Office of the Registrar of Regulations,
Legislative Council,
State of Delaware

# DEPARTMENT OF HEALTH AND SOCIAL SERVICES

## DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

## PROPOSED

### PUBLIC NOTICE

### Medicaid Provider Screening and Enrollment

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 Title XIX Medicaid State Plan regarding *Medicaid Provider Screening and Enrollment*.

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 March 31, 2012.

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 Title XIX Medicaid State Plan regarding *Medicaid Provider Screening and Enrollment*.

**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;
- 42 CFR Part 455 Subpart E

**Background**

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 CHIP. Section 1866(j)(2)(B) of the Act requires the Secretary 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.

**Summary of Proposal**

CMS recently issued a State plan preprint to assure compliance with and implementation of Section 6401.

The Division of Medicaid and Medical Assistance (DMMA) intends to make the appropriate changes to the Medicaid State Plan pertaining to the federally required changes in Medicaid provider enrollment processes pursuant to the Affordable Care Act of 2010. As such, the Medicaid state plan will be amended at General Program Administration, 4.46 - Provider Screening and Enrollment.

Initiated to combat fraud and abuse, these directives apply to newly enrolling providers and currently enrolled providers. As implementation of this mandate moves forward, DMMA will notify providers via provider alerts, provider newsletters, remittance advice banners and the Delaware Medical Assistance Program (DMAP) website.

The provisions of this state plan amendment are subject to approval by the Centers for Medicare and Medicaid Services (CMS).

**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, criminal background checks and fingerprinting.

**DMMA PROPOSED REGULATION #12-04**
**REVISION:**

79aa

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: **DELAWARE**

**4.46 Provider Screening and Enrollment**

| Citation | The State Medicaid agency gives the following assurances: |
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| 1902(a)(77)<br>1902(a)(39) of<br>the Act adds 1902(kk);<br>P.L. 111-148 and<br>P.L. 111-152 | |
| 42 CFR 455<br>Subpart E | PROVIDER SCREENING<br>__X__ Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act. |
| 42 CFR 455.410 | ENROLLMENT AND SCREENING OF PROVIDERS<br>__X__ Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq.<br><br>__X__ Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals, who are not enrolled in Medicare, to be enrolled under the State plan or under a waiver of the Plan as participating providers. |
| 42 CFR 455.412 | VERIFICATION OF PROVIDER LICENSES<br>__X__ Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers' licenses have not expired or have no current limitations at the time of enrollment or recertification. |
| 42 CFR 455.414 | REVALIDATION OF ENROLLMENT<br>__X__ Assures that providers will be revalidated regardless of provider type at least every 5 years. |

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: **DELAWARE**

**4.46 Provider Screening and Enrollment Continued**

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| 42 CFR 455.416 | TERMINATION OR DENIAL OF ENROLLMENT |

__X__ Assures that the State Medicaid agency will comply with 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

42 CFR 455.420

REACTIVATION OF PROVIDER ENROLLMENT

__X__ Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422

APPEAL RIGHTS

__X__ Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

42 CFR 455.432

SITE VISITS

__X__ Assures that pre-enrollment and post enrollment site visits of providers who are in “moderate” or “high risk” categories will occur

42 CFR 455.434

CRIMINAL BACKGROUND CHECKS

__X__ Assures that providers as a condition of enrollment will be required to consent to criminal background checks including fingerprints if required to do so under State law or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

42 CFR 455.436

FEDERAL DATABASE CHECKS

__X__ Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

42 CFR 455.440

NATIONAL PROVIDER IDENTIFIER

__X__ Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.





**4.46 Provider Screening and Enrollment Continued**

42 CFR 455.450

SCREENING LEVELS FOR MEDICAID PROVIDERS

__X__ Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for

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| | a provider. |
| 42 CFR 455.470 | TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS<br>__X__ Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance. |