

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID AND MEDICAL ASSISTANCE
Statutory Authority: 31 Delaware Code, Section 512 (31 Del.C. §512)

PROPOSED

Medicaid Provider Screening Requirements and Enrollment Fee and Program Integrity

PUBLIC NOTICE

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code) and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend the Delaware Medical Assistance Program (DMAP) Manual specifically, the General Policy Provider Manual regarding *Medicaid Provider Screening Requirements and Provider Enrollment Fee and Program Integrity*.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Planning & Policy Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to 302-255-4425 by September 30, 2013.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSAL

The proposed provides notice to the public that the Division of Medicaid and Medical Assistance (DMMA) intends to amend the Delaware Medical Assistance Program (DMAP) Manual specifically, the General Policy Provider Manual regarding *Medicaid Provider Screening Requirements and Provider Enrollment Fee and Program Integrity*.

Statutory Authority

- Patient Protection and Affordable Care Act (Pub. L. No. 111-148 as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152)), together known as the Affordable Care Act. Specifically, Section 6401, *Provider Screening and Other Enrollment Requirements Under Medicare, Medicaid, and CHIP*; and Section 6501, *Termination of Provider Participation Under Medicaid If Terminated Under Medicare or Other State Plan*
- 42 CFR Part 455 Subpart E

Background

Section 6401

Section 6401(a) of the Affordable Care Act, as amended by section 10603 of the Affordable Care Act, establishes procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under Medicare, Medicaid, and Children's Health Insurance Program (CHIP). Section 1866(j)(2)(B) of the Act requires the Secretary of the U.S. Department of Health and Human Services to determine the level of screening to be conducted according to the risk of fraud, waste, and abuse with respect to the category of provider or supplier. Section 1866(j)(2)(C) of the Act requires the Secretary to impose a fee on each institutional provider of medical or other items or services or supplier, to be used by the Secretary for program integrity efforts. Section 6401(b) of the Affordable Care Act includes requirements for States to comply with the process of screening providers and suppliers and imposing temporary enrollment moratoria for the Medicaid program as established by the Secretary. The Centers for Medicare and Medicaid Services (CMS) implemented these requirements with Federal regulations at 42 CFR Part 455 Subpart E. These regulations were published in the Federal Register, Volume 76, February 2, 2011, and were effective March 25, 2011.

Section 6501

Section 6501 of the Affordable Care Act (ACA) 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. 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 ACA only applies in cases

where providers, suppliers or eligible professionals have been terminated or had their billing privileges revoked “for cause.” Section 6501 builds upon section 6401(b)(2) which requires that CMS establish a process to make provider termination information available to State Medicaid programs.

Summary of Proposal

To receive reimbursement under the Delaware Medical Assistance Program (DMAP), a provider must be eligible and actively enrolled. The provider is enrolled when certain conditions are met and are applicable to the provider type.

Section 6401 and Section 6501 of the Affordable Care Act mandate provider screening and enrollment requirements that State Medicaid agencies must implement. Please refer to *42 CFR 455 Subpart E – Provider Screening and Enrollment* for the complete set of rules and regulations. Delaware Medicaid must implement these requirements to comply with Federal law.

To become compliant with ACA-mandated provider screening and enrollment requirements, the Division of Medicaid and Medical Assistance (DMMA) is updating the Program Integrity provisions of the General Policy Provider Manual at Section 1.39 to include the following provisions:

- An enrollment fee for institutional providers as described in 42 CFR §455.460 (section 6401(a));
- Compliance in the event that CMS imposes a temporary enrollment moratoria as described in 42 CFR §455.470 (section 6401(b));
- Termination of provider participation in Medicaid and CHIP upon termination from Medicare or another State’s Medicaid program or CHIP on or after January 1, 2011 as described in 42 CFR §455.416 (section 6501); and,
- Screening of providers in accordance with 42 CFR 455.400 et seq. at enrollment, reenrollment and revalidation (section 6401).

Fiscal Impact Statement

These revisions impose no increase in cost on the General Fund.

The costs for system changes are already budgeted in the General Fund.

There will be additional costs for some providers associated with the enrollment/revalidation fee.

DMMA PROPOSED REGULATION #13-25

REVISION:

1.39.2 Provider Screening and Enrollment

Sections 6401 and 6501 of the Affordable Care Act require States to incorporate additional program integrity provisions within Medicaid and the Children’s Health Insurance Program to prevent fraud, waste and abuse. The enhanced provisions include enrollment fees, additional provider screening requirements, temporary provider enrollment moratoria, and provider termination.

1.39.2.1 Provider Enrollment Fee

Effective, March 30, 2010, Section 6401(a) of the Affordable Care Act (ACA) requires states to impose a fee on institutional providers for program integrity efforts. The fee is required at initial enrollment and reenrollment. The enrollment fee amount is established by the Centers for Medicare and Medicaid Services (CMS) and updated annually. The Delaware Medical Assistance Program (DMAP) will begin collection of fees in August of 2013. Institutional providers who have paid the enrollment fee to a Medicare contractor or another State’s Medicaid program or Children’s Health Insurance Program (CHIP) within the last 365 days are not required to pay an additional enrollment fee to the DMAP. The enrollment fee may also be waived for providers who present proof of hardship exception from CMS.

1.39.2.2 Provider Screening and Enrollment Requirements

The Affordable Care Act (ACA) requires states to perform enhanced screening of providers at initial enrollment, reenrollment, establishment of a new location, change of location, and revalidation. Providers will also need to complete an annual online disclosure statement identifying persons with 5% or more ownership, controlling interest, and all managing employees. Ordering and referring providers are required to enroll with DMAP in a limited capacity and are subject to the new provider screening initiatives. The ACA requires DMAP to deny or terminate enrollment of any providers, disclosed entities, or individuals who do not meet ACA screening guidelines.

1.39.2.2.1 Provider Risk Categories

Based on the potential for fraud, waste, and abuse, CMS has assessed the various Medicare provider types and assigned risk categories. DMAP will assign a risk category in accordance with CMS guidelines for non-Medicare providers. Provider screening requirements vary depending on ACA-defined risk categories. The risk categories are “limited”, “moderate”, and “high”. Providers falling within two risk levels will be assigned the higher risk category. DMAP reserves the right to modify provider risk levels as it pertains to encumbrances, adverse actions, sanctions, terminations and suspensions.

Limited Risk Level- All providers and disclosure-identified individuals must verify Social Security number, licensure status, taxpayer identification number, and National Provider Identifier. Various databases will be checked for sanctions, exclusions, terminations, and encumbrances. Limited risk level providers include but are not limited to the following as identified by CMS:

Physicians
Non physician practitioners
Medical groups or clinics
Hospitals
Ambulatory Surgical Centers (ACSS)
Early Stage Renal Disease (ESRD) facilities
Federally Qualified Health Centers (FQHCs)
Skilled Nursing Facilities (SNFs)

Moderate Risk Level- Moderate risk providers are subject to unannounced pre-enrollment and post-enrollment site visits. Moderate risk providers and disclosure-identified individuals must verify Social Security number, licensure status, taxpayer identification number, and National Provider Identifier. Various databases will be checked for sanctions, exclusions, terminations, and encumbrances. Moderate risk level providers include but are not limited to the following as identified by CMS:

Ambulance providers
Community Mental Health Centers
CORF - Comprehensive Outpatient Rehabilitation Facilities
Revalidating Durable Medical Equipment (DME) suppliers
Revalidating Home Health Agencies (HHA)
Hospice organizations
Laboratories - independently owned

High Risk Level- High risk providers and disclosure-identified persons with 5% or more ownership are required to comply with a fingerprint-based background check and unannounced pre-enrollment and post enrollment site visits. High risk providers and disclosure-identified persons must verify Social Security number, licensure status, taxpayer identification number, and National Provider Identifier. Various databases as directed by CMS will be checked for sanctions, exclusions, terminations, and encumbrances. High risk level providers include but are not limited to the following as identified by CMS:

Durable Medical Equipment suppliers (newly enrolling)
Home Health Agencies (newly enrolling)

1.39.2.2.2 Ordering, Referring and Prescribing Providers (ORPs)

Physicians and non-physician practitioners whose sole interaction with clients is limited to ordering, referring, or prescribing items and/or services, are required to enroll with DMAP in a limited capacity for purposes of identifying the providers who write the orders, referrals and prescriptions. Providers who are members of Delaware's risk-based managed care organizations are exempt from this requirement. Failure to enroll with DMAP will result in the denial of claims for items ordered, referred, or prescribed for Medicaid beneficiaries by an ORP.

1.39.2.3 Temporary Provider Enrollment Moratoria

The ACA requires States to comply with a temporary provider enrollment moratorium when directed by the federal Secretary of Health and Human Services to combat fraud, waste, and abuse. States may also implement restrictions on new enrollment for provider types that are identified as high risk for fraud, waste, and abuse.

1.39.2.4 Provider Termination

Section 6501 of the ACA mandates that States terminate enrollment of providers who have been terminated from Medicare or another State's Medicaid or CHIP program. On a monthly basis, DMAP will screen all enrolled providers through various federal databases for sanctions, exclusions, and terminations. All individuals and entities identified through annual disclosure statements are also subject to these screenings. DMAP will terminate providers and disclosed entities or individuals who do not meet ACA screening guidelines.

1.39.2.5 Provider Appeal Rights

Providers may appeal denial and termination decisions as a result of ACA provider screening and enrollment requirements. Refer to Section 6.0 Appendix A in the General Policy Provider Manual for information regarding provider appeals.

17 DE Reg. 282 (09/01/13) (Prop.)