**Compliance Guide for New Regulations for Small Businesses**

* ***What does this regulation do?***

The proposed action clarifies and codifies requirements for all providers who submit claims to Maryland Medicaid by eliminating the requirement to continuously resubmit claims after initial denial in order to keep a claim “alive”, and clarifying requirements for clean claim submission. This action also codifies the Program’s authority to analyze and, when appropriate, end enrollment for all lines of business affiliated with an individual or entity terminated for-cause by the Program itself, the federal government, or another state Medicaid agency. Additionally, it enables the Department to recover an overpayment when a provider fails to comply with applicable regulations and sets forth provider appeal rights when overpayments are recovered. Finally, the proposed action codifies a federal requirement to impose a payment suspension immediately when the Program determines a credible fraud allegation has been made.

* ***Who is Subject to the new regulation?***

All providers who submit claims to Maryland Medicaid

* ***Why were the new regulations adopted?***

To promote program integrity and improve the department’s ability to comply with federal requirements pertaining to the exclusion of sanctioned providers, and to address claims adjudication backlog by allowing the Program to adhere to federal requirements for timely claim submission and adjudication more closely than existing regulations permit.

* ***When are the regulations effective?***

Anticipated effective date of these regulations is 3/9/2020.

* ***Is funding available to implement new requirements established by the regulation?***

The proposed action does not have an economic impact. Therefore, funding is not necessary for implementation.

* ***Are there other resources available for implementing the requirements of the regulation?***

No.

* ***Is there assistance available to help understand the requirements of the regulation?***

Yes. The Office of Provider Policy and Compliance is available to explain changes to existing requirements and new requirements made by these regulations. Questions about specific provisions of the regulation should be directed to Alison Donley at (410)767-6541 at Alison.donley@maryland.gov.

Key Terms and Definitions

“Affiliated lines of business” means an individual or entity with an affiliation

“Affiliation” means a 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization; a general or limited partnership interest that an individual or entity has in another organization; an interest in which an individual or entity exercises operational or managerial control over or directly or indirectly conducts the day-to-day operations of another organization, either under contract or through some other arrangement, regardless of whether the managing individual is a W-2 employee of the organization; or an interest in which an individual is acting as an officer or director of a corporation.

“Clean Claim” means a claim that can be processed consistent with applicable regulations without obtaining additional information from the provider of the service or from a third party. Clean claim includes a claim with errors originating in a State’s claims system.

“Overpayment” means any payment made by the Medicaid Program to a provider for medical care provided to a participant which at the time of payment, or at a subsequent date, is determined to be a duplicate payment, a payment for services billed in violation of one or more regulations, excessive in amount, or the primary obligation of health insurance carrier or any other person, including the participant, who is legally or contractually obligated to pay for that medical care.

“Participant” means an individual who is certified as eligible for, and is receiving, Medical Assistance benefits.

“”Terminate” means a decision by the Program, the federal government, or a state Medicaid agency to end an individual’s or entity’s enrollment with the Program, Medicare, or a state Medicaid program due to a sanction for failure to comply with applicable federal or state laws or regulations or because of a credible allegation of fraud.

“Withold payment” means the Program’s decision to not pay or suspend payment to a provider as a sanction for failure to comply with applicable federal or State laws or regulations or because of a credible allegation of fraud.