

# Presentation for Health Care Compliance Association "New Enrollment Rules Reflect a Focus on Fraud and Abuse Prevention"

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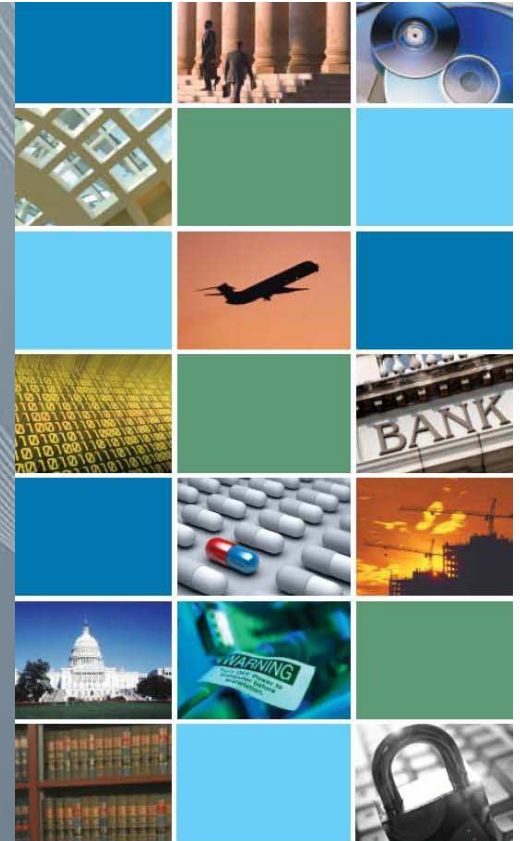
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February 16, 2011



## February 2011 Final Rule – Summary of Enrollment/Payment Changes

- Establishing procedures under which more rigorous *screening* is conducted for providers and suppliers;
- Requiring an *application fee* to be imposed on institutional providers;
- Imposing temporary *moratoria* on enrollment of Medicare, Medicaid and CHIP providers/suppliers;
- *Suspending payments* pending credible allegations of fraud;
- Establishing *compliance programs*;
- *Terminating provider participation under Medicaid and CHIP* if terminated under Medicare or another State Medicaid program or CHIP;
- *Terminating provider participation under Medicare* if terminated under a State Medicaid program.



## Affordable Care Act/ACA – Genesis of Enrollment Changes

- The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively known as the "Affordable Care Act" or "ACA"), made significant changes to Medicare, Medicaid and the Children's Health Insurance Program (CHIP) to reduce fraud, waste, and abuse at the provider enrollment level of program participation.
- Public Law No. 111-148, effective March 23, 2010, as amended by Public Law No. 111-152, effective March 30, 2010.

# Final Rule

- New enrollment Final Rule expands the ability of CMS and State agencies to monitor the enrollment of providers and suppliers in Medicare, Medicaid and CHIP and to combat fraud, abuse and waste in those programs through a variety of new techniques.
- Comments to the Proposed Rule were due by November 16, 2010; the *Federal Register* issuance containing the Final Rule was released on February 2, 2011 (76 Fed. Reg. 5862).
- Most of the discussion regarding Medicaid applies equally to CHIP.
- CMS decided not to apply the provisions of the Final Rule to Medicare managed care plans (e.g., Medicare Advantage plans). Look for separate rulemaking for MCOs/MAOs.

# Assignment of Provider/Supplier Types to Risk Categories

Limited	Moderate	High
<ul style="list-style-type: none"> <li>Physicians, NPPs (<u>including PAs, NPs, CRNAs, OTs, speech language pathologists and audiologists</u>), medical groups and clinics</li> <li><u>Pharmacies newly enrolling or revalidating via the CMS 855B (FINAL RULE)</u></li> <li>Hospitals, including critical access hospitals</li> <li>Skilled nursing facilities</li> <li><del>Publicly traded providers or suppliers (ELIMINATED IN FINAL RULE)</del></li> <li>Ambulatory surgical centers</li> <li>Radiation therapy centers</li> <li>Others (noted below)</li> </ul>	<ul style="list-style-type: none"> <li>Comprehensive outpatient rehabilitation facilities (CORFs)</li> <li>Independent diagnostic testing facilities (IDTFs)</li> <li>Independent clinical laboratories</li> <li>Currently enrolled (re-validating) home health agencies</li> <li>Currently enrolled (re-validating) suppliers of DMEPOS*</li> <li>Hospice organizations</li> <li><u>Physical therapists and PT groups (ADDED IN FINAL RULE)</u></li> <li><u>Portable x-ray suppliers (ADDED IN FINAL RULE)</u></li> <li>Others (noted below)</li> </ul>	<ul style="list-style-type: none"> <li>Newly-enrolling home health agencies</li> <li>Newly-enrolling suppliers of DMEPOS*</li> </ul>

ii “Limited” risk category also includes End stage renal disease (ESRD) facilities; Federally qualified health centers (FQHCs); histocompatibility laboratories; Indian health service facilities; mammography screening centers; organ procurement organizations; mass immunization roster billers; religious nonmedical health care institutions; rural health clinics; competitive acquisition program/Part B vendors (ADDED) and Dentists (ADDED) ~~public or government owned or affiliated ambulance services suppliers.~~ (DISTINCTION BETWEEN PUBLIC/GOV'T OWNED AND NON-PUBLIC/GOV'T OWNED IS ELIMINATED – ALL UNDER MODERATE RISK).

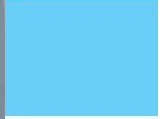
iii “Moderate” risk category also includes community mental health centers; and ~~nonpublic, nongovernment owned or affiliated ambulance services suppliers.~~



# Medicare - Moving Risk Categories

CMS will move providers and suppliers from a "limited" or "moderate" risk level to the "high" risk level if the following occurs:

- ~~CMS has evidence from or concerning a physician or non-physician practitioner that another individual is using his/her identity within the Medicare program. (CHANGE IN FINAL RULE)~~
- CMS imposes a payment suspension on a provider or supplier at any time in the last 10 years
- CMS lifts a temporary moratorium applicable to such providers or suppliers at which point the move to the "high" risk level will last for six months after the lifting of the moratorium.



## Medicare - Moving Risk Categories (Cont.)

CMS will move providers and suppliers from a "limited" or "moderate" risk level to the "high" risk level if the following occurs:

- The provider or supplier –
  - A. Has been excluded from Medicare by the OIG; or
  - B. Had billing privileges revoked by a Medicare contractor within the previous 10 years and is attempting to establish additional Medicare billing privileges by –
    1. Enrolling as a new provider or supplier; or
    2. Billing privileges for a new practice location;
  - C. Has been terminated or is otherwise precluded from billing Medicaid;
  - D. Has been excluded from any Federal health care program; or
  - E. Has been subject to any final adverse action as defined at §424.502, within the previous 10 years.

## Screening Procedures

- The level of screening depends on the risk category a provider or supplier is assigned. (See next slide.)
- States can rely on the results of the Medicare contractor's screening to meet the provider screening requirements under Medicaid and CHIP.
- State Medicaid agencies can also rely on the results of another State's Medicaid program or CHIP's screening.
- See Slides 13-17 regarding Medicaid/CHIP screening rules.

TYPE OF SCREENING REQUIRED (Medicare)	Current Rule	Proposed Rule– “Limited”	Proposed Rule- “Moderate”	Proposed Rule- “High”
Verification of any provider/supplier-specific requirements established by Medicare	X	X	X	X
Verification of license (may include licensure checks across States)	X	X	X	X
Database checks: <ul style="list-style-type: none"> <li>• Social Security Number</li> <li>• National Provider Identifier</li> <li>• National Practitioner Data Bank licensure</li> <li>• Office of Inspector General (OIG) exclusion</li> <li>• Verify taxpayer identification number</li> <li>• <del>Tax delinquency (REMOVED)</del></li> <li>• Death of individual practitioner, owner, authorized or delegated official, or supervising physician</li> </ul>	X	X	X	X
Unscheduled or unannounced pre-enrollment and/or post-enrollment site visits	Only DMEPOS and IDTFs pre-enrollment; ad hoc for others		X	X
Fingerprint-based Criminal History Record Check of law enforcement repositories – individual owners with 5% or more direct/indirect ownership <del>authorized or delegated officials and managing employees (ONLY APPLIES TO OWNERS)</del> (TO BE REQUIRED 60 DAYS FOLLOWING <b>SUBREGULATORY GUIDANCE</b> )				X



## Medicare - "High" Category Risk

- Criminal background checks and fingerprinting will be done on all owners, ~~authorized or delegated officials or managing employees~~. (CHANGED IN FINAL RULE)
- Final Rule confirmed that criminal history record (including fingerprinting) will include individuals with 5% or greater direct/indirect ownership interest (not corporate entities).
- The submission of fingerprints is the only way to obtain a criminal history record check from the FBI.

# Timing of New Screening Procedures

- **Newly enrolling providers/suppliers – effective March 25, 2011**
- **Currently enrolled MCR, MCD and CHIP providers/suppliers who revalidate their enrollment information – between March 25, 2011 and March 23, 2012**
- **Currently enrolled MCR, MCD and CHIP providers/suppliers – effective March 23, 2012 (SSA § 1866(j)(2)(ii)) – although see NOTE on following slide.**



## Timing of New Screening Procedures

- **NOTE: CMS can now require that a provider or supplier revalidate its enrollment at any time.**
- **After the revalidation under the new rules, the current revalidation cycle (3 years for DMEPOS and 5 years for all others) will apply.**
- **Additional high level screening procedures (fingerprint-based criminal history record checks) will be implemented 60 days following the publication of the subregulatory guidance – EXPECT MANUAL ISSUANCE(S).**

## Medicaid/CHIP – Federal Screening Rules

- For types of providers that are recognized as a provider or supplier under Medicare, States will use the same screening level that is assigned to that category of provider by Medicare. See Revised 42 CFR §455.450.
  - Limited risk – (1) Verify that a provider meets any applicable Federal regulations, or State requirements for the provider type; (2) License verification; (3) Database checks
  - Moderate risk – (1) Perform Limited risk screening; (2) Conduct on-site visits in accordance with 455.432
  - High risk – (1) Perform Limited and Moderate risk screenings; (2) Conduct a criminal background check and (3) require the submission of a set of fingerprints (455.434).
  
- For those Medicaid and CHIP provider types that are not recognized by Medicare, States will assess the risk posed by a particular provider or provider type.

## Medicaid/CHIP – Federal Screening Rules

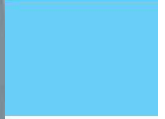
- States can assess the risk of provider type themselves; however, CMS states that it "expects" States will assess the risk using criteria similar to those used in MCR.
  - For example, physicians, NPPs, medical groups and clinics that are State-licensed or State-regulated would generally be categorized as limited risk.
  - Those provider types that are generally highly dependent on MCR, MCD and CHIP to pay salaries and other operating expenses and which are not subject to additional government or professional oversight would be considered moderate risk.
  - Those provider types identified by the State as being especially vulnerable to improper payments would be considered high risk.

## Medicaid/CHIP – Federal Screening Rules

- States can go beyond the MCR-required provider screening activities, including assigning a particular provider type to a higher screening level than the MCR-assigned level.
- **INFORMATION SHARING** - CMS is "examining" to what extent it can support a centralized information sharing solution for provider enrollment across programs and across States.

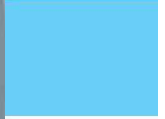
# Medicaid/CHIP – Screening

- Conduct license verifications (including those across state lines)
- Database checks
  - verify SSN;
  - LEIE/EPLS upon initial enrollment and monthly for all persons disclosed under §455.104 (including 5% direct/indirect owners of equity or debt interests, partners, and officers/directors of corporations);
  - SSA's Death Master File
  - National Plan & Provider Enumeration System (NPPES) - NPI
- Site visits – pre- and post-enrollment site visits are required for those providers that are determined to be in a moderate or high risk category of fraud, waste or abuse (even for out-of-state providers). (§455.432(a), §455.450(b))



## Medicaid/CHIP- Criminal Background Checks & Fingerprinting

- Currently 20 States report that they conduct some type of criminal background check as part of their MCD enrollment practices.
- **FINGERPRINTING** – limited to providers and persons with a 5% or more direct/indirect ownership interest in the provider.
- States will not be required to implement criminal background checks and fingerprinting until CMS issues additional guidance.



## Medicaid/CHIP - Revalidation

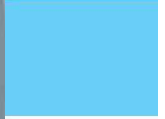
- **5-year revalidation of enrollment information, including re-screening as well as the collection of updated disclosure information for providers regardless of provider type**
  - **Screening component (e.g., license verification, database checks, site visits, background checks and fingerprinting) to be conducted by either the MACs (for dually-participating providers) or by the States (for MCD-only or CHIP-only providers).**
- **Timing – First revalidation cycle should be complete by 2015 with 20% of providers being revalidated each year beginning 2011.**

## Medicaid/CHIP – Ordering & Referring Physicians

- SSA 1902(kk)(7) requires that States must require all ordering or referring physicians or other professionals to be enrolled under a Medicaid State plan or waiver of the plan as a participating provider.
- "Ordering" or "referring" including prescribing/ordering lab tests.
- CMS did not expand this enrollment requirement to risk-based managed care organizations.
- CMS also left it to the State's discretion to require entrance of the NPI on the encounter record.
- CMS mentioned the States' ability to minimize the administrative burden of enrolling additional providers by implementing a streamlined process for those providers who only refer or order, but do not bill for services, similar to the CMS-855-O process in MCR.

## Fingerprinting – Solicitation of Additional Comments – Medicare, Medicaid & CHIP

- **CMS seeks comment on the following:**
  - methods that CMS can use to ensure the privacy and confidentiality of the records that will be generated pursuant to adopting the criminal history records check provisions;
  - Methods by which CMS can measure the effectiveness of its adoption of criminal history records checks;
  - Whether CMS should adopt additional technology to identify providers and suppliers that are enrolling in the program.
- **Public comment period will last 60 days following publication of the final rule with comment period.**



# Application Fee – Statutory Mandate

- **ACA § 6401(a) requires the Secretary to impose a fee on each “institutional provider of medical or other items or services or supplier” to cover costs of screening and to carry out screening and other program integrity efforts.**

## Application Fee – "Institutional Providers"

- **"Institutional providers" means "any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (not including physician and nonphysician practitioner organizations), CMS-855S or associated Internet-based PECOS enrollment application."**
- **Medicaid-only and CHIP-only institutional providers include nursing facilities, intermediate care facilities for persons with mental retardation (ICF/MR), psychiatric residential treatment facilities, and may include other institutional provider types designated by a State in accordance with their approved State plan.**

# Application Fee - Amount

- The statutorily-mandated application fee (statutorily set at \$500 for 2010 and adjusted yearly based on the CPI for all urban consumers) is required in the following instances –
  - (1) with the submission of an initial enrollment application,
  - (2) with an application to establish a new practice location, or
  - (3) as part of revalidation.
- The application fee is not linked to the risk level associated with the provider or supplier, i.e., you do not pay more because you are at a "high" level versus a "limited" risk level.

# Application Fee – Nonrefundable except...

- The application fee is nonrefundable except if submitted with one of the following:
  1. A request for hardship exception that is subsequently approved;
  2. An application that is rejected prior to initiation of screening processes;
  3. An application that is subsequently denied as a result of the imposition of a temporary moratorium.

# Application Fee – How it works

- A provider or supplier enrolled in more than one program (i.e., Medicare and Medicaid or CHIP, or all three programs, or Medicaid and CHIP in multiple States) would only be subject to the application fee once and that fee would cover screening activities for enrollment in all programs.
  - **INFORMATION SHARING** - The operational logistics will be addressed in **subregulatory guidance**.
  - States must collect the applicable fee from MCD-only and CHIP-only providers and suppliers.
- States have the flexibility to waive the application fee for particular providers or a class of providers if it determines that this would help assure access to services for beneficiaries.

# Application Fee – How it works

- If applying for two different kinds of institutional providers, e.g., DMEPOS and HHA, you will be required to submit the fee for each enrollment.
- Requirement – a provider/supplier will pay the application fee whenever a Form CMS-855 is submitted.
- An application will be rejected and, in the case of revalidations, billing privileges may be revoked, if the institutional provider does not submit the application fee or hardship exception.
  - If application is received without the fee, the CMS contractor will send out a request for additional information and give the provider 30 days to furnish the missing items.

# Application Fee – Effective Dates

## ➤ EFFECTIVE DATES –

- On March 25, 2011, the fees and other requirements of the regulation are applicable for currently enrolled providers that are revalidating their enrollment in the period between March 25, 2011 and March 23, 2012.
- For all other currently enrolled providers and suppliers, the fees and other provisions of the proposed rule are effective on March 23, 2012.

# Application Fee - Hardship Exemption

- There is no blanket exception based on financial status, e.g., nonprofit or public provider/supplier.
- Providers or suppliers can apply for a hardship exemption to the enrollment fee by including a letter with the application.
- Hardship requests will be considered on a case-by-case basis, and the proposed rule provided one example that might support a request for hardship exception (a national public health emergency where a provider or supplier is enrolling for purposes of furnishing services required as a result of the emergency situation).

# Temporary Moratoria on Enrollment – Statutory Changes

- **ACA § 6401(a) (SSA 1866(j)(7)) - the Secretary may impose a temporary moratoria on the enrollment of new Medicare, Medicaid or CHIP providers and suppliers, if the Secretary determines such moratoria are necessary to prevent or combat fraud, waste, or abuse.**

# Temporary Moratoria on Enrollment - Medicare

- CMS may impose a moratorium in six-month increments in situations where:
  - (1) CMS identifies a trend that appears to be associated with a high risk of or determines there is a significant potential for fraud, waste or abuse with respect to a particular provider or supplier type or particular geographic area or both;
  - (2) a State has imposed a moratorium on enrollment in a particular geographic area or on a particular provider or supplier type; or
  - (3) CMS, in consultation with the OIG or DOJ, identifies a particular provider or supplier type or a particular geographic area as having a significant potential for fraud, waste or abuse.

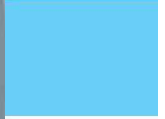


# Temporary Moratoria on Enrollment - Medicare

- CMS will not provide advance notice of any planned moratorium as such a notice would likely cause a rush of enrollments.
- Notice of the moratorium will be published in the *Federal Register* and discuss the rationale for the imposition of the moratorium, the particular provider or supplier type or the establishment of new practice locations of a particular type in a particular geographic area (424.570(a)).
- The moratoria would be limited to:
  - (1) newly enrolling providers and suppliers (including any pending applications except in certain circumstances); and
  - (2) the establishment/addition of new practice locations, not a change of practice locations.

# Temporary Moratoria on Enrollment - Medicare

- The moratoria would not apply in situations involving changes in ownership of existing providers or suppliers, mergers, consolidations, except changes in ownership of HHAs that would require initial enrollment under 424.550 (under the 36-month rule).
- Moratorium may be lifted in the following circumstances: (1) in the case of a Presidentially-declared disaster under the Stafford Act; (2) circumstances warranting the imposition of a moratorium have abated or CMS has implemented program safeguards to address any program vulnerability that was the basis for the moratorium; (3) in the Secretary's judgment, the moratorium is no longer needed; or (4) a public health emergency declared by the Secretary under Section 319 of the Public Health Service Act.
- Lifting of the moratorium will be published in the *Federal Register*.



# Enrollment Moratoria – Medicaid or CHIP

- State Medicaid agencies must comply with a moratorium unless it determines that compliance would adversely affect Medicaid beneficiaries' access to medical assistance. (SSA §1902(kk)(4).)
- States also have the authority to impose moratoria (in six-month increments), numerical caps, or other limits for providers that are identified by the Secretary as being at "high" risk for fraud, waste, or abuse.
- In such cases, the State must first seek CMS' concurrence and provide written details of the proposal, including anticipated duration and a "substantial justification" explaining why disallowing newly enrolling providers would reduce the risk of fraud.
  - CMS will issue **subregulatory guidance** on the operational aspect of implementing this provision.

# State Medicaid Enrollment Moratoria

- Prior to imposing a moratorium in any State, CMS will consult with the State so that the State may have an opportunity to seek an exception from the moratorium.
- Additionally, States must provide CMS with written details of the moratorium's adverse impact on Medicaid beneficiaries.
  - Additional information regarding the operational processes that should be used by States will be addressed in **subregulatory guidance**.
- The moratorium will not apply to Medicaid managed care.

## Medicare Payment Suspension – Statutory Changes

- **ACA § 6402(h) provides that the Secretary may suspend payments to a provider or supplier *pending an investigation of a credible allegation of fraud, unless* the Secretary determines that there is *good cause* not to suspend payments.**
  - **Section 6402(h) requires that the Secretary consult with the OIG in determining whether there is a credible allegation of fraud.**
  - **Applies to Part A and Part B programs, not C and D.**

# Medicare Payment Suspension

- Under current Medicare rules (in place since 1996), CMS is allowed to suspend payments for 180 days based upon reliable information that an overpayment or fraud or willful misrepresentation exists or that the payments to be made may not be correct.
  - The suspension has been limited to 180 days except in certain circumstances.
- The Final Rule eliminates that 180-day limit in cases of "credible allegations of fraud" from any source.

# Medicare Payment Suspension

- Although CMS may maintain a suspension for an unspecified period of time, CMS must evaluate whether there is good cause not to continue a suspension of payments every 180 days after initiation of a suspension.
- As part of its ongoing evaluation, CMS will request a certification from the OIG or other law enforcement agency as to whether the agency continues to investigate the matter.

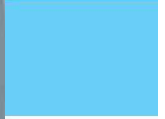
## Medicare Payment Suspension - "Credible Allegation of Fraud"

- The Secretary is required to consult with the OIG in determining whether there is a *credible allegation of fraud*.
  - Mechanics of the consultation between CMS and law enforcement "partners" (e.g., OIG and DOJ) to determine the credibility of allegations will be detailed in a [Memorandum of Understanding](#) between the respective agencies.
  
- A "credible allegation of fraud" is defined as an allegation from any source, including but not limited to fraud hotline complaints, claims data mining, patterns identified through provider audits, civil false claims cases, and law enforcement investigations.



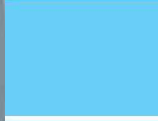
## Medicare Payment Suspension - "Credible Allegation of Fraud"

- CMS stated that it did not intend the definition of "credible allegation of fraud" to detail a precise evidentiary standard.
- CMS intended the definition to give examples of sources of allegations of fraud and explain that assessing the reliability of an allegation is a process that will occur on a case-by-case basis.
- Allegations are considered to be credible when they have *indicia of reliability* (which CMS did not define).
- Any issues related to this definition will be evaluated on a case-by-case basis by looking at all relevant factors, circumstances and issues.
- CMS did not define a timeframe for informing providers/suppliers of the payment suspension.



## Medicare Payment Suspension – "Resolution of Investigation"

- CMS added a provision for when an investigation is resolved and thus the basis for suspension of payments no longer exists.
- A "resolution of investigation" occurs when legal action is terminated by settlement, judgment, or dismissal, or when the case is closed or dropped because of insufficient evidence.



## Medicare Payment Suspension – "Good Cause"

- In accordance with the ACA, despite credible allegations of fraud, CMS can choose not to impose a suspension (or not to continue a suspension) if there is "good cause."
- Circumstances that may qualify as good cause include:
  - (1) *OIG or law enforcement has specifically requested* that a payment suspension not be imposed because it may compromise or jeopardize an investigation;
  - (2) *beneficiary access to items or services* would be so jeopardized as to cause a danger to life or health;
  - (3) *other available remedies* implemented by CMS or a Medicare contractor more effectively or quickly protect Medicare funds than would implementing a payment suspension; or
  - (4) CMS determines that a payment suspension or a continuation of a payment suspension is *not in the best interests of the Medicare program*.

## Medicare Payment Suspension – "Good Cause"

- Good cause not to continue to suspend payments must be deemed to exist if a payment suspension has been in effect for *18 months* and there has not been a resolution of the investigation, except CMS may extend the suspension if –
  1. The case has been referred to, and is being considered by, the OIG for administrative action (e.g., CMPs); or such administrative action is pending or
  2. The DOJ submits a written request to CMS that the suspension of payments be continued based on the ongoing investigation and anticipated filing of criminal or civil action or both or based on a pending criminal or civil action or both.

## Medicaid Payment Suspension – Statutory Changes

- ACA §6402(h) amended SSA §1903(i)(2) to provide that *FFP in the Medicaid program shall not be made with respect to any amount expended for items/services (other than an emergency item or service, not including items or services furnished in an ED) furnished by an individual or entity to whom a State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity as determined by the State in accordance with these regulations, unless the State determines in accordance with these regulations that *good cause* exists not to suspend such payments.*

# Medicaid Payment Suspension

- Current regulations provide that a State Medicaid agency may withhold payments to a provider in whole or in part based upon the receipt of *reliable evidence* that the need for withholding payments involves fraud or willful misrepresentation under the Medicaid program.
  - At the time of the final rule, OIG declined to provide a specific definition of "reliable evidence," noting that it is not easily and readily definable.
- Under the revised regulations, payment suspensions are mandatory where a *pending investigation of a credible allegation of fraud* under the Medicaid program exists— thus, as acknowledged by CMS, adopting a lesser threshold for a payment suspension than is in the current regulation.



# Medicaid Payment Suspension

- "Credible allegation" will have the same broad definition and States must review all allegations, facts and evidence carefully and "act judiciously" on a case-by-case basis.
- CMS does not require that investigations originate in or with a law enforcement agency – investigations can originate with the State agency.
- Under Medicaid, there is no 180-day time limit similar to the Medicare process.

# Medicaid Payment Suspension

- ***Notification must take place within 5 days of payment suspension (similar to the current regulation), but can be delayed in 30 days increments up to 90 days by law enforcement request.***
  
- **The "good cause" exceptions in the Medicaid rule are similar to the Medicare rule with the addition of exceptions that would permit (but not require) a State to discontinue an existing suspension**
  - **to the extent law enforcement declines to cooperate in certifying that a matter continues to be under investigation;**
  - **if the State determines, based on the submission of written evidence by the individual or entity, that the suspension should be removed; or**
  - **when an individual/entity is the sole community physician or the sole source of essential specialized services in a community.**



# Medicaid Payment Suspension

- **Duration** – suspension will be temporary and will not continue after (1) authorities discern that there is insufficient evidence of fraud upon which to base a legal action, or (2) legal proceedings related to the alleged fraud are completed.
- Unlike other provisions in the Final Rule, the Medicaid payment suspension provisions *apply to Medicaid managed care entities*.
- With regard to timing, CMS stated that it expects States to suspend payments to providers against whom there exist pending investigations of credible allegations of fraud, so expect (some) immediate action.

## Payment Suspension - MFCU

- States must make a formal, written suspected fraud referral to its Medicaid Fraud Control Unit (MFCU) or if no MFCU, to an appropriate law enforcement agency for each instance of payment suspension as the result of a State agency's preliminary investigation of a credible allegation of fraud.
  - If MFCU/law enforcement agency refuses the referral, then State must release the payment suspension unless it refers the matter to another law enforcement entity or unless there is an alternate basis for payment suspension.
  
- On a quarterly basis, a State must request a certification from the MFCU/law enforcement agency that any matter accepted on the basis of a referral continues to be under investigation or in the course of enforcement proceedings warranting the continuation of the payment suspension.

## Payment Suspension - MFCU

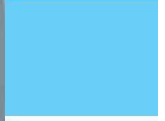
- MFCU may also refer to the State agency any provider against which there is pending an investigation of a credible allegation of fraud for purposes of payment suspension in accordance with §455.23.
  - Such referrals must be in writing.

## Compliance Programs – Statutory Changes

- **ACA § 6102** requires a nursing facility to have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil and administrative violations and in promoting quality of care.
- **ACA § 6401(a)** requires providers and suppliers to, as a condition of enrollment in Medicare, Medicaid or CHIP, establish a compliance program that contains certain “core elements.”
  - The statute requires that in the case of an organization that has 5 or more facilities, the formality or specific elements of the program vary with the size of the organization.

## Compliance Programs – Core Elements

- In the Proposed and Final Rules, CMS solicits comments on “core elements” of a compliance program.
- CMS did not finalize compliance plan requirements when the other proposals in the Proposed Rule were finalized, but instead will do further rulemaking on compliance plan requirements.
- CMS is most interested in receiving comments on the use of the 7 elements of an effective compliance and ethics program as described in the U.S. Federal Sentencing Guidelines Manual as the basis for the core elements, but has not limited the core elements to those seven elements.
- Other comment areas are detailed at page 5942 of the *Federal Register* issuance.



# Terminations – Statutory Change

- ACA § 6501 requires a State's Medicaid program to terminate an individual's or entity's participation if the individual or entity has been terminated under Medicare or another State's Medicaid program on or after January 1, 2011.
  - State Medicaid programs would terminate a provider only after the provider exhausted all available appeal rights in the State that originally terminated the provider or the timeline for appeal has expired. (*This is unlike Payment Suspensions which can occur before appeal rights are exhausted.*)
  - States would be required to terminate participation only in cases where providers, suppliers or eligible professionals were terminated or had their billing privileges revoked for cause (i.e. fraud, integrity or quality issues).

# Terminations

- States are required to report on a monthly basis those providers who were terminated from January 1, 2011 forward.
- CMS is in the process of establishing a web-based portal that will allow States to share information regarding terminated providers.
- Timeline and parameters for termination will vary depending on the State in which the termination occurs because the termination process is governed by the State's administrative appeals processes.
- The requirement for termination applies to enrolled providers generally, not just billing providers.
  - An enrolled provider that has had its billing privileges revoked by Medicare must be terminated by the States' Medicaid programs, regardless of whether the provider is submitting claims.



# Terminations

- It is the provider, not the identifiers which are to be terminated.
- Is the provider the same provider in another state?
  - CMS suggests that the State look at a variety of factors including, but not limited to, NPI and correspondence address.
  - The State could also communicate with the Medicaid agency that originally terminated the provider to help resolve the question of the provider's identity.
  - States could also conduct background checks.
  - This does not apply to affiliates/parent entities, only to the provider itself.

## Terminations – Medicare Provider Enrollment Provisions

- CMS has discretion to revoke Medicare billing privileges when a State Medicaid agency terminates, revokes, or suspends a provider or supplier's Medicaid enrollment or billing privileges. (424.535(a)(11)).

# Questions?

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