ATTACHMENT 14

GUIDELINES FOR THE DEVELOPMENT OF PROGRAM INTEGRITY

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GOBIERNO DE PUERTO RICO

Puerto Rico Government
Puerto Rico Health Insurance Administration

Guidelines for the Development of Program Integrity Plan

2023 - 2026

(This document is to be used by all Contractors participating in the Government Health Plan (GHP) of Puerto Rico. The purpose of this document is to assist Contractors as they formulate their own GHP Program Integrity Plans.)

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The Contractor shall comply with the following **Medicaid Program Integrity** requirements:

A. Sixty (60) Calendar Days after the date of execution of the GHP Contract, the Contractor must submit to the ASES Compliance Office a copy of the policies and procedures for (i) identifying and tracking potential provider fraud cases, (ii) conducting preliminary and full investigation, and (3) referring cases of suspected fraud to an appropriate law enforcement agency. This Compliance Plan shall be developed in accordance with 42 CFR 438.608 and Section 13.2 of the Contract.

B. On a quarterly basis, each Contractor must submit to the ASES Compliance Office a report with the following information for the most recent quarter: (i) a list of preliminary and full investigations conducted and the results of such investigations, (ii) a list of all audits performed and any audit findings, (iii) a list of any administrative actions issued against Contractor, Subcontractors or Providers, (iv) a list of any overpayments and provider referrals referred to the Department of Justice or Medicaid Fraud Control Unit. If there are no such items to report, submit a certification signed by the Compliance Director and the Authorized Certifier attesting to that fact.

C. On a quarterly basis, each Contractor must submit to the ASES Compliance Office a report with the following information: (i) a list of fraud investigations pending but not yet initiated, (ii) a list of fraud investigations currently in progress, and (iii) a list of completed fraud investigations. If there are no such items to report, submit a certification signed by the Compliance Director and the Authorized Certifier attesting to that fact.

D. Each Contractor shall Immediately notify ASES of any suspected or confirmed instances of provider fraud, waste or abuse or enrollee abuse or neglect so that such cases can be referred to the appropriate federal or state agency, including but limited to the U.S. Department of Justice, the Office of Inspector General of the U.S. Department of Health and Human Services, or the Medicaid Fraud Control Unit.

E. Each Contractor must submit to the ASES Compliance Office a certification signed by the Compliance Director and the Authorized Certifier indicating that any full investigations were conducted in accordance with 42 CFR 455.15.

F. Each Contractor must notify ASES within two (2) Business Days to notify ASES of any adverse or negative action that the Contractor has taken with regard to a network provider application (upon initial application or application renewal), or any other action that limits the ability of providers to participate in the network or program, as set forth in Section 13.5.11 of the GHP Contract.

G. Each Contractor must ensure prompt terminations of inactive Providers due to inactivity in the past 12 months.

H. Each Contractor must assist in the Medicaid Provider Enrollment process as necessary to validate information submitted by providers. This assistance may include, but is not limited to, the following actions as required of all Contractors:

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1. Each Contractor must review the credentialing forms of all providers and any subcontractors performing services under the GHP Contract to ensure that any disclosures required by 42 CFR 455.104 are included.

2. Each Contractor must ensure all Provider Contracts incorporate appropriate language with regard to the ownership of, and any significant business transactions with, subcontractors to ensure that the disclosures required by 42 CFR 455.105 will be made. Each Contractor must also request that providers complete a business transactions form and verify compliance with this regulation.

3. Each Contractor must establish a method to capture criminal convictions and other adverse actions for any individuals or entities with ownership and control interests in the provider, as well as for any managing employees of the provider, to ensure that the disclosures required by federal regulation 42 CFR 455.106 have been made.

4. The Contractor must develop and implement procedures to ensure that such convictions and other actions identified during the Contractor's credentialing and contracting process are reported Immediately to ASES in accordance with GHP contract requirements. Copies of such procedures shall be submitted to the ASES Compliance Office.

5. Each Contractor must submit to the ASES Compliance Office a certification signed by the Compliance Director and the Authorized Certifier certifying all of the above.

I. Each Contractor must comply requirements set forth in 42 CFR 455.20 and 42 CFR 438.608(a)(5) to ensure that services represented to have been delivered by network providers were in fact received by enrollees. The Contractor shall document in a quarterly report compliance with these regulations.

J. Each Contractor shall conduct a risk assessment of the Contractor's various Fraud, Waste, and Abuse processes. The risk assessment shall include a listing of the Contractor's top three (3) vulnerable areas and outline action plans to mitigate risks.

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Introduction

Under the authority of Sections 1902(a)(4), 1903(i)(2), and 1909 of the Social Security Act the Medicaid Program must have a program to detect and investigate fraud, waste and abuse. Medicaid Managed Care Organizations (hereinafter "Contractors") have similar responsibilities as set forth in 42 CFR 438.608.

The Puerto Rico Government, the Department of Health, and the Medicaid Office, acting as the single state agency, are responsible for the management of the Medicaid and SCHIP grant funds. These funds are transferred to the Puerto Rico Health Insurance Administration (ASES), and are combined with state funds to provide health benefits coverage to the medically indigent population through contracts with health plans. Acting as a sub-grantee to the Puerto Rico Medicaid Program, ASES establishes contracts with Contractors and other organizations to facilitate enrollee access to covered services through provider networks.

Program Integrity Program Basis and Scope

This document sets forth guidelines with minimum criteria for the compliance with Program Integrity Policies and Procedures that each Contractor must have for the administration of the Government Health Plan as set forth in Article 13 of the Contract. This document includes guidelines for the elaboration of the three (3) main sections in the Contractors' Program Integrity Plan (PIP):

1. Fraud Detection and Investigation
2. Providers and Fiscal Agents Disclosure of Information on Ownership and Control
3. Program Integrity Program

Regulation Citation

Sections 1902(a)(4) [42 USC 1396(a)(4)1, (61)2, (64)3]; 1903(i)(2) [42 USC 1396(b)(i)(2)]4 1936[42 USC 1396u-6]5) and regulations at 42 CFR Parts 438, 455, 1001 and 1002.

Overall Requirement

In accordance with ASES's obligations under 42 CFR 455.436 and the CMS State Medicaid Director Letter #09-001, all Contractors and Providers are required to regularly perform the federal database searches set forth at 42 CFR 455.436 upon enrollment and re-enrollment as well as on a monthly basis thereafter.

Contractors are also required to notify ASES, which shall in turn notify the Department of Health and Human Services-Office of Inspector General (HHS-OIG), of any action taken to limit the ability of an individual or entity to participate in its program, as stated in 42 CFR 1002.3.

Each Contractor must consult ASES prior to taking any proposed actions on a Provider Contract based on program integrity concerns. Contractors shall report each provider whom it proposes to disenroll, suspend, terminate or otherwise restrict from participation in its provider network based on program

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integrity concerns. Contractors are required to report such affected providers directly to ASES for potential referral to HHS-OIG and the Medicaid Fraud Control Unit.

Definitions

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Contract means The written agreement between ASES and the Contractor for the GHP; comprised of the Contract, any addenda, appendices, attachments, or amendments thereto.

Contractor means the Managed Care Organization that is a Party of this Contract, licensed as an insurer by the Puerto Rico Commissioner of Insurance ("PRICO"), which contracts hereunder with ASES under the GHP program for the provision of Covered Services and Benefits to Enrollees on the basis of PMPM Payments.

Conviction or *Convicted* means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

Disclosing Entity means a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.

Exclusion means that items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit for him/her or some other person. It includes any act that constitutes fraud under applicable Federal or Puerto Rico law.

Furnished refers to items and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a provider, or other supplier of services. (For purposes of denial of reimbursement within this part, it does not refer to services ordered by one party but billed for and provided by or under the supervision of another.)

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Immediately means within twenty-four (24) hours.

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Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

(b) Any Medicare intermediary or carrier; and

(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Person with an ownership or control interest means a person or corporation that—

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

Provider or Practitioner means a physician or other individual licensed under Puerto Rico law to practice his or her profession.

Program Integrity Plan (PIP) means the program, processes and policies that each Contactor has implemented to comply with integrity requirements. The PIP shall be developed in accordance with federal regulations and these guidelines.

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Provider Contract means any written contract between the Contractor and a Provider that requires the Provider to order, refer, provide or render Covered Services under this Contract. The execution of a Provider Contract makes the Provider a Network Provider.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means—

(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Stakeholder means the single state agency, the sub-grantee and all organizations contracted to provide health care management and services to Medicaid beneficiaries.

Suspension means that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

Termination means—

(1) For a—

(i) Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and

(ii) Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.

(2)(i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary.

(ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.

(3) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to—

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(i) Fraud;
(ii) Integrity; or
(iii) Quality.

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

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Program Integrity Plan

Fraud Detection and Investigation (Sub Part A) represents the first element that must be included as part of program integrity activities. The Contractors must also comply with required elements for disclosure of information by providers and Subcontractors (Sub Part B) as well as provider screening and enrollment (Sub Part E).

All Contractors, and any Subcontractors delegated responsibility for the coverage of services and payment of claims under the GHP Contract must have dedicated staff, resources, and policies and procedures to detect and prevent Fraud, waste, and Abuse in accordance with Federal and Puerto Rico regulations. Contractors shall have written policies setting forth (i) methods for the identification, investigation and referral of suspected cases; (ii) procedures to perform preliminary investigations and full investigations; (iii) procedures to address the resolution of full investigations; (iv) procedures to comply with reporting requirements; and (v) policies for assessing provider's statements and attestations, such as those included in any reports, claims or other submissions. These policies and practices must also address cooperation with the Puerto Rico Government and the Medicaid Fraud Control Unit as well as procedures to withhold payments in cases of credible allegations of Fraud. Contractors are required to submit to the ASES Compliance Office a copy of their PIPs for evaluation by August 12, 2018 and annually thereafter. The PIP shall be developed in accordance with 42 CFR 438.608 and the guidelines provided herein.

Each guideline includes the name or title of the guideline, scope, purpose, process and general information. This document shall be incorporated as Attachment 14 to the GHP Contract each Contractor holds with ASES.

The Program Integrity Plan (PIP) of each Contractor shall be monitored by ASES on a periodic basis. ASES shall reserve the right to request changes to the Contractor's PIP as necessary to address any actual or potential non-compliance or program integrity issues.

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Title SA1	State Plan Requirements
Scope	Applies to Single State Agency (Medicaid Office) and Sub-Grantee (ASES)
Purpose	This guideline describes the commitment of the single state agency and the sub-grantee in adhering to the statute rules and regulations and the implementation of a Program Integrity Plan for the Medicaid Program.
General	The grantee and the sub-grantee will abide by the following guidelines on how to manage the integrity program activities in the whole service delivery system.
Guidelines	1. The single state agency and sub-grantee acknowledge the need to adhere to a Medicaid Integrity Program as defined in the state plan. 2. The grantee and sub-grantee agree to establish a structure to manage Program Integrity Plan (PIP) activities. 3. The organization structure to perform above mentioned activities is furnished with a Program Integrity Plan (PIP) of members representing the single state agency, the sub-grantee and each contracted organization. 4. The PIP leads the efforts toward achieving compliance with state plan requirements regulation by establishing the minimum criteria of required PI program policies and procedures. 5. The PIP monitors Contractor's PIP compliance on regular basis. 6. The PIP chairman develops the meeting calendar each year, develops the committee agenda, and keeps minutes of all meetings and call for meetings. 7. Sub-grantee facilitates the development and update of the Program Integrity Plan guidelines, reports and notification to guarantees its distribution and final acceptance among contracted companies and regulatory agencies. 8. Sub-grantee review performance of each organization, level of adherence to policies and recommend corrective action plan development for areas that must be improved. 9. Sub-grantee develops an annual report that is to be submitted to the Medicaid Integrity Group and to the CMS Region 2. The report will include the areas and companies reviewed during the period and the findings of each company, if any. 10. The PIP provides guidance and guarantees that each contracted companies develop and implement policies and procedures in their organizations. 11. The PIP guidelines are integrated into each Contractor's Program Integrity Plan Policies and Procedures; and are assumed as a standard operating procedure to prevent fraud, waste and abuse in the management of Medicaid funds and health plan benefit coverage for the indigent population.

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Title SA02	Methods for identification, investigation and referral
Scope	Grantee, Sub-grantee and Contractors
Purpose	This guide describes what the Contractor must include in their PIP to guarantee the use of methods for the identification, investigation, and referral of suspected fraud and abuse cases.
General	The Contractor must establish methods for the identification, investigation and referral of suspected cases, that guarantees the use of a consistent and objective approach that does not infringe on the rights of the persons involved to address fraud, waste and abuse when performing PIP activities.
Guidelines	The PIP must include an explicit definition of methods to perform identification of cases suspected of fraud, waste and abuse a. what is fraud, waste and abuse b. how is detected fraud, waste and abuse c. who performs the identification d. when preliminary, full investigation and resolutions are done The PIP must have a detailed process to perform investigations on each suspected case guaranteeing objective methods to identify potential cases and perform investigations a. open and documents the case b. initiate data gathering process c. follow a protocol to verify information d. issue a report of findings e. refer case to next level f. close the case The PIP must include a variety of methods for the identification, investigation and referral of suspected cases, accepted in the industry and without infringing provider or beneficiary rights. Methods might include a. electronic data exchanges b. data mining c. claims registries / reconciliation d. targeted procedures e. profiling The PIP must include a systematic approach of data analysis by: a. flagging the case b. identifying cause for flagging (i.e. over-under payment) c. establishing actions and sanctions The PIP must have procedures in place for referring suspect fraud cases to ASES including at a minimum:

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Guidelines	a. an organizational structure to address the reports. b. a due process that includes but is not limited to: case identification, complete record with supporting materials, notification letter to suspect, notification letter to single state agency, documentation of entrance and exit interviews, and if necessary copy of referral letters and case resolution letter to and from legal authorities. c. a flowchart to work in cooperation with the grantee and sub-grantee as well as with the state legal authorities such as: Contractor's Legal Affairs Department, ASES, Single State Agency – Department of Health Legal Department, State Department of Justice, and the Office of Inspector General. d. a follow up process to work with legal authorities each case of fraud, waste and abuse suspicion until final disposition and notification to the single state agency.

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Title SA03	Preliminary Investigations
Scope	Grantee, Sub-grantee and Contractors
Purpose	To provide guidance on how to perform a preliminary investigation when the agency or Contractor receives a complaint of fraud or abuse from any source or identifies any questionable practices.
General	The Contractor must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.
Guidelines	The PIP defines a standard operating procedure to complete a preliminary investigation of all suspect cases of fraud, waste and abuse. The PIP identifies the requirements to complete the preliminary investigation when evaluating providers and beneficiaries. It should include at least: a. Source of information b. Identification method (how the case is detected) c. Cause for investigation d. Case documentation e. Analysis of Data and documents f. Report of Findings g. Action Taken (Recommended Action) The PIP includes a mechanism to keep tracking and documentation of all preliminary investigations and results. The PIP establishes a mechanism to report preliminary investigations activity to the sub-grantee (ASES) which will be in charge of reporting activity to the single state agency (Medicaid Office) or other applicable federal and state agencies.

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Title SA04	Full Investigations
Scope	Grantee, Sub-grantee and Contractors
Purpose	To provide guidance and minimum set of elements in the PIP to perform full investigations on incidents of fraud and abuse.
General	If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the organization must take the appropriate actions.
Guidelines	The PIP must define the process to conduct a full investigation and specify when a case requires the full investigation. Full investigations must be done in accordance with federal regulation and based in the company written policy. The company must submit copy of the written policies to ASES for review and approval. The PIP must define the process to refer the cases to the Contractor's fraud liaison (i.e. Contractor's compliance office), to the single state agency (Medicaid Office), and to ASES which will be in charge of referring the case to the appropriate law enforcement agency when there is a reason: a. to suspect a provider has engaged in fraud or abuse of the program. b. to suspect a beneficiary is defrauding the program. c. to suspect a beneficiary has abused the Medicaid program. The PIP must have a mechanism to keep tracking and documentation of all full investigations performed in progress and closed. The PIP must have a mechanism to report to the sub-grantee (ASES) investigations in progress, conducted and results.

Title SA05	Resolution of full investigation
Scope	Grantee, Sub-Grantee and Contractors
Purpose	To provide guidance on minimum actions that must be taken in order to complete the process of a full investigation.
General	The full investigations must continue until the cases are referred, solved or closed.
Guidelines	The PIP must include the process to guarantee that a full investigation must continue until: a. appropriate legal action is initiated. b. the case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse; or c. the matter is resolved between the organization and the provider or beneficiary ✓ The resolution may include but is not limited to: 1) Sending a warning letter to the Provider or beneficiary, giving notice that continuation of the activity in question will result in further action; 2) Suspending or terminating the Provider from network participation (if not suspended or terminated from participation in the Medicaid program as determined by ASES); 3) Seeking recovery of payments made to the Provider; or 4) Imposing other sanctions provided under the Contractor's PIP plan. The PIP must guarantee that there is a mechanism to keep tracking and documentation of all full investigations until resolution.

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Title SA06	Reporting Requirements
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on how to adhere to a minimum set of elements that must be included in the process to report fraud and abuse information to the appropriate organizations officials.
General	The Contractor must submit a progress report of the fraud and abuse information and statistics to ASES on quarterly basis.
Guidelines	The PIP must describe the mechanism to report fraud and abuse data to the appropriate fraud liaison, sub-grantee (ASES) and grantee (Office for the Medically Indigent). The PIP progress report must include at least the following information: a. # of complaints on fraud and abuse received. b. # of complaints that warrant preliminary investigation. c. Detailed information for each case of suspected provider fraud and abuse that warrants a full investigation: ✓ Provider's name and ID number ✓ Source of the complaint ✓ Type of provider ✓ Nature of the complaint ✓ Estimate amount of money involved ✓ Legal and administrative disposition of the case and actions taken by the law enforcement officials to whom the case has been referred. Suspected fraud cases must be reported immediately in a written format to ASES Compliance Office or Office of Program Integrity. The PIP reports must be submitted in electronic format to facilitate its inclusion in the Puerto Rico Government Medicaid Program PI Annual Report.

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Title SA07	Provider's statements on claims forms
Scope	Grantee, Sub-Grantee and Contractors
Purpose	To provide guidance on how to comply with regulation on Provider's statements on claims forms.
General	The Contractor must provide that all provider claims forms be imprinted in boldface type with the following statement, or with alternate wording that is approved by the CMS Regional Office.
Guidelines	The PIP must include that providers are required to attest in the claim forms that they agree with the following statement: ✓ "This is to certify that the foregoing information is true accurate and complete". ✓ "I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact, maybe prosecutes under Federal and State laws". For electronic claims, providers must attest that they agree with the following statements: ✓ "This is to certify the truthfulness of the foregoing information and certify that is true, accurate, complete and that the service was provided". The statements may be printed above the claimant's signature or, if they are printed on the reverse of the form, a reference to the statements must appear immediately preceding the claimant's signature.

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Title SA08	Provider's statements on check
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on how to comply with regulation on provider's statements on check.
General	The Contractor may print the following wording above the claimant's endorsement on the reverse of checks or warrants payable to each provider.
Guidelines	The PIP must include that Providers are required to attest (in addition to the statements required in Providers claims form) that they agree with the following statement either by having it written on checks or temporarily in a legal document as an affidavit: ✓ "I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws". The above attestation must be included in all electronic and checks payment. The PIP must indicate frequency and responsible for conducting spot checks to guarantee the Contractor complies with the Provider's statements and / or the Provider signature appears on a legal document attesting compliance.

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Title SA09	Enrollee verification procedure
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To verify that the services listed on claims forms have been rendered.
General	The organization must have a method for verifying with Enrollees whether services billed by providers were received.
Guidelines	The PIP must include a description of how the Contractor performs claims matches with medical records to guarantee adequacy of billing. The PIP must define the mechanism to monitor frequency of encounters and services rendered to Enrollees billed by providers. The PIP will provide periodic updates on reconciliation findings report to the sub-grantee and grantee. ASES will select a sample to perform independent reviews to verify that Enrollee's services billed by providers (as well as encounters under capitated environment) were indeed rendered. This review will be performed through confirmations with Enrollees.

Note: All Contractors are required to comply with Law 114 which requires that the beneficiaries must receive an Evidence of Medical Benefits with a detailed of the services and expenses incurred during a quarter. ASES Compliance Office will review each Contractor's compliance with Law 114.

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Title SA10	Cooperation with Medicaid Fraud Control Units and/or law enforcement agencies
Scope	Grantee, Sub-Grantee and Contractors Organizations
Purpose	To provide guidance on how to communicate findings and to cooperate with any Puerto Rico or federal law enforcement agency. To request that all contracted companies must communicate preliminary findings to ASES.
General	The Contractor must have a mechanism to provide information to the regulatory and legal authorities on cases, investigations, schemes and any other activity where intention to commit fraud, abuse and waste of services occur.
Guidelines	The PIP must demonstrate it has an effective mechanism to cooperate with the Medicaid Office, ASES, the Medicaid Fraud Control Unit as well as with other program divisions in charge of preventing and prosecuting cases related to fraud, waste and abuse of services under the Medicaid program. To this end, ASES has established the Medicaid Integrity Group (MIG) with the participation of the OIG and the Medicaid office. The PIP must establish a process to guarantee that the organization complies with the following: ✓ All cases of suspected provider fraud are referred to the antifraud / integrity organization's unit. ✓ If the antifraud / integrity unit determines that it may be useful in carrying out the unit's responsibilities, promptly comply with a request from the unit for -- i. Access to, and free copies of, any records or information kept by the organization or its contractors; ii. Computerized data stored by the organization or its contractors. These data must be supplied without charge and in the form requested by the unit; iii. Access to any information kept by providers to which the organization is authorized access. In using this information, the unit must protect the privacy rights of beneficiaries; ✓ Communicate to ASES (and other appropriate Federal and State agencies, as required) preliminary findings within 2 business days of completing the investigation; and ✓ On referral from the unit, coordinate with ASES and the appropriate law enforcement agency before initiating any available administrative or judicial action to recover improper payments to a provider.

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	The PIP must recommend the Contractor to have in the Provider's Contract a disclaimer that as a contracted provider any data related to services or payments provided must be available for review of the integrity staff.

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Title SA11	Suspension of payments in cases of potential fraud
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on elements to be considered when suspending payments to providers who committed fraud.
General	The organization must suspend payments to providers as a mechanism to prevent wrong disbursement of payments when there is a credible allegation of fraud for which an investigation is pending unless the agency has a good cause to not suspend payments or to suspend payment only in part.
Guidelines	The PIP will establish a mechanism and adhere to the following elements concerning suspension of payments: (a) *Basis for suspension*. • The State Medicaid Agency (ASES) must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part. • The State Medicaid Agency (ASES) may suspend payments without first notifying the provider of its intention to suspend such payments. • A provider may request, and must be granted, administrative review where State law so requires. Therefore, the Contractor must refer to ASES all suspected cases of fraud as indicated in item (d) below, in order for ASES to make a determination related to the suspension of payment after the proper evaluation and in consultation with the applicable law enforcement agency, such as the Medicaid Fraud Control Unit. In addition, the Contractor must suspend payments at the direction of ASES if ASES finds that a credible allegation of fraud exists for which an investigation is pending under the Medicaid program. (b) *Notice of suspension*. If directed by ASES, the Contractor must send notice of its suspension of program payments within: • Five (5) days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold such notice. • Thirty (30) days if requested by law enforcement in writing to delay sending such notice, which request for delay may be

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renew in writing up to twice and in no event may exceed ninety (90) days.

- The notice must include or address all of the following:
  - ✓ State that payments are being suspended in accordance with 42 CFR 455.23;
  - ✓ Set forth the general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation
  - ✓ State that the suspension is for a temporary period, as stated on 42 CFR 455.23(c) and cite the circumstances under which suspension will be terminated;
  - ✓ Specify, when applicable, to which type or types of Medicaid claims (capitation or claims) or business units of a provider suspension is effective.
  - ✓ Inform the provider of the right to submit written evidence for consideration by the agency.
  - ✓ Set forth the applicable administrative appeals process and corresponding citations to State law.

(c) *Duration of suspension*

1) All suspension of payment actions under this section will be temporary and will not continue after either of the following:

- ✓ The agency or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider.
- ✓ Legal proceedings related to the provider's alleged fraud are completed.

2) It must be documented in writing the termination of a suspension including, where applicable and appropriate, any appeal rights available to a provider.

(d) *Referrals to the ASES, Medicaid, Medicaid Fraud Control Unit and OIG.*

(1) Whenever the Contractor investigation may lead to the initiation of a payment suspension in whole or part, the Contractor must make a fraud referral to ASES who will notify the OIG and the Medicaid Fraud Control Unit and any other appropriate law enforcement agency as required by 42 CFR 455.23(d)

(2) The fraud referral must meet all of the following requirements:

- Be made in writing and provided to ASES not later than the next two (2) Business Days after the Contractor determines that there is a potential fraud.
- Conform to fraud referral performance standards issued by the Secretary.
- A recommendation of the Contractor related to good cause not to suspend payments or to suspend payment only in part after evaluating the elements included in items (e) and (f) below.

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(3)(i) If the Medicaid Fraud Control Unit or other law enforcement agency accepts the fraud referral for investigation, a payment suspension may be approved until such time as the investigation and any associated enforcement proceedings are completed.

(ii) On a quarterly basis, the Contractor must request a certification from the Medicaid Fraud Control Unit or other law enforcement agency that any matter accepted on the basis of a referral continues to be under investigation thus warranting continuation of the suspension.

(4) If the Medicaid Fraud Control Unit or other law enforcement agency declines to accept the fraud referral for investigation, an approved payment suspension may be discontinued by ASES unless ASES has alternative Federal or State authority by which it may impose a suspension or makes a fraud referral to another law enforcement agency. In that situation, the provisions of paragraph (d)(3) of this section apply equally to that referral as well.

(5) A decision to exercise the good cause exceptions in paragraphs (e) or (f) of this section not to suspend payments or to suspend payments only in part does not relieve the Contractor of the obligation to refer any suspected case of fraud as provided in paragraph (d)(1) of this section.

(e) *Good cause not to suspend payments.* ASES may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

(1) Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

(2) Other available remedies can be implemented by Contractor more effectively or quickly protect Medicaid funds.

(3) ASES determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed.

(4) Beneficiary access to items or services would be jeopardized by a payment suspension because of either of the following:

(i) An individual or entity is the sole community physician or the sole source of essential specialized services in a community.

(ii) The individual or entity serves a large number of beneficiaries within a HRSA-designated medically underserved area.

(5) Law enforcement declines to certify that a matter continues to be under investigation per the requirements of paragraph (d)(3) of this section.

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(6) ASES determines that payment suspension is not in the best interests of the Medicaid program.

(f) *Good cause to suspend payment only in part.* ASES may find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to an individual or entity against which there is an investigation of suspected fraud if any of the following are applicable:

(1) Beneficiary access to items or services would be jeopardized by a payment suspension in whole or part because of either of the following:

(i) An individual or entity is the sole community physician or the sole source of essential specialized services in a community. (ii) The individual or entity serves a large number of beneficiaries within a HRSA-designated medically underserved area.

(2) ASES determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension to the Contractor, that such suspension should be imposed only in part.

(3)(i) The allegation of fraud focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and

(ii) Contractor documents in writing to ASES that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.

(4) Law enforcement, Medicaid Fraud Control Unit or OIG declines to certify that a matter continues to be under investigation per the requirements of paragraph (d)(3) of this section.

(5) ASES determines that payment suspension only in part is in the best interests of the Medicaid program.

g) Termination of Payment Suspension:

1. Reasons for termination of payment suspension:
   a. determination by the Medicaid Fraud Control Unit that there is insufficient evidence of fraud by the provider
      i. law enforcement declination to investigate a fraud referral
      ii. discontinuance of a pending investigation
   b. legal proceedings related to the provider's alleged fraud are completed
      i. settlement
      ii. judgment
      iii. dismissal
2. The following steps will be taken when the Payment Suspension process is to be discontinued:
   a. ASES will notify the entity in writing with effective date to end payment suspension

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b. The entity must notify the provider in writing of effective date to end payment suspension and will provide blind copies to previously identified parties.
c. The entity must take the necessary action to remove the payment suspension.

3. After payment suspension has ended, Contractor is responsible for monitoring claims to ascertain whether or not any inappropriate payments are made or to identify aberrant billing patterns, in which case appropriate action will be initiated.
4. Contractor must submit to ASES on a quarterly basis a report summarizing information on the following:
   a. With regard to recommended payment suspensions:
      1. The nature of the suspected fraud;
      2. The basis for the proposed suspension; and
      3. The outcome of implemented suspensions.
   b. With regard to situations in which Contractor recommends that good cause exists to not suspend payments, to suspend payments only in part, or to discontinue a payment suspension:
      1. The nature of the suspected fraud; and
      2. The nature of the good cause.

(h) *Documentation and record retention.* Contractor must meet the following requirements:

(1) Maintain for a minimum of ten (10) years from the date of issuance all materials documenting the life cycle of a payment suspension that was imposed in whole or part, including the following:

(i) All notices of suspension of payment in whole or part.

(ii) All fraud referrals to the Medicaid Fraud Control Unit or other law enforcement agency.

(iii) All quarterly certifications of continuing investigation status by law enforcement.

(iv) All notices documenting the termination of a suspension.

(2)(i) Maintain for a minimum of ten (10) years from the date of issuance all materials documenting each instance where a payment suspension was not imposed, imposed only in part, or discontinued for good cause.

(ii) This type of documentation must include, at a minimum, detailed information on the basis for the existence of the good cause not to suspend payments, to suspend payments only in part, or to discontinue a payment suspension and, where applicable, must specify how long the Contractor anticipates such good cause will exist.

(3) Annually report to ASES summary information on each of following:

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		(i) Suspensions of payment, including the nature of the suspected fraud, the basis for suspension, and the outcome of the suspension. (ii) Situations in which the good cause existed to not suspend payments, to suspend payments only in part, or to discontinue a payment suspension as described in this section, including describing the nature of the suspected fraud and the nature of the good cause.

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Title SB12	Disclosure of Information by Providers and Fiscal Agents
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide definition of concepts in order to fully adhere to the regulation on providers control and ownership of facilities and on disclosure of information on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, or the title XX services program.
General	The Contractor must adhere to standard definitions when dealing with disclosure of information by providers and Subcontractors when establishing mechanism to regulate providers' control and ownership of facilities
Guidelines	The PIP will adhere to the following definitions of concepts to keep consistency with federal regulation and application of law: *Agent* means any person who has been delegated the authority to obligate or act on behalf of a Provider. *Disclosing entity* means a Medicaid Provider (other than an individual practitioner or group of practitioners), or a fiscal agent. *Other disclosing entity* means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the federal programs (Medicaid, CHIP, FQHCs). This includes: (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII); (b) Any Medicare intermediary or carrier; and (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act. *Fiscal agent* means a contractor that processes or pays vendor claims on behalf of the Medicaid agency. *Group of practitioners* means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment). *Indirect ownership interest* means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. The amount of indirect ownership interest is determined by multiplying

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	the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.
Guideline	*Managing employee* means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. *Ownership interest* means the possession of equity in the capital, the stock, or the profits of the disclosing entity. *Person with an ownership or control interest* means a person or corporation that – (a) Has an ownership interest totaling 5 percent or more in a disclosing entity; (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity; (c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity; (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; (e) Is an officer or director of a disclosing entity that is organized as a corporation; or (f) Is a partner in a disclosing entity that is organized as a partnership. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported. *Significant business transaction* means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses. *Subcontractor* means –

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	(a) An individual, agency or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or (b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement. *Supplier* means an individual, agency or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm). *Wholly owned supplier* means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

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Title SB13	Disclosure by disclosing entities: Information on ownership and control.
Scope	Grantee, Sub-Grantee and Contractors
Purpose	To provide guidelines on what information must be disclosed by entities that have ownership and control over facilities.
General	The Contractor must have a mechanism to monitor on a timely manner the providers and fiscal agents that own or control facilities where Medicaid beneficiaries receive services.
Guidelines	The Contractor must require each disclosing entity to disclose the following information in a timely manner: (a) *Type of Information that must be disclosed.* (1) (i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or the entity contracted by ASES. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. (ii) Date of birth and Social Security Number (in the case of an individual). (iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or the entity contracted by ASES) or in any subcontractor in which the disclosing entity (or fiscal agent or the entity contracted by ASES) has a 5 percent or more interest. (2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or the entity contracted by ASES) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or the entity contracted by ASES) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling. (3) The name of any other disclosing entity (or fiscal agent or the entity contracted by ASES) in which an owner of the disclosing entity (or fiscal agent or the entity contracted by ASES) has an ownership or control interest. (4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or the entity contracted by ASES). *(b) When the disclosures must be provided.*

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	(1)Disclosures from providers or disclosing entities. Disclosure from any Provider or disclosing entity is due at any of the following times: (i) Upon the provider or disclosing entity submitting the provider application. (ii) Upon the provider or disclosing entity executing the provider agreement. (iii) Upon request of ASES during the re-validation of enrollment process under § 455.414. (iv) Within 35 days after any change in ownership of the disclosing entity. (2) Disclosures from Contractors or other state-contracted entities - Disclosures are due at any of the following times: (i) Upon submitting the proposal in accordance with the State's procurement process. (ii) Upon executing the contract with the State. (iii) Upon renewal or extension of the contract. (iv) Within thirty five (35) days after any change in ownership of the fiscal agent, manage care organizations or contracted entity. Updated information must be furnished to ASES or the Contractor, as applicable, at intervals between recertification or contract renewals, within thirty five (35) days of a written request. *(c) Consequences for failure to provide required disclosures.* ✓ Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section. ✓ The Contractor shall not approve a Provider Contract, and must terminate an existing agreement or contract, if the Provider or fiscal agent fails to disclose ownership or control information as required by this section. The PIP will include the process to provide an annual report to ASES on above information and data.

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Title SB14	Disclosure by providers: Information related to business transactions.
Scope	Grantee, Sub-Grantee and Contractors
Purpose	The Contractor must establish a mechanism to facilitate the Providers disclose information related to their business transactions when own or control facilities where Medicaid beneficiaries received services.
Guidelines	The PIP must describe the mechanism to allow providers owning or controlling facilities disclose information related to business transactions. The PIP must attest the organization abide by the following regulation: (a) *Provider Contracts*. The Contractor must enter into an agreement with each Provider or Provider group under which the Provider agrees to furnish to it or to the grantee / sub-grantee on request, information related to business transactions. (b) *Information that must be submitted.* A Provider must submit, within 35 days of the date on a request by the organization full and complete information about – ✓ The ownership of any Subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and ✓ Any significant business transactions between the Provider and any wholly owned Supplier, or between the Provider and any Subcontractor, during the 5-year period ending on the date of the request. The PIP must include withholding of payment processes and procedures to enforce above guideline.

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Title SB15	Disclosure by Providers: Information on persons convicted of crimes
Scope	Grantee, Sub-Grantee and Contractors
Purpose	To provide guidance on type of information providers must report in compliance with integrity program.
General	The Contractor is obliged to request providers to report any conviction of crimes or any other in the program integrity regulation.
Guidelines	The PIP must include a mechanism to confirm that information included below is considered as part of the integrity activities. (a) *Information that must be disclosed*. Before the Contractor enters into or renews a Provider Contract, or at any time upon written request by the Contractor, the Provider must disclose to the Contractor the identity of any person who: (1) Has ownership or control interest in the Provider, or is an agent or managing employee of the provider; and (2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XXI services program since the inception of those programs. (b) *Notification to Inspector General*. (1) The Contractor must notify ASES of any disclosures made under paragraph (a) of this section within 20 Business Days from the date it receives the information, as set forth in Section 29.4 of the GHP Contract. (c) ASES will notify the HHS Inspector General and the Medicaid Fraud Control Unit of any disclosures related to criminal convictions within twenty (20) Business Days from the date that ASES receives the information (Section 29.6) *Denial or termination of provider participation.* (1) The Contractor may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the Provider, or who is an agent or managing employee of the Provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program. (2) The Contractor may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

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Title SE16	Provider Screening and Enrollment
Scope	Grantee, Sub-Grantee and Contractors
Purpose	To provide guidance on termination or denial of network participation and criminal background checks.
General	The Contractor is obligated to establish procedures for termination of Provider Contracts and to obtain Provider consent to criminal background checks.
Guidelines	The PIP must include a process to confirm that the requirements included below are considered as part of the integrity activities. 1. Terminations or denials -: (a) Contractor shall terminate the Provider Contract of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any required screening methods in 42 CFR part 455. (b) Contractor shall not offer a Provider Contract to any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years, unless ASES determines that denial or termination of enrollment is not in the best interests of the Medicaid program and that determination is documented in writing. (c) ASES must deny enrollment or terminate the enrollment of any provider that is terminated on or after January 1, 2011, under Medicare and Medicaid, or CHIP in any other State. (d) ASES must terminate a provider's enrollment or deny enrollment of the provider if the provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information, unless ASES determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing. (e) ASES must terminate or deny enrollment if the provider, or any person with a 5 percent or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the ASES within 30 days of a CMS or a ASES request, unless ASES determines that termination or denial of enrollment is not in the best interests of the Medicaid program and ASES documents that determination in writing.

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	(f) ASES must terminate or deny enrollment if the provider fails to permit access to provider locations for any site visits under § 455.432, unless ASES determines that termination or denial of enrollment is not in the best interests of the Medicaid program and that determination is documented in writing. (g) ASES may terminate or deny the provider's enrollment if: (1) it is determined that the provider has falsified any information provided on the application; or (2) the identity of any provider applicant cannot be verified. 2. Reactivation of Provider Contract After terminating a Provider Contract for any reason, before the provider is offered a new Provider Contract, the Contractor must re-screen the provider. 3. Criminal background checks As a condition of executing a Provider Contract, the Contractor must require providers to consent to criminal background checks including fingerprinting when required by ASES, law enforcement agencies or Puerto Rico law. 4. Verification of Provider License As a condition of executing a Provider Contract, the Contractor must confirm that the provider purporting to be licensed in accordance with the laws of Puerto Rico is so licensed and that the provider's license has not expired or is currently subject to any limitations.

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Title SE17	Screen to Confirm the Identity and Exclusions Status
Scope	Grantee, Sub-Grantee and Contractors
Purpose	To provide guidance on the process to confirm the identity and determine exclusion status
General	The Contractor is obligated to confirm the identity and determine the exclusion status of Providers and any person with an ownership or control interest or who is an agent or managing employee of the Provider through routine checks of Federal databases.
Guidelines	The PIP must ensure Provider compliance with screening employees for identity and exclusions. To further protect against payments for items and services furnished or ordered by excluded parties, all current Providers and providers applying to contract with the Contractor must take the following steps to confirm identities and to determine whether their employees and contractors are excluded individuals or entities: ✓ Providers have the obligation to screen all employees and subcontractors to confirm the identity and determine the exclusion status through routine checks of Federal databases. The Contractor should communicate this obligation to providers. ✓ Providers should explicitly be required to agree to comply with this obligation as a condition of contracting. ✓ Providers should be informed that they must search the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe. ✓ Contractors and Providers should search the LEIE and EPLS no less frequently than monthly to capture exclusions and reinstatements that have occurred since the last search. ✓ Providers should be required to immediately report to the Contractor any exclusion information discovered. Contractors are required to immediately report to ASES any exclusion information discovered. This line of defense in combating fraud and abuse must be conducted accurately, thoroughly, and routinely. The Contractor must notify ASES promptly of any administrative action recommended against a provider for failure to comply with these screening and reporting obligations. *See* 42 CFR section 1002.4(b)(3). The Contractor can satisfy this obligation by communicating the relevant information to ASES, whom shall notify the and the appropriate Regional Office of the OIG Office of Investigations and the Medicaid Fraud Control Unit. The Contractors also should inform Providers that civil monetary penalties may be imposed by ASES against Medicaid providers and entities contracted by ASES who

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	employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. (Section 1128A(a)(6) of the Act; and 42 CFR section 1003.200(a)(3)).

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL #09-001

January 16, 2009

Dear State Medicaid Director:

The Center for Medicaid and State Operations (CMSO) is issuing this State Medicaid Director Letter to strengthen the integrity of the Medicaid program and help States reduce improper payments to providers. This letter advises States of their obligation to direct providers to screen their own employees and contractors for excluded persons. This letter specifically:

(1) Clarifies Federal statutory and regulatory prohibitions regarding Medicaid payments for any items or services furnished or ordered by individuals or entities that have been excluded from participation in Federal health care programs;

(2) Reminds States of the consequences for failure to prevent payments for items or services furnished or ordered by excluded individuals and entities;

(3) Sets forth the Centers for Medicare & Medicaid Services' (CMS) policy with respect to States' responsibility to communicate to providers their obligation to screen employees and contractors for excluded individuals and entities both prior to hiring or contracting and on a periodic basis, and the manner in which overpayment calculations should be made; and

(4) Identifies the List of Excluded Individuals/Entities (LEIE) as a resource providers may utilize to determine whether any of their employees and contractors has been excluded.

Background

The HHS Office of Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all Federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including sections 1128, 1128A, and 1156.

When the HHS-OIG has excluded a provider, Federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. (Section 1903(i)(2) of the Act; and 42 CFR section 1001.1901(b)) This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

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- all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;
- payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and
- payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded. (42 CFR section 1001.1901(b))

The listing below sets forth some examples of types of items or services that are reimbursed by Medicaid which, when provided by excluded parties, are not reimbursable*:

- Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are reimbursed directly or indirectly (such as through a pay per service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients;
- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by excluded ambulance drivers, dispatchers and other employees involved in providing transportation reimbursed by a Medicaid program, to hospital patients or nursing home residents;
- Services performed for program recipients by excluded individuals who sell, deliver or refill orders for medical devices or equipment being reimbursed by a Medicaid program; Services performed by excluded social workers who are employed by health care entities to provide services to Medicaid recipients, and whose services are reimbursed, directly or indirectly, by a Medicaid program;
- Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Medicaid program;

* This list is drawn from the 1999 HHS-OIG Special Advisory Bulletin: The Effect of Exclusion From Participation in Federal Health Care Programs.

- Items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Medicaid program; and

- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients and reimbursed, directly or indirectly, by a Medicaid program.

Consequences to States of Paying Excluded Providers

Because it is prohibited by Federal law from doing so, CMS shall make no payments to States for any amount expended for items or services (other than an emergency item or service not provided in a hospital emergency room) furnished under the plan by an individual or entity while being excluded from participation (unless the claim for payment meets an exception listed in 42 CFR section 1001.1901(c)). Any such payments actually claimed for Federal financial participation constitute an overpayment under sections 1903(d)(2)(A) and 1903(i)(2) of the Act, and are therefore subject to recoupment. It is thus incumbent on States to take all reasonable steps to prevent making payments that must ultimately be refunded to CMS.

Previous Guidance Regarding Preventing Payments For Goods and Services Furnished by Excluded Individuals and Entities

In a State Medicaid Director Letter issued on June 12, 2008, CMS notified States of their own obligation to attempt to determine whether an excluded individual has an ownership or control interest in an entity that is a Medicaid provider, and of States' obligation to report information regarding such excluded individuals to the HHS-OIG. In a State Medicaid Director Letter issued on March 17, 1999, and in a follow-up State Medicaid Director Letter issued on May 16, 2000 ("Medicare/Medicaid Sanction Reinstatement Report"), CMS described the HHS-OIG's authority to exclude persons based on actions taken by State Medicaid Agencies.

In the State Medicaid Director Letter dated May 16, 2000, CMS reminded States that the Medicare/Medicaid Sanction-Reinstatement Report, formerly known as HCFA Publication 69 and now replaced by the Medicare Exclusion Database (the MED) is a vital resource available to States for ascertaining and verifying whether an individual or entity is excluded and should not be receiving payments. The guidance also stated that the payment prohibition applies to any managed care organization contracting with an excluded party.

In a second State Medicaid Director Letter dated May 16, 2000 ("State's Obligation to notify the Department of Health and Human Services Office of Inspector General"), CMS reminded States of their responsibility to promptly notify the HHS-OIG of any action taken by a State to limit the ability of an individual or entity to participate in its program. *See* 42 CFR section 1002.3(b)(3).

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Policy Clarification: States Should Advise Medicaid Providers to Screen for Exclusions

To further protect against payments for items and services furnished or ordered by excluded parties, States should advise all current providers and providers applying to participate in the Medicaid program to take the following steps to determine whether their employees and contractors are excluded individuals or entities:
States should advise providers of their obligation to screen all employees and contractors to determine whether any of them have been excluded. States should communicate this obligation to providers upon enrollment and reenrollment.
States should explicitly require providers to agree to comply with this obligation as a condition of enrollment.
States should inform providers that they can search the HHS-OIG website by the names of any individual or entity.
States should require providers to search the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search.
States should require that providers immediately report to them any exclusion information discovered.

This line of defense in combating fraud and abuse must be conducted accurately, thoroughly, and routinely. States must notify the HHS-OIG promptly of any administrative action the State takes against a provider for failure to comply with these screening and reporting obligations. *See* 42 CFR section 1002.3(b)(3). States can satisfy this obligation by communicating the relevant information to the appropriate Regional Office of the OIG Office of Investigations.

States also should inform providers that civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs)† who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients. (Section 1128A(a)(6) of the Act; and 42 CFR section 1003.102(a)(2))

Policy Clarification: Calculation of Overpayments to Excluded Individuals or Entities

As stated above, Federal health care programs, including Medicaid, are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. The amount of the Medicaid overpayment for such items or services is the actual amount of Medicaid dollars that were expended for those items or services. When Medicaid funds have been expended to pay an excluded individual's salary, expenses, or fringe benefits, the amount of the overpayment is the amount of those expended Medicaid funds. We recognize that there may be instances when the connection between expended Medicaid funds and the

† This State Medicaid Director Letter uses the term "managed care entity" to refer briefly to managed care organizations (MCOs), prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case management (PCCM). States should not confuse this abbreviation with the statutory definition of managed care entity which only refers to MCOs and PCCMs. *See* section 1932(a)(1)(B) of the Act.

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items or services furnished by the excluded individual or entity are too attenuated to trace. When such circumstances arise, the overpayment is no more than the amount which the State is certain was paid with Medicaid dollars.

Where Providers Can Look for Excluded Parties

While the MED is not readily available to providers, the HHS-OIG maintains the LEIE, a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. The LEIE website is located at http://www.oig.hhs.gov/fraud/exclusions.asp and is available in two formats. The on-line search engine identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a Social Security Number (SSN) or Employer Identification Number (EIN). The downloadable version of the database may be compared against an existing database maintained by a provider. However, unlike the on-line format, the downloadable database does not contain SSNs or EINs.

Additionally, some States maintain their own exclusion lists, pursuant to 42 CFR section 1002.210 or State authority, which include individuals and entities whom the State has barred from participating in State government programs. States with such lists should remind providers that they are obligated to search their State list routinely whenever they search the LEIE.

Conclusion

We know you share our commitment to combating fraud and abuse. We all understand that provider enrollment is the first line of defense in this endeavor. If we strengthen our efforts to identify excluded parties, the integrity and quality of the Medicaid program will be improved, benefiting Medicaid recipients and taxpayers across the country.

If you have any questions or would like any additional information on this guidance, please direct your inquiries to Ms. Claudia Simonson, Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations, Medicaid Integrity Group, 233 North Michigan Avenue, Suite 600, Chicago, Illinois 60601 or claudia.simonson@cms.hhs.gov. Thank you for your assistance in this important endeavor.

Sincerely,

/s/
Herb B. Kuhn
Deputy Administrator
Acting Director, Center for Medicaid and State Operations

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№ 23-0046

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