is mandatory, and AHCCCS could be subject to federal disallowance for failing to follow these requirements. Furthermore, under the old regulation, the standard of proof for whether suspension of payment was warranted was higher. The State Medicaid Agency could suspend a provider’s payment only if “reliable evidence of fraud” was found. Now, the State Medicaid Agency must suspend payment if a “credible allegation of fraud” is found.

The regulation also lists five “good cause” exceptions to the suspension:

- 1) Law enforcement requests that suspension not happen because the suspension may compromise or jeopardize an investigation;
- 2) Other available remedies implemented by the State more effectively or quickly protect Medicaid funds;
- 3) The State determines, after submission of written evidence by the provider, that the suspension should be removed;
- 4) Member/recipient access to care would be jeopardized by the suspension because (a) the provider is the sole community physician or the sole source of essential specialized services; or (b) the provider services a large number of recipients within a HRSA-designated medically underserved area;
- 5) Law enforcement declines to certify that the matter is still under investigation.

If AHCCCS finds that good cause exists, the suspension may not be imposed or may be lifted. In some cases, the suspension can be a partial payment suspension.

This regulation also requires AHCCCS to refer every provider whose payments have been suspended to the Medicaid Fraud Control Unit (MFCU) at the Arizona Attorney General’s Office. The referral must occur within 24 hours of the suspension and the MFCU will provide a quarterly report to AHCCCS that their investigation is either ongoing and the suspension should continue, or that MFCU is declining the investigation and the suspension may be lifted absent another law enforcement agency’s acceptance of the case.

For more information refer to the following links:

- Provider Screening and Enrollment Fee
<http://www.azahcccs.gov/commercial/ProviderRegistration/registration.aspx>
- HHS-OIG FAQs On Provider Payment Suspension
<http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/payment-suspensions-info-bulletin-3-25-2011.pdf>