"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

Michael A. Gargano, Secretary

MEMORANDUM

To: HHS
From: Indiana Family and Social Services & MFCU
Re: 9/23/10 Federal Register Proposed Rules; vol. 75, No. 184, 58223-7 and 58243-4
Date: November 16, 2010

The State of Indiana's Family and Social Services Administration (FSSA) appreciates this opportunity to comment on the proposed rules for Medicare and Medicaid provider screening and new compliance requirements. In order to complete this comment the FSSA solicited comment internally from the Medicaid Fraud Control Unit (MFCU) and the Office of Medicaid Policy and Planning (OMPP) as well as from Indiana Medicaid providers through an online questionnaire form. Notations below which indicate the concern of Indiana providers are drawn from the feedback submitted by providers through this format.

CONCERNS:

I. Retroactivity

The State of Indiana is concerned with the applicability of this Rule to investigations currently underway at the time of this Rule's adoption. The Rule, as it is read, could be interpreted to mean that the Medicaid Agency must suspend all providers that have already been referred to MFCUs or law enforcement agencies. If the law included language which clarified whether this Rule was applicable to investigations initiated before the adoption of this rule, questions will not arise as to which investigations this Rule applies.

II. Investigation

"We propose to implement section 6402(h)(2) of the ACA by modifying the existing § 455.23(a) to make payment suspensions mandatory where an investigation of a credible allegation of fraud under the Medicaid program exists."

The State is concerned this section does not adequately define the word "investigation." It may be interpreted to mean that the Medicaid Agency must suspend payment for all law enforcement agency investigations, whether or not the state agencies know of the

investigation. The rule should define the term "investigation" to only include those cases which are a part of the Medicaid Agency's SUR function and not law enforcement investigations that SUR may or may not be aware of. This will alleviate administrative burden for the Medicaid agency and ensure the Agency is not forced into becoming too cautious. For example, this rule could result in suspending payments on every provider where the Agency receives an investigative query from outside agencies, simply to avoid CMS audit findings.

III. Referrals

"The fraud referral made under paragraph (d)(1) of this section must meet all of the following requirements: (i) Be made in writing and provided to the Medicaid fraud control unit not later than the next business day after the suspension is enacted.
(ii) Conform to fraud referral performance standards issued by the Secretary. (3)(i) If the Medicaid fraud control unit or other law enforcement agency accepts the fraud referral for investigation, the payment suspension may be continued until such time as the investigation and any associated enforcement proceedings are completed."

We are concerned with the effect that this Rule will have on the number and type of referrals received from the Medicaid Agency. MFCU oftentimes receives tips or information from the Medicaid Agency, which have not been substantiated, but are worthy of investigation. We feel requiring the Medicaid Agency to strictly comply with specific guidelines for every referral may hinder communication between agencies on time sensitive issues. We do, however, understand the reason for formality with these types of referrals. In order to expedite the referral process, we would recommend the Medicaid Agency being allowed to share potentially helpful information with MFCU without immediately following the fraud referral performance standards.

IV. Notification

We are concerned with the role that Managed Care Organizations would play in this proposed Rule. The Rule is unclear about the manner in which Managed Care Organizations would be alerted to credible allegations of fraud, and whether they would be required to suspend payment as well. Further guidance on whether Managed Care Organizations' credible allegations of fraud follow the same path of referral to MFCU and law enforcement agencies would be helpful.

V. Credible allegation of fraud

"This section implements section 1903(i)(2)(C) of the Act which prohibits payment of FFP with respect to items or services furnished by an individual or entity with respect to which there is pending an investigation of a credible allegation of fraud except under specified circumstances."

We are concerned with the definition of "credible allegation of fraud." As the Rule is written, it is not clear whether it means criminal fraud, civil fraud, or both.

Indiana providers are also concerned about what constitutes a "credible allegation of fraud" or overpayment. Providers want assurance that payment suspensions will not occur without clear evidence of a discrepancy.

VI. Overpayments

The Patient Protection and Affordable Care Act (PPACA) requires mandatory reporting and repayment of overpayments by providers. Given this new mandate, it may be foreseeable that a provider's retention of an overpayment qualifies as a false claim. This situation could invoke the penalties and whistle bowler provisions. This raises other issues such as retained credit balances not reported properly to Medicaid. We request clarification of how overpayment retentions and unreported credit balances will be treated under the new provider screening regulations.

Providers urge that cases of overpayment and fraud be treated differently. They desire clarification on what constitutes 'reliable information' that an overpayment has been made. Indiana providers point out that overpayments can be in error, while fraud is intentional. They do not feel that punishment with payment suspension is valid in the case of most overpayments.

VII. License Verification

The proposed rule states on page 58213, ". . . we are proposing that a State be required to verify the status of a provider's license by the State of issuance . . ." Table 5 on the same page indicates that license verifications ". . . may include licensure checks across State lines . . ." implying that it is permissive rather than required.

Indiana requests further clarification on this rule. Either the chart should be changed to indicate that license verification must include checks across state lines when the license is issued by another State or that the text be changed to indicate it is permissive.

VIII. Screening Procedures

Indiana's Office of Medicaid Policy and Planning is very supportive of many of these screening requirements. The new requirements will protect the State and give greater authority to parse the good providers from the bad. Our biggest concern is related to timely guidance from CMS so the screening procedures can be implemented appropriately.

However, Indiana providers in general are not supportive of the majority of the screening procedures. Providers express concern about the cost of the new procedures, who will fund them, and how they will be managed. The fingerprinting provision represents significant logistical concern, and the input from Indiana Providers suggests that they are very unsupportive of fingerprinting any risk category as a screening measure. The State would like clarification and specific suggestions on what it is to do with fingerprints that it collects. Is there an expectation that the program retains the prints in some manner? Are there specific benefits to be obtained over and above the benefits obtained by performing the required criminal background check?

Providers also expressed concern regarding unscheduled and unannounced site visits. The State is intending to use such visits as a form of oversight, and Indiana is supportive of this measure. However, additional guidance on conducting these visits and guidelines for provider compliance may help to reduce provider anxiety and aid Indiana in education and outreach efforts.

An additional suggestion by Indiana providers includes the consideration of a provider's previous compliance record when assigning a risk level. Providers request that an impeccable compliance record and a consistent location be taken into account when they receive their rating for risk.

Overall, providers indicate the majority of the increased screening measures will reduce their likelihood of participating as providers for public coverage programs. This is a critical concern for our State; though Indiana supports refining the screening procedures we want to ensure that these new procedures do not yield a loss of Medicaid providers. Our current payments rates are already a concern for providers and these further administrative burdens may reduce access to care for Medicaid participants.

Indiana suggests that the rules incorporate an additional requirement that providers found to have falsified information on an application will be terminated.

IX. Background Checks

Obtaining finger prints is listed as an element of a robust criminal background check. Please clarify whether requesting a criminal background check fully satisfies the finger print requirement. If not are the Medicaid plans required to obtain fingerprint records? If Medicaid is required to obtain fingerprint records, please describe the specific actions Medicaid is to take once it has the prints in its possession.

Indiana recommends criminal background checks every 5 years for all levels. Provider comments also support background checks as the main screening measure. Indiana recommends mandatory rescreening every three years instead of five.

X. Risk levels

Indiana considers the providers included in the limited and moderate risk as high risk providers. Are risk categorizations envisioned such that providers can be moved from one category to the next? Indiana understands and supports categorizing providers into risk levels. However, each state has their unique provider challenges. It may be advisable to allow states to integrate state specific knowledge into a nationalized risk assessment tool designed by a weighted point system; thereby, capitalizing on state provider experience. For instance, if a provider had previous affiliations with any provider/supplier that has uncollected debt, had its payment suspended or has been excluded from participating in a federal health care program the possibility exists that with the proposed risk level model that they may receive a low risk assessment. However, if a nationalized tool was designed which allowed states to incorporate this type of information into the assessment of risk, the result may be very different. Scarce resources could be utilized to focus on screening high risk providers prior to enrollment or revalidation.

XI. $500 Provider Application Fee

Indiana providers do not support the mandatory $500 fee for Medicare providers or the optional $500 fee for Medicaid providers. The providers make the point that they already accept lower payment rates from patients with public insurance, and take on more time intensive patients when they participate as public program providers. Indiana providers indicate that this fee, along with many of the screening provisions, will decrease the likelihood that they will participate as providers in public coverage programs.

XII. Dually Participating Providers

The proposed rule states that, ". . . for dually participating providers, the application fee would be imposed at the time of the Medicare enrollment applications . . ."

Please provide information on the work flow in the instance where an existing, screened, Medicaid provider applies to participate in Medicare. Will Medicare accept the State's screening? What is the communication mechanism or business process for Medicare to be aware of these instances?