

Department of Health Care Services | Provider Enrollment Division

STAKEHOLDER MEETINGS

Implementation of the Affordable Care Act and Final Rule – Program Integrity

Session 1

Wednesday, July 25, 2012
9:30 A.M. to 11:30 A.M

Session 2

Wednesday, July 25, 2012
1:30 P.M. to 3:30 P.M.

Session 3

Thursday, July 26, 2012
1:30 P.M. to 3:30 P.M.

Steps Towards Implementation

- Legislation – SB 1529 (Alquist)
 - Introduced February 24, 2012
 - Passed through the Senate
 - Passed through Assembly Health Committee
 - Currently with Assembly Appropriations Committee
- State Plan Amendment (SPA)
 - Required for most of the CFR provisions
 - Submitted to CMS on March 30, 2012
 - SPA has not yet been approved
- Provider/Regulatory Bulletin(s)
 - Regulatory and informational
- January 1, 2013
 - Target date for full implementation of new requirements

SESSION 1
Wednesday, July 25, 2012
9:30 A.M. to 11:30 A.M.

SCREENING LEVELS FOR MEDICAID PROVIDERS
42 CFR § 455.450

FINGERPRINTING & CRIMINAL BACKGROUND CHECKS
42 CFR § 455.434

TERMINATION OR DENIAL OF ENROLLMENT AND
REPORTING
42 CFR § 455.416

Screening Levels for Medicaid Providers

42 CFR § 455.450

- 42 CFR § 455.450 requires states to screen providers according to **limited**, **moderate** and **high** risk categories.
- Federal law designates **specific provider types** within the three categories at 42 CFR § 424.518.
- The State Medicaid agency must screen providers in accordance with the federal designations.

Screening Levels for Medicaid Providers

42 CFR § 455.450

- 42 CFR § 424.518: Provider types designated as limited categorical risk include:
 - Physicians
 - Nonphysician practitioners
 - Ambulatory surgical centers
 - Federally qualified health centers (FQHC)
 - Hospitals, including critical access hospitals, Department of Veterans Affairs hospitals, and other federally owned hospital facilities
 - Health programs operated by an Indian Health Program
 - Pharmacies
 - Rural health clinics
 - Skilled nursing facilities

Screening Levels for Medicaid Providers

42 CFR § 455.450

- 42 CFR § 424.518: Provider types designated as moderate categorical risk include:
 - Ambulance service suppliers
 - Community mental health centers
 - Comprehensive outpatient rehabilitation facilities
 - Hospice organizations
 - Independent clinical laboratories
 - Independent diagnostic testing facilities
 - Physical therapists (individual & groups)
 - Portable x-ray suppliers
 - Revalidating home health agencies
 - Revalidating DME suppliers

Screening Levels for Medicaid Providers

42 CFR § 455.450

- 42 CFR § 424.518: Provider types designated as high categorical risk include:
 - Prospective (newly enrolling) home health agencies
 - Prospective (newly enrolling) DME suppliers

Screening Levels for Medicaid Providers

42 CFR § 455.450

- Screening procedures required of the categorical risk levels:
 - 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 and criminal background checks (§ 455.434)
 - All screening procedures required of the Limited and Moderate risk levels

Screening Levels for Medicaid Providers

42 CFR § 455.450

- All providers, regardless of provider type, must be screened at the high categorical risk level if any of four conditions 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

Screening Levels for Medicaid Providers

42 CFR § 455.450

➤ CMS Clarification:

- The Department may take into consideration the basis of overpayments when elevating providers to the high categorical risk level. SB 1529 was amended to restrict these overpayments to those based on “fraud, waste, or abuse.”
- If an applicant can provide evidence of completed screening by a Medicare contractor or State Medicaid Agency within the previous 12 months. A complete screening for Medi-Cal enrollment may not be necessary.

Screening Levels for Medicaid Providers

42 CFR § 455.450

➤ Steps Towards Implementation:

- DHCS is working internally to develop new screening procedures based on this requirement.
- DHCS will release a provider bulletin describing the requirement in further detail.

Fingerprinting & Criminal Background Checks

42 CFR § 455.434

➤ 42 CFR § 455.434:

- Requires all providers designated within the high categorical risk level to submit fingerprints
- Defines providers as any person or entity that holds 5% or more ownership or control interest
- Requires providers to submit a set of fingerprints in the “form and manner” determined by the State Medicaid agency
- Requires fingerprints to be submitted within 30 days of a request from CMS or the Medicaid agency

Fingerprinting & Criminal Background Checks

42 CFR § 455.434

➤ Steps Towards Implementation:

- DHCS is awaiting guidance from CMS regarding implementation of the fingerprinting and criminal background check requirement.
- DHCS will release a provider bulletin describing the requirement in further detail.

Termination or Denial of Enrollment and Reporting

42 CFR § 455.416

- 42 CFR § 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 deactivate the enrollment of providers.
- States have discretion in some situations when denial or termination can be documented as "not in the best interest of the Medi-Cal program."

Termination or Denial of Enrollment and Reporting

42 CFR § 455.416

- New denial/termination causes beginning January 1, 2013, when SB 1529 becomes law.
 - Provider is terminated under Medicare, Medicaid or Children's Health Insurance Program (CHIP) of any other State.
 - DHCS now has access to MCSIS database and plans to perform checks and deny or terminate for this cause beginning 1/1/2013 based on amended Welfare and Institutions (W&I) Code sections.
 - Provider or agent or managing employee fails to submit timely and accurate information and doesn't cooperate with required screening procedures.
 - DHCS will have authority to deactivate any currently enrolled provider for this cause beginning 1/1/2013 based on amended W&I Code; wording is permissive.

Termination or Denial of Enrollment and Reporting

42 CFR § 455.416

- New denial/termination causes beginning January 1, 2013, when SB 1529 becomes law.
 - Provider fails to submit fingerprints within 30 days of a CMS or a State Medicaid request.
 - DHCS will implement this as part of the high-risk provider screening beginning 1/1/2013 based on amended W&I Code.
 - Provider fails to permit access to provider locations for any site visits.
 - DHCS will begin to deny for this cause beginning 1/1/2013 based on amended W&I Code.

Termination or Denial of Enrollment and Reporting

42 CFR § 455.416

- Reporting provider terminations
 - 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. DHCS now has access to MCSIS and will notify the provider community via an informational bulletin prior to beginning to report provider terminations on the MCSIS; probably sometime later this year.
- 42 CFR § 455.101 states that a Medicaid or CHIP provider is terminated when:
 - The State has taken action to revoke billing privileges.
 - The provider has exhausted all applicable State appeal rights.
 - The revocation is not temporary.
 - The provider must re-enroll (and be re-screened per Section 455.420) to establish billing privileges.

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QUESTIONS?
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Implementation of the Affordable Care Act and Final Rule – Program Integrity

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SESSION 2
Wednesday, July 25, 2012
1:30 P.M. to 3:30P.M.

TEMPORARY MORATORIA
42 CFR § 455.470

ORDERING, REFERRING AND
PRESCRIBING PROVIDERS
42 CFR § 455.410

Temporary Moratoria

42 CFR § 455.470

- CMS may establish Medicaid wide temporary moratoria on the enrollment of new providers or provider types:
 - The State Medicaid agency must impose moratoria established by CMS unless it would create an access to care issue
 - The State must then notify CMS in writing
- The State Medicaid agency may otherwise impose moratoria, numerical caps, or other limits on the enrollment of new providers:
 - When fraud, waste or abuse is identified in the Medicaid program and CMS has identified the provider type as being at high risk for fraud, waste and abuse
 - The State must notify CMS and obtain concurrence with the imposition of the moratoria

Temporary Moratoria

42 CFR § 455.470

➤ CMS Clarification:

- Existing Medi-Cal moratoria must be approved by CMS.
 - California received approval from CMS for all current Moratoria on June 19, 2012.
- DHCS will notify CMS of continuance for each moratorium upon renewal.

Ordering and Referring Providers

42 CFR § 455.410

- 42 CFR § 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. 42 CFR § 455.440 requires all claims for items and services ordered or referred to contain the National Provider Identifier (NPI) of the ordering or referring provider.
- If Systems permit, DHCS plans to rely on the results of Medicare's provider screening.

Ordering and Referring Providers

42 CFR § 455.410

- Provider Types that may be required to enroll as ordering/referring providers include but are not limited to:
 - Audiologist
 - Certified Nurse Midwife
 - Chiropractor
 - Clinical Social Worker
 - Certified Registered Nurse Anesthetist
 - Dentist
 - Nurse Practitioner
 - Optometrist
 - Osteopathic Physician
 - Physician
 - Physician Assistant
 - Podiatrist
 - Psychologist
 - Speech Pathologist

Ordering and Referring Providers

42 CFR § 455.410

- Basic requirements for ordering and referring:
 - The physician or non-physician practitioner must be enrolled in Medi-Cal or Medicare.
 - The ordering/referring/prescribing National Provider Identifier (NPI) must be for an individual physician or non-physician practitioner (not an organizational NPI).
 - The physician or non-physician practitioner must be of the specialty type that is eligible to order/refer/prescribe.

Ordering and Referring Providers

42 CFR § 455.410

➤ CMS Clarification:

- Risk-based Managed Care Organization (MCO) providers are exempt from this enrollment requirement, provided that the beneficiary is a beneficiary of the plan. This exemption applies to both MCO covered benefits and carved-out services.
- Medical Residents: All interns and residents who order/refer must specify the name and National Provider Identifier (NPI) of the teaching physician on the claim form. However, a state-licensed resident may enroll to order and refer and may be listed on the claims.

Ordering and Referring Providers

42 CFR § 455.410

- Steps Towards Implementation:
 - DHCS is drafting the Ordering/Referring/Prescribing application form. DHCS is hosting smaller workgroups to work through the drafting of the application.
 - DHCS will release a provider bulletin describing the requirement in further detail.
 - Forms will be available to the public on implementation date January 1, 2013.
 - DHCS will establish a grace period to allow providers to enroll before the automated edits are turned on.
 - The next Ordering, Referring and Prescribing Sub-workgroup meeting is scheduled for August 13, 2012.

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QUESTIONS?
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SESSION 3
Thursday, July 26, 2012
1:30 P.M. to 3:30 P.M.

APPLICATION FEE
42 CFR § 455.460

REVALIDATION
42 CFR § 455.414

Application Fee

42 CFR § 455.460

- 42 CFR § 455.460 requires States to collect an application fee from all prospective or re-enrolling providers EXCLUDING the following:
 - Individual physicians or 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 Fee

42 CFR § 455.460

- CMS calculates the application fee for each Calendar Year.
- The fee is adjusted annually by the percentage change in the consumer price index for all urban consumers.
 - 2010 ~ \$500.00
 - 2011 ~ \$505.00
 - 2012 ~ \$523.00
- If the fees collected by the State exceed the application screening costs, the State must return the remainder to the Federal Government.

Application Fee

42 CFR § 455.460

- To request a waiver of the application fee:
 - Individual providers may submit a request to DHCS for a hardship exception in the form of a letter that describes the hardship and explains why it justifies an exception. DHCS will forward the request to CMS for approval.
 - DHCS 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.

Application Fee

42 CFR § 455.460

➤ CMS Clarification:

- Contrary to DHCS' previous understanding, a recent discussion with CMS has revealed that physician and nonphysician practitioner groups are subject to the application fee, but only when applying for Medicaid enrollment.

Application Fee

42 CFR § 455.460

➤ Steps Towards Implementation:

- DHCS is working internally to develop procedures for collection application fees.
- DHCS will release a provider bulletin describing the requirement in further detail.

Revalidation

42 CFR § 455.414

- 42 CFR § 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 is new.

Revalidation

42 CFR § 455.414

➤ CMS Clarification:

- Required Disclosure by Medicaid Providers and Fiscal Agents:
 - § 455.104 - Information on ownership and control
 - § 455.105 - Information related to business transactions
 - § 455.106 - Information on persons convicted of crimes
- If the provider has been revalidated by Medicare, another State Medicaid or CHIP within the previous 12 months, there is no need to submit the Short Form or the Disclosure Statement. Proof of revalidation is required.
- Application fees are NOT required for Medicaid revalidations.

Revalidation

42 CFR § 455.414

➤ Steps Towards Implementation:

- DHCS is drafting the Revalidation Short Form. DHCS is hosting smaller workgroups to work through the drafting of the application.
- DHCS will release a provider bulletin describing the requirement in further detail.
- DHCS will begin to notify providers of revalidation on the implementation date January 1, 2013.
- The next Revalidation Sub-workgroup meeting is scheduled for August 13, 2012 to finalize the Revalidation Short Form, discuss the drafted Revalidation Approval Letter and the phases in which DHCS will revalidate providers.

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