Affordable Care Act Requirements For Screening and Enrollment of Medi-Cal Providers and Healthy Families Program (CHIP) Providers

State of California

Department of Health Care Services (DHCS)

February 2012

Background on New Federal Requirements for State Medicaid Agencies

March 2010 - Patient Protection and Affordable Care Act (PPACA) passed by Congress and signed by the President

September 2010 - **Proposed** Regulatory Rule

Oct/Nov 2010 - States' Comment Period

February 2, 2011 - **Final Rule** published in Federal Register incorporating States' comments and responses

March 25, 2011 - Effective Date for Final Rule changes to the Code of Federal Regulations (CFR)

Legal Authority Is Necessary For Implementation

State Legislation

Amendment to State Plan

Regulatory Changes

Stakeholder Meetings

Regulatory Bulletins

Administrative Changes Are Needed For Implementation

- Revisions of CURRENT enrollment process & procedures
- Development of NEW enrollment and payment system processes & procedures
- Budgeting for increased costs to Departments
- Training of staff on new and revised processes and procedures
- Communication of changes to provider and stakeholder communities
- Coordination and cooperation between DHCS and all other Departments responsible for screening providers

Overview of Federal Requirements

42CFR 455 Subpart E – Provider Screening and Enrollment

State Medicaid agencies must comply with the process for screening providers under sections 1902(a)(39), 1902(a)(77) and 1902(kk) of the Affordable Care Act and 42 CFR Section 455.400 et seq.

Disclosure Information

Ownership and Control

- 42 CFR Section 455.104 requires specific information about ownership and control from disclosing entities, fiscal agents and managed care entities (MCE).

- This Section was revised as to the following:
  - Who must disclose
  - What must be disclosed
  - When disclosures must be provided
  - To whom disclosures must be provided
  - Consequences for failure to provide required disclosures

Ownership Information Requirements

(continued)

- **All Departments** that collect disclosure information from disclosing entities, as defined in 42 CFR Section 455.101, are required to comply.
- **All Departments** that collect disclosure information from fiscal agents and/or managed care entities are required to comply.
- **Some Departments** already collect all required information; others will be required to change disclosure requirements to match Federal mandate.

What Disclosures Must Be Provided

- **Names and Addresses of any individual or corporation with ownership or control interest**
  - every business address, location and P.O. Box for corporations
  - Date of Birth and Social Security Number for individuals
  - Other Taxpayer Identification Number for corporations with ownership or control interest in disclosing entity, fiscal agent, MCE or in any subcontractor in which there is 5% or more control interest
- **If an owner or control interest is related to another person with ownership or control interest in the disclosing entity or in any subcontractor, and if so, what is the familial relationship**
- Name(s) of any other owned or controlled disclosing entity(ies), fiscal agent(s) or MCE(s)
- Information about any managing employees

Enrollment of Ordering and Referring Providers

- 42 CFR Section 455.410 requires all providers, including ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers

AND

- 42 CFR Section 455.440 says State must require all claims for items and services ordered or referred to contain the National Provider Identifier (NPI) of the ordering or referring provider.

- States are permitted to rely on the results of provider screening performed by any Medicare contractor or Medicaid agency or CHIP of other States when enrolling ordering and referring providers.

Ordering and Referring Providers

(continued)

- Provider Types that may enroll as ordering/referring providers-
  - Doctors of Medicine or Osteopathy
  - Doctors of Dental Surgery and Dental Medicine
  - Doctors of Podiatric Medicine
  - Doctors of Optometry
  - Physician Assistants
  - Certified Clinical Nurse Specialists
  - Nurse Practitioners
  - Clinical Psychologist
  - Certified Nurse Midwives
  - Clinical Social Workers
  - Doctors of Chiropractic Medicine
  - Audiologists and Hearing Aid Dispensers

Ordering and Referring Providers

(continued)

Physician and non-physician practitioners who will be required to enroll in Medi-Cal (and Medicare) solely for the purpose of ordering and referring may be…

- Department of Veterans Affairs employees
- Public Health Service employees
- Department of Defense Tricare employees
- IHS or tribal organization employees
- Federally Qualified Health Centers, Rural Health Clinics or Critical Access Hospital employees
- Community Clinic or Free Clinic employees
- Or Licensed Medical Residents or Fellows

Ordering and Referring Providers

(continued)

Medicare began implementing the enrollment of Ordering and Referring Providers in Fall 2011 with a new form, CMS-8550.

As of today, Medicare has not turned on the automated edits that would deny claims for items and services ordered or referred by providers not yet enrolled in Medicare.

Once the automated edits are turned on ---

1. Claims from the "filling providers" (i.e. pharmacies) will be denied if the ordering or referring provider's name and NPI listed on the claim is not enrolled.

OR

2. Patients may not receive needed items or services (i.e. medication) if the "filling providers or suppliers" refuse to accept orders or referrals from providers that are not enrolled.

Verification of Provider Licenses

- 42 CFR Section 455.412 requires State Medicaid agencies to have methods in place for verifying provider licenses and confirming that provider licenses have not expired or do not have current limitations.

Revalidation of Enrollment

(AKA Re-Enrollment)

- 42 CFR Section 455.414 requires revalidation of enrollment for all provider types at least every 5 years.

- Federal regulation also allows States to rely on the results of the provider screening performed by Medicare contractors and Medicaid or CHIP programs of any State to fulfill this requirement.

- California regulations already contain requirements for re-enrolling and re-certifying providers, but the **"every five years"** revalidation requirement will be new.

Denial or Termination of Enrollment

- 42 CFR Section 455.416 specifies causes for the denial and/or termination of enrollment of providers.
- This section broadens the State's current authority to deny and/or to deactivate enrollment of providers.
- All Departments that deny and/or deactivate enrollment of providers must comply with this section.
- States have discretion in some situations when denial or termination can be documented as "not in the best interest of the Medi-Cal program".

New Denial/Termination Causes

- provider is terminated on or after January 1, 2011, under Medicare, Medicaid or CHIP of any other State
- provider, or agent or managing employee fails to submit timely and accurate information & doesn't cooperate with required screening
- provider fails to submit fingerprints within 30 days of a CMS or a State Medicaid request
- provider fails to permit access to provider locations for any site visits
- provider falsifies any information on an application or their identity cannot be verified

Reporting of Provider Terminations

- 42 CFR Section 455.101 defines termination of Medi-Cal and CHIP providers as follows:
- State has taken action to revoke billing privileges
- Provider has exhausted all applicable State appeal rights
- Revocation is not temporary
- Provider must re-enroll (and be re-screened per Section 455.420) to establish billing privileges again.

California is required to report terminated providers on the Medicaid and Children's Health Insurance Program State Information Sharing System (MCSIS) so that other States and Medicare can determine which providers have been terminated by California.

Reactivation of Enrollment

- 42 CFR Section 455.420 requires States to re-screen providers and to require payment of associated provider application fees under 455.460 after deactivation of enrollment for any reason.

Provider Appeal Rights

- 42 CFR Section 455.422 requires State to give terminated or denied providers any appeal rights available under procedures established by State Law.

Site Visits

- 42 CFR Section 455.432 requires State to conduct pre-enrollment and post-enrollment site visits of providers designated as "moderate" or "High" categorical risks to Medi-Cal Program.

Federal Database Checks Required

- 42 CFR Section 455.436 requires States to confirm the identity and exclusion status of -
  - Providers
  - Any person with ownership or control interest in the provider
  - Agents of the provider
  - Managing employees of the provider

- For Exclusion Status- States must Check at time of application and at least on a monthly basis--
  - List of Excluded Individuals and Entities (LEIE)
  - Excluded Parties List System (EPLS)

- For Termination Status- States must Check at time of application and at regular intervals -- **the new Medicaid and Children's Health Insurance Program State Information Sharing System (MCSIS)**

Three Screening Levels for Medicaid Providers

- 42 CFR Section 455.450 requires States to screen applicant providers according to **limited**, **moderate** and **high** risk categories.
- Federal law designates **specific provider types** within the three categories at 42 CFR Section 424.518.

Three Screening Levels (continued)

- The categorical risk levels are defined as:
  - Limited
    - Requires license verifications (§ 455.412)
    - Database checks (§ 455.436)
  - Moderate
    - Requires onsite inspections (§ 455.432)
    - All screening procedures required of the Limited risk level
  - High
    - Requires fingerprinting/criminal background checks (§ 455.434)
    - All screening procedures required of the Limited and Moderate risk levels

Three Screening Levels for Medicaid Providers (continued)

- Any provider, regardless of provider type can be 'bumped up' to the high screening level if any of four situations exist.
  - **Payment suspension that is based on a credible allegation of fraud, waste or abuse**
  - **Existing Medicaid overpayment**
  - **Excluded by OIG or another State's Medicaid program within the previous 10 years**
  - **A Moratorium was lifted within previous six months prior to applying and the provider would have been prevented from enrolling due to the moratorium**

Criminal Background Checks Including Fingerprinting

- 42 CFR Section 455.434 requires all providers in the High category screening level to submit fingerprints.
- Defines providers as any person or entity that holds five percent or more ownership or control interest
- Fingerprints must be submitted in the form and manner determined by the State Medicaid agency
- Fingerprints must be submitted within 30 days of a request from CMS or the Medicaid agency

Application Fees for Some Providers

- 42 CFR Section 455.460 requires States to collect an application fee from all prospective or re-enrolling providers EXCLUDING the following:
  - Physicians and all other licensed non-physician practitioners
  - Providers already enrolled with Medicare
  - Providers already enrolled in any State's Medicaid or CHIP
  - Providers who have already paid an application fee to either a Medicare contractor or another State's Medicaid or CHIP program

Application Fees (continued)

- Amount of Application Fee is calculated by CMS
- Amount is adjusted annually by the % change in consumer price index for all urban consumers
  - Fee Amounts to Date
    - 2010 - $500.00
    - 2011 - $505.00
    - 2012 - $523.00
- All Hardship Exception Requests shall be subject to CMS' Decision

Application Fees (continued)

- **To request a waiver of the application fee:**
  - **Individual applicants/providers may submit** a request to CMS for a hardship exception in the form of a letter that describes the hardship and explains why it justifies an exception
  - **State may submit** a request to CMS for a fee waiver applicable to a group or category of providers by demonstrating that the fee will have a negative impact on beneficiary access to care

Temporary Moratoria

- **Per 42 CFR Section 455.470**, the State Medicaid agency shall comply with any temporary moratorium on the enrollment of new providers or provider types imposed by CMS, provided that such temporary moratorium would not adversely impact beneficiaries' access to medical assistance.
- California already has statutory authority to establish moratoria, with some limitations on the provider types that can be affected.
- **CMS moratoria authority is broader than the current State authority.**

Summary and Conclusion

- There is a lot of work yet to be done for California's Medicaid program to achieve full compliance with the new Federal requirements.
- All State Departments and their divisions responsible for screening and enrolling providers, fiscal agents and managed care entity providers into Medi-Cal and the Healthy Families Program need to…

WORK TO BE DONE…

- Become educated about the new Federal Enrollment Requirements
- Develop legal authority needed to implement Federal Regulations
- Develop policy and procedure necessary to implement Federal Regulations
- Communicate with their provider communities
- Provide training on new requirements within their organizations
- Budget so as to have resources to comply with Federal Regulations
- Cooperation between Departments and Divisions for a well-coordinated and successful implementation of new Federal Medicaid requirements

Email Contact Address for Questions about the Provider Screening and Anti-Fraud Provisions of the Affordable Care Act

PEDACA@dhcs.ca.gov

THE END

Presented in Sacramento, California,
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