

Department of Health Care Services | Provider Enrollment Division

Affordable Care Act (ACA) Overview

Tribal/Indian Health Program

March 7, 2013



February 2, 2011 – Final Rule Published in the Federal Register Federal Regulations Implement Social Security Act as amended by ACA



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Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 424, 447 et al.

Office of Inspector General

42 CFR Part 1007
Medicare, Medicaid, and Children's Health Insurance Programs; Additional
Screening Requirements, Application Fees, Temporary Enrollment
Moratoria, Payment Suspensions and Compliance Plans for Providers and
Suppliers; Final Rule

Steps Towards Implementation

➤ Legislation – SB 1529 (Alquist)

- Agency sponsored bill - introduced February 24, 2012.
- Signed by Governor Brown on September 29, 2012.
- Chapter 797, Statutes of 2012.
- Codifies Program Integrity provisions of the ACA and the Code of Federal Regulations (CFR) in the Welfare and Institutions Code (W&I) and Health and Safety Code.

Steps Towards Implementation

- State Plan Amendment (SPA) #12-008
 - Required for most of the CFR provisions.
 - Submitted to Centers for Medicare & Medicaid Services (CMS) on March 30, 2012.
 - SPA was approved on November 21, 2012.
 - The Director of the Department of Health Care Services (DHCS) published the required Declaration in December 2012, announcing CMS' approval of the SPA and its January 1, 2013 effective date.

Steps Towards Implementation

- Provider Regulatory and Informational Bulletins
 - Regulatory Bulletins: Published in November 2012.
 - Effective on January 1, 2013.
 - Informational Bulletins: Published in December 2012.
 - The Provider Bulletin “Medi-Cal Requirement to Submit Fingerprints for a Criminal Background Check” will be published when DHCS receives further guidance from CMS.

Ordering, Referring & Prescribing Providers 42 CFR §455.410

- 42 CFR §455.410(b) 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.
- For this new requirement, States are permitted to rely on the results of the provider screening performed by Medicare or another State Medicaid agency or CHIP Program.

Ordering, Referring & Prescribing 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 NPI must be for an individual (Type 1) physician or non-physician practitioner, not an organizational (Type 2) NPI.
 - The physician or non-physician practitioner must be of the specialty type that is eligible to order/refer/prescribe.

Ordering, Referring & Prescribing Providers 42 CFR §455.410

- Provider types that may be required to enroll as ordering/referring providers include:
 - 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 Psychologists
 - Certified Nurse Midwives
 - Clinical Social Workers
 - Doctors of Chiropractic Medicine
 - Audiologists and Hearing Aid Dispensers

Ordering, Referring & Prescribing Providers 42 CFR §455.410

- Who will need to enroll as an ordering, referring or prescribing only provider in the Medi-Cal program?

Physicians and non-physician practitioners who will be required to enroll in Medi-Cal solely for the purpose of ordering/referring/prescribing are those:

- Employed at Federally Qualified Health Centers (FQHCs).
- Employed at Rural Health Centers (RHCs).
- Employed at Community Clinics or Free Clinics.
- Indian Health Services (IHS) or Tribal Organizations

Ordering, Referring & Prescribing Providers 42 CFR §455.410

- Ordering, Referring & Prescribing Providers, Regulatory Provider Bulletin “Medi-Cal Requirement for Ordering/Referring/Prescribing Providers Forms and Procedures”:
 - Effective January 1, 2013.
 - This regulatory bulletin implements the amended W&I Code §14043.1(b) & (o) and §14043.15(b)(3).

- Medi-Cal Ordering/Referring/Prescribing Provider Application/Agreement/Disclosure Statement for Physician and Non-physician Practitioners (DHCS 6219).
 - An original signature of the Ordering/Referring/Prescribing provider is required.

Ordering, Referring & Prescribing Providers 42 CFR §455.410

➤ Failure to enroll the ordering/referring/
prescribing provider in the Medi-Cal Program:

- **Once the automated edits are turned on.....:**

- Claims from the “filling providers”, (e.g., pharmacies, DMEs, etc.) will be denied if the ordering or referring provider’s name and NPI listed on the claim is not enrolled.
- Patients may not receive needed items or services, (e. g., medication) if the “filling providers or suppliers” refuse to accept orders or referrals from providers that are not enrolled.

However, DHCS will provide a grace period to allow providers to enroll before the automated edits are turned on.

Ordering, Referring & Prescribing Providers 42 CFR §455.410

What Medicare is doing:

- **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.**

Revalidation for Continued Enrollment

42 CFR §455.414

- 42 CFR §455.414 requires revalidation of enrollment for all provider types at least every 5 years.
- California regulations currently contain requirements for continued enrollment. The requirement that of revalidation all providers every 5 years is new.
- Federal regulations allow States to rely on the results of a provider's screening performed within the previous 12 months by a Medicare contractor or another State's Medicaid or CHIP program to fulfill this requirement.

Revalidation for Continued Enrollment

42 CFR §455.414

- **Please note that DHCS will only be able to rely on Medicare's revalidation if:**
 - Providers completed their Medicare revalidation within the previous 12 months;
 - The provider is enrolled in Medicare and Medi-Cal;
 - The provider's information in Medicare (Legal name, TIN, Business Address, etc.) matches the provider's information on Medi-Cal's system exactly.
- DHCS is still developing its process and procedures for revalidation. The Department will notify those providers that will need to complete Medi-Cal's revalidation process.
- Also, the DHCS will publish an informational provider bulletin on the Department's website when our revalidation process begins.

PED Affordable Care Act (ACA) Implementation

QUESTIONS?

Application Fees 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 physician or non-physician practitioners (*groups are required to submit the application fee, unless otherwise exempt*).
 - Providers already enrolled with Medicare. – *Verification required*
 - Providers already enrolled in any State’s Medicaid or CHIP program. – *Verification required*
 - Providers who have already paid an application fee to either a Medicare contractor or another State’s Medicaid or CHIP program. - *Verification required*
 - * Re-enrolling: Previously enrolled, but with a break in active enrollment status and is required to apply for enrollment. – *Not to be confused with DHCS process for continued enrollment of providers.*
 - *Applications subject to application fee will be evaluated on a case-by-case basis to determine if a fee is required or appropriate.*

Application Fees 42 CFR §455.460

- Providers subject to paying the fee
 - Medicaid only provider types* will have to pay the fee to Medi-Cal unless...
 - They have paid the fee to another state Medicaid or CHIP program.
 - They are enrolled with another state Medicaid or CHIP program.
 - They obtain approval of a fee waiver request for their application requesting enrollment.

*Medicaid only provider types include:

- Non-Emergency Medical Transportation
- Adult Day Care Centers (ADHCs operating as CBAS providers)
- Alternative Birth Centers – Specialty Clinics
- Blood Banks
- Personal Care Agency
- Private Non-Profit Proprietary Agency
- Residential Care Facilities for the Elderly (RCFE)

Physician and Non-Physician Practitioner Groups will also need to pay the fee if they are not exempt from paying the fee otherwise.

Application Fees 42 CFR §455.460

- CMS calculates the application fee for each Calendar Year.
- The fee is adjusted annually by CMS according to the percentage change in the Consumer Price Index for all Urban Consumers(CPI-U):
 - 2010~\$500.00
 - 2011~\$505.00
 - 2012~\$523.00
 - 2013~\$532.00
- If the fees collected by the State exceed the application screening costs, the State must return the remainder to the Federal Government.

Application Fees 42 CFR §455.460

- The application fee may not be required of a provider that requests and obtains approval of a fee waiver.
 - 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 all requests 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.

All waiver requests are to be considered by CMS, even for provider types that do not enroll with Medicare.

CMS has 60 days to make a determination on a request for fee waiver according to Medicare CFR.

Application Fees 42 CFR §455.460

- New regulatory provider bulletin and forms.
 - Regulatory Provider Bulletin, “Medi-Cal Application Fee Requirements for Compliance with 42 Code of Federal Regulations §455.460,” published on November 29, 2012 – effective January 1, 2013.
 - Application Forms updated to include Application Fee information, new forms now available.
 - Updated forms include:
 - Medi-Cal Durable Medical Equipment Provider Application (DHCS 6201)
 - Medi-Cal Provider Group Application (DHCS 6203)
 - Medi-Cal Provider Application (DHCS 6204)
 - Medi-Cal Clinical Medical Laboratory Application (DHCS 6204)
 - Medi-Cal Pharmacy Provider Application (DHCS 6205)
 - Medi-Cal Medical Transportation Provider Application (DHCS 6206)

Application Fees 42 CFR §455.460

- Other important information regarding the application fee requirement...
 - The purpose of the application fee is to offset the cost of screening the applicant provider.
 - The fee is to only be paid once to either Medicare or Medicaid or CHIP program.
 - The application fee is required specific to the legal name and business location of the applicant.
 - More information is available in the regulatory provider bulletin.
 - Current information on the application fee amount and method of payment is available on the www.dhcs.ca.gov and on the www.medi-cal.ca.gov on the Provider Enrollment page.
 - At this time, only a **cashier's check** will be accepted as payment of the fee for Medi-Cal provider enrollment.

Application Fees 42 CFR §455.460

- What if your application is subject to the fee?
 - NOT a cause for deficiency:
 - Application fees cannot be requested via a deficiency letter.
 - Lack of the fee is an automatic...
 - Cause for denial:
 - If an application that requires a fee is submitted with neither an application fee check nor a fee waiver request, that application will be denied for failure to submit an application fee as required pursuant to W&I Code §14043.26(f)(4)(F) prior to any review.
 - *Applicants are encouraged to submit both the application fee and the fee waiver to guarantee their application will be reviewed if the waiver is not granted.*
 - Cause for reimbursement:
 - Fee is submitted with an application fee waiver request, which is subsequently granted by CMS.
 - A fee was submitted and cashed by DHCS, but the applicant is found to be exempt from paying the application fee.

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.

PED Affordable Care Act (ACA) Implementation

QUESTIONS?

Screening Levels For Medicaid Providers

42 CFR §455.450

- 42 CFR §455.450 requires States to screen providers according to limited, moderate and high level risk categories.
- Federal law designates specific provider types within the three categories at 42 CFR §424.518.
- DHCS shall, at a minimum, utilize the Federal regulations in determining a provider's/applicant's categorical risk level.

Screening Levels For Medicaid Providers

42 CFR §455.450

➤ Screening Levels for Medicaid Providers
Informational Bulletin “Medi-Cal Screening
Level Requirements for Compliance with 42
Code of Federal Regulations §455.450”:

- Published November 30, 2012.
- Effective on January 1, 2013.
- This informational bulletin implements the W&I Code §14043.38.

Screening Levels For Medicaid Providers

42 CFR §455.450

➤ Screening procedures required of the categorical risk levels:

- Limited
 - Requires license verifications – pursuant to 42 CFR §455.412.
 - Database checks – pursuant to 42 CFR §455.436.
- Moderate
 - All screening procedures required of the Limited risk level.
 - Requires onsite inspections – pursuant to 42 CFR §455.432.
- High
 - All screening procedures required of the Limited and Moderate risk levels.
 - Requires fingerprinting and criminal background checks – pursuant to 42 CFR §455.434.

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 (RHC)
 - 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
 - Physical therapists (individuals & groups)
 - Portable x-ray suppliers
 - Revalidating Home Health Agencies (HHA)
 - 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.
 - Enrolled by California Department of Public Health (CDPH).
 - Prospective (newly enrolling) DME suppliers.

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 4 criteria are met:
- 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 the previous 6 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. The W & I Code 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 another State’s Medicaid agency within the previous 12 months, a complete screening for Medi-Cal enrollment may not be necessary.

Fingerprinting & Criminal Background Checks

42 CFR §455.434

- Implements Federal requirements for the State Medicaid agency (Medi-Cal) to obtain fingerprints from certain providers and conduct a criminal background check.
- Requires providers screened at the high categorical risk level for fraud, waste, or abuse to submit fingerprints for a criminal background check.
- Includes all persons with a 5 % or greater direct or indirect ownership interest that are screened at the high categorical risk level for fraud, waste, or abuse.
- Must submit fingerprints within 30 days from a request from CMS or the State Medicaid agency, i.e., Medi-Cal.

Fingerprinting & Criminal Background Checks

42 CFR §455.434

➤ Further Steps Towards Implementation:

- 42 CFR §455.434 is codified in California State statute at W & I Code §14043.38(b).
- Provisions of W & I Code §14043.38 become effective on January 1, 2013.
- DHCS' fingerprinting & criminal background check program has been delayed and will be fully implemented 60 days following the release of CMS Guidance.
- DHCS published a Regulatory Provider Bulletin, "Medi-Cal Requirement to Submit Fingerprints for a Criminal Background Check" describing the process applicants/providers must follow if they meet either the provider enrollment type or are required to be screened at the high categorical risk level for fraud, waste, or abuse.

Federal Database Checks and Reporting of Terminations

42 CFR §455.436 and 42 CFR §455.101

➤ Federal Database Checks Required:

- 42 CFR §455.436 requires State 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

Federal Database Checks and Reporting of Terminations

42 CFR §455.436 and 42 CFR §455.101

- For *Exclusion* Status:
 - ❖ Federal regulations require States to check *at the time of application* and at least on a *monthly basis*:
 - List of Excluded Individuals and Entities (**LEIE**), and
 - Excluded Parties List System (**EPLS**) – *now part of the System for Award Management (SAM)*.
- For *Deceased* Providers:
 - ❖ States are required to periodically check the Social Security Administration's Death Master File (SSADMF).

Federal Database Checks and Reporting of Terminations

42 CFR §455.436 and 42 CFR §455.101

For *Termination* Status:

States must check *at the time of application*, and *at regular intervals*, the new Medicaid and Children's Health Insurance Program State Information Sharing System (MCSIS).

- The application review process incorporated this new database check in January 2013.
- Monthly crosschecks of active enrolled providers in the Medi-Cal payment system began by PED in January 2013.

Federal Database Checks and Reporting of Terminations

42 CFR §455.436 and 42 CFR §455.101

➤ Reporting of Provider Terminations:

- 42 CFR §455.101 defines *termination* of Medicaid and CHIP providers as follows:
 - State has taken action to revoke billing privileges “for cause”.
 - Provider has exhausted all applicable State appeal rights.
 - Revocation is not temporary.
 - Provider must re-enroll (and be re-screened per 42 CFR §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.

Federal Database Checks and Reporting of Terminations

42 CFR §455.436 and 42 CFR §455.101

PED published an informational provider bulletin in December 2012, “Medi-Cal Requirement to Report Provider Enrollment Terminations”

- The actions that PED will report after all appeals are exhausted are limited to specific “For Cause Terminations” based on fraud, integrity, or quality.
- CMS has stated that the following do not qualify as “for cause” terminations:
 - Provider voluntarily ends participation (as long as provider is not doing this to avoid a sanction).
 - Provider allowed their professional license to expire in one State simply because they relocated to another State.

Denials & Terminations 42 CFR §455.416

- 42 CFR §455.416 specifies new causes for the denial and/or termination of enrollment of providers.
- This section broadens DHCS' 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".

Denials & Terminations 42 CFR §455.416

- New denial and deactivation causes became effective in State law on January 1, 2013
- Also published in informational provider bulletin on November 30, 2012 - “Provisions of the Affordable Care Act Create New Medi-Cal Provider Application Screening and Enrollment Requirements”
 - FOUR new causes for denial of provider applications.
 - FIVE new causes for deactivation.

Denials & Terminations 42 CFR §455.416

➤ FOUR New Denial Causes:

1. The provider is currently terminated by Medicare or by the Medicaid or CHIP (Children's Health Insurance Program) of another State.
 - *W & I Code §14043.36(b)*
2. Provider did not submit application fee when required.
 - *W&I Code §14043.26(f)(4)(F)*
3. *Enrolled Provider* doesn't permit access for onsite.
 - *W&I Code §14043.7(a)*
4. Provider did not submit fingerprints for a criminal background check when required.
 - *W&I Code §14043.26(f)(4)(E)*

Denials & Terminations 42 CFR §455.416

➤ FIVE New Deactivation Causes:

1. Enrolled Provider is currently terminated by the Medicare or Medicaid/CHIP program of another State.
 - *W&I Code §14043.36(b)*
2. *Enrolled Provider* fails to permit access for Onsite Inspection.
 - *W&I Code §14043.7(a)*
3. Provider fails to submit fingerprints within 30 days of a request.
 - *W&I Code §14043.28(b)*
4. Provider fails to resubmit application timely after a deficiency notice has been sent.
 - *W&I Code §14043.26(h)(2)(B)*
5. Provider fails to remediate material discrepancies post-onsite.
 - *W&I Code §14043.26(i)(2)(B)* and *W&I Code §14043.4(a)*

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QUESTIONS?