



CPI-CMCS INFORMATIONAL BULLETIN

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**SUBJECT: Affordable Care Act Program Integrity Provisions - Guidance to States --
Section 6501 - Termination of Provider Participation under Medicaid if
Terminated under Medicare or other State Plan**

This Informational Bulletin clarifies earlier guidance the Centers for Medicare & Medicaid Services (CMS) provided in a May 31, 2011, Informational Bulletin and accompanying Frequently Asked Questions (FAQs) on section 6501 of the Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, together called the “Affordable Care Act.” See <http://www.cms.gov/CMCSBulletins/downloads/6501-Term.pdf>.

Section 6501 of the Affordable Care Act amends section 1902(a)(39) of the Social Security Act (the Act) and requires State Medicaid agencies to terminate the participation of any individual or entity if such individual or entity is terminated under Medicare or any other State Medicaid plan.¹ In final implementing regulations at 42 CFR § 455.101, CMS generally defined “termination” as occurring when a State Medicaid program, CHIP, or the Medicare program has taken action to revoke a Medicaid or CHIP provider’s or Medicare provider or supplier’s billing privileges and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. CMS also indicated in final implementing regulations at 42 CFR § 455.101, that the requirement to terminate under section 6501 of the Affordable Care Act only applies in cases

¹ Although Section 6501 of the Affordable Care Act does not specifically include terminations from CHIP, CMS has required CHIP, through Federal regulations, to take similar action regarding termination of a provider that is also terminated or had its billing privileges terminated under Medicare or any State Medicaid plan.

where providers, suppliers or eligible professionals have been terminated or had their billing privileges revoked “for cause.”

For Cause Terminations

Certain States have requested clarification regarding CMS’s definition of “for cause” terminations. For example, some States consider providers who were terminated because they no longer maintain an active medical license in the State, regardless of the reason for the inactive license, e.g., the provider relocated to another State, as meeting the definition of a “for cause” termination. CMS does not consider this type of termination to be a “for cause” termination within the meaning of the final rule. 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.

As indicated in the FAQs, “for cause” does not include any voluntary action taken by the provider to end its participation in the Medicaid program, except where that “voluntary” action is taken to avoid sanction. Accordingly, CMS believes that providers who are terminated by States because they allow their medical license to expire due to relocation to another State does not qualify as a “for cause” termination and should not be reported or shared with other States. CMS believes that this type of termination is not within the spirit of the final rule and does not meet the definition of “for cause.” We clarify here that “for cause” terminations that are shared with other States should be limited to terminations based upon fraud, integrity, or quality.

Examples of For Cause Terminations

CMS understands that States must follow their own State law regarding terminations. CMS recognizes that there are numerous circumstances which may qualify as “for cause” terminations and that States may have different interpretations of what constitutes “for cause” terminations. The following list reflects examples of conduct for which providers may be terminated and that CMS believes meet the definition of “for cause” terminations and should be shared with other States. The list is not exhaustive and is intended only to give States guidance as to the type of “for cause” terminations that CMS believes to be within the spirit of the final rule. Although the examples provided below are limited to the Medicaid program, the same type of conduct would constitute “for cause” terminations in CHIP.

1. Providers that are terminated by State Medicaid Agencies as a result of adverse licensure actions, e.g., providers who are reported into the National Practitioner Data Bank (NPDB).
2. Providers that are terminated by State Medicaid Agencies because they have engaged in fraudulent conduct.

3. Providers that are terminated by State Medicaid Agencies due to abuse of billing privileges, e.g., billing for services not rendered or for medically unnecessary services.
4. Providers that are terminated by State Medicaid Agencies due to misuse of their billing number.
5. Providers that are terminated by State Medicaid Agencies due to falsification of information on enrollment application or information submitted to maintain enrollment.
6. Providers that are terminated by State Medicaid Agencies due to continued billing after the suspension or revocation of the provider's medical license.
7. Providers that are terminated by State Medicaid Agencies based on a State and/or Federal exclusion.
8. Providers that are terminated by State Medicaid Agencies due to falsification of medical records which support services billed to Medicaid.

Waivers

Section 6501 of the statute provides for the same limitations on termination that apply to exclusion under §§ 1128(c)(3)(B) and 1128(d)(3)(B) of the Act. Accordingly, States may request a waiver from the Secretary of the Department of Health and Human Services from carrying out a “for cause” termination. A State may request a waiver from CMS of the requirement to terminate a particular provider's participation if the termination would impose a hardship on Medicaid beneficiaries in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community. State agencies may submit such waiver request to their respective CMS Regional Offices.

As a reminder, CMS has established a secure web-based application that allows States to share information regarding terminated providers. Using this web-based application, commonly referred to as MCSIS, a State is able to download information regarding terminated providers in other States and Medicare and to upload information regarding its own terminations. We strongly encourage all States to use this web-based application to share information on terminated providers. We believe it is a valuable tool that states can use to facilitate compliance with this requirement. If you have any questions regarding the system or the list of users for your State, please send an email to: providerterms@cms.hhs.gov.

Thank you for your continued commitment to combating fraud, waste and abuse in the Medicaid program. We look forward to continuing to work with States in order to successfully implement the requirements of Section 6501 of the Affordable Care Act. Questions regarding this information can be directed to Angela Brice-Smith at 410-786-4340 or via email at Angela.Brice-Smith@cms.hhs.gov.