Federal Government Extends Moratorium on New HHAs and Ambulance Suppliers

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Highlights Government's Efforts to Combat Fraud

In what has come to be an expected issuance every six months, on Friday, July 29, 2016, the Department of Health & Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) released Notice of its renewal of the 6-month moratorium on new provider enrollment for Home Health Agencies (HHAs) and Part B Non-Emergency Ground Ambulance Suppliers, to be effective that same day (you can see our previous alerts on this moratorium here). In a surprising twist, however, HHS has changed the Moratorium's reach by making the freezes ***state-wide***, as opposed to the limited geographical areas affected in the past. New HHA enrollments are now on hold in the following states: Florida, Illinois, Michigan, and Texas.

In addition, HHS lifted the moratoria on the enrollment of new Part B ground emergency ambulance suppliers in select counties in Texas, Pennsylvania, and New Jersey that had been in place since July 2013, while continuing the freeze on non-emergency ground services and expanding it state-wide in these three states. For ambulance suppliers providing both emergency and non-emergency services, HHS indicated that any new enrollment in these states would be for the emergency services only. Any services billed by new enrollees for non-emergency services rendered will be denied.

Concurrently with this state-wide expansion of the moratorium, CMS issued a Second Notice on July 29, announcing a demonstration project under the authority provided in Section 402(a)(l)(J) of the Social Security Amendments of 1967 (42 U.S.C. 1395b-l(a)(l)(J)). Recognizing its limitation on creating exceptions to the moratorium authority, CMS has issued the demonstration to address instances of need.

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This Second Notice announced the creation of the "Provider Enrollment Moratoria Access Waiver Demonstration" (PEWD). Under the PEWD, CMS is authorized to grant waivers to the state-wide enrollment moratoria on a case-by-case basis in response to access to care issues. However, like all good things, there are conditions to the waiver—newly enrolled providers under a waiver are subject to heightened screening, oversight and investigations. Under the PEWD, once enrollment is granted the provider/supplier will be subject to restrictions on the geographic service area based on saturation levels and number of beneficiaries in the area. Reimbursement for services that are rendered outside the permitted area will be denied. Early in 2016, CMS published saturation data on its website that applicants can use for their access to care justification. In addition to the information supplied with the CMS-855, the PEWD application will also require information for the heightened review, including:

- License verification;
- Background investigations including evaluation of affiliations as outlined in the March 1, 2016 proposed rule;
- Federal debt review;
- Credit history review;
- Fingerprint-based criminal background checks (FCBC) of persons with a 5 percent or greater direct or indirect ownership interest, partners and managing employees;
- Enhanced site visits;
- Ownership interest verification in LexisNexis and state databases; and
- Evaluation of past behavior in other public programs.

Once a waiver is granted, applicants are subject to a one-year heightened oversight. For those applications denied, there is a limited appeal process that an applicant can pursue, but the time-frame for doing so is a mere 15 days.

As we have advised before, the continuation of this moratorium indicates that federal regulatory and law enforcement authorities regard fraud and abuse as a significant problem in these geographic areas. HHA fraud, in particular, has seen an up-swing in enforcement activity in recent months, with an unprecedented National Health Care Fraud Takedown in June 2016 resulting in charges against 301 individuals and involving nearly $900M in false billings and culminating in an OIG Online Portfolio consolidating the OIG's body of work related to HHA fraud, including enforcement actions, reports, recommendations and guidance.

With the capability of tracking claims, HHS with CMS is able to quickly identify outliers (those whose claim numbers outnumber other providers in their area) and take necessary actions against them through the various task forces that have been created by state and Federal authorities. For HHAs and those providing services to them in the metro-Detroit and Miami areas, HHS's scrutiny is even greater. According to a recently issued Report by the OIG, Detroit and Miami are the only two areas that met 3 out of 3 characteristics for the designation of an HHA "Hotspot" for fraud.

These recent efforts by the OIG and other government authorities reinforce how critically important it is that home care agencies and ambulance providers—and all healthcare providers—have rigorous and effective compliance programs in place. Butzel Long attorneys have experience with enforcement efforts in the Detroit area, and have represented healthcare providers who have been charged with Medicare and Medicaid fraud related to a wide variety of healthcare services, as well as in regulatory proceedings and civil litigation that often flow from allegations of fraud and abuse.

If you have questions regarding this moratorium, other matters involving HHAs or Ambulance providers, other compliance issues, or other healthcare law matters generally, please contact your regular Butzel Long attorney, the authors of this alert, or any member of Butzel Long's Health Care Industry Group.

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