Report on
MEDICARE COMPLIANCE
Volume 21, Number 4 • January 30, 2012

CMS Sets Forth the Reasons for Medicaid Terminations in 50 States

Providers that lose their Medicaid billing privileges in one state may quickly find themselves blacklisted from all Medicaid plans, according to a Jan. 20 CMS bulletin that elaborates on why providers could be terminated.

States are required to act on another state's Medicaid termination and Medicare's termination as long as it is based on "cause." Providers may be terminated for a number of reasons, including billing for services that were not medically necessary, according to the CMS bulletin, which was signed by Peter Budetti, director of the Center for Program Integrity, and Cindy Mann, director for Medicaid and CHIP Services.

But the government has been known to make mistakes, which is another reason why providers should pay close attention to CMS's use of provider screening, enrollment and re-enrollment to crack down on overpayments and fraud, one attorney says. "The particular focus on provider enrollment is three or four years old, but people are not taking enrollment as seriously as they should," says San Francisco attorney Judy Waltz, with Foley & Lardner LLP. With heightened Medicare and Medicaid scrutiny of enrollment information and updates and revalidations of existing providers, it may be important to take a closer look at this area (see box, p. 4 and below).

The CMS bulletin on reciprocal Medicaid terminations is an attempt to prevent providers who lose their billing privileges in one state from setting up shop in another. It's one of the provider screening and enrollment initiatives of the health reform law. Sec. 6501 requires state Medicaid agencies to terminate an individual or entity if it's terminated under Medicare or any other state Medicaid plan. Termination means Medicaid, Medicare or CHIP has revoked the provider's or supplier's billing privileges, and all appeals have been exhausted — or the time has expired for appeals, the bulletin explains. But termination of the provider's and supplier's Medicaid billing numbers had to be for cause.

The bulletin addresses the definition of "cause." It starts by saying what cause isn't. For example, CMS says termination for failing to maintain an active license in the state doesn't count as cause. "Accordingly, we neither expect states to share information regarding this type of termination with other states, nor do we expect other states to initiate their own termination action based upon such termination," CMS states.

However, there are plenty of reasons for states to spread the terminations around, CMS notes. The bulletin says states could terminate providers and suppliers from their Medicaid programs if another state has terminated providers and suppliers for:

- ◆ Engaging in fraudulent conduct.
- ◆ Misusing their billing number.
- ◆ Falsifying information on enrollment applications or information submitted to keep their enrollment.
- ◆ Billing for services not rendered or that are medically unnecessary.
- ◆ Dummying medical records to support services billed to Medicaid.
- ◆ Billing after the provider or supplier's medical license was suspended or revoked.
- ◆ Billing despite being excluded from state or federal health programs.
- ◆ Having adverse licensure actions against them ("e.g., providers who are reported into the National Practitioner Data Bank"), the bulletin notes.

Waltz has concerns about the reciprocal termination process. For one thing, CMS and Medicaid may make mistakes when communicating about terminations. "I am very worried for providers that have operations in multiple states," she says. If one Medicaid program makes an error in processing termination paperwork, it could spread quickly across the country and be a nightmare to get fixed.

Suppose a provider is threatened with Medicaid disenrollment for putting incorrect information about related parties on an enrollment form. "At the end of the day, it gets worked out, but what if that was reported to 50 states? Can you imagine what you'd have to do to fix that?"

Another concern is how terminated providers will get re-enrolled in all state Medicaid programs once their billing privileges are restored in the original state that took them away, Waltz says. "There is a lot in the bulle-

tin about getting someone out, but it's not so clear about getting someone back in," she says. "They are leaving it to the states to pay attention to communications from other states. Someone in each state probably has to take action." That could be a challenge, especially for providers who are terminated for inadvertent mistakes, Waltz says. While terminations must be for cause, "the standard is not high," she contends.

Waltz advises health care organizations to delegate Medicaid and Medicare enrollment responsibility to "a pretty high-level employee." Some have enrollment forms reviewed by compliance officers or general counsel. She says it may be worth hiring a vendor to do the job for you because enrollment forms now demand more detailed information *(RMC 11/7/11, p. 1)*. "It's like requiring tax returns for the first time in terms of the specificity," she says. "You have to be able to detail your corporate structure and some of it's mindboggling — parents, subsidiaries, sisters and related parties. It's a lot of work and there are a lot of components."

One reason for the emphasis on ownership and relationships appears to be part of finding out which entities and people are accountable if something goes wrong, Waltz says.

Contact Waltz at jwaltz@foley.com. ✧