DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

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

FINAL

ORDER

Medicaid Provider Screening and Enrollment

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend existing rules in the Title XIX Medicaid State Plan regarding *Medicaid Provider Screening and Enrollment*. The Department's proceedings to amend its regulations were initiated pursuant to 29 Delaware Code Section 10114 and its authority as prescribed by 31 Delaware Code Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 Delaware Code Section 10115 in the March 2012 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by March 31, 2012 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

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.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. The Division of Medicaid and Medical Assistance (DMMA) has considered each comment and responds as follows.

As background, CMS issued regulations in February, 2012 which are effective March 25, 2012 implementing changes in the U.S. Code. CMS provided states with a template for certifying compliance within the respective state plans. Delaware is now providing the assurances contained in the template.

GACEC and SCPD endorse the proposed regulation since DMMA is essentially adopting a mandatory change in its State Medicaid Plan prompted by CMS.

Agency Response: DMMA thanks the Councils for their endorsement.

Further analysis by Division staff resulted in a change to the proposed State plan page. The provision to assure compliance with 42 CFR §455.460, *Application Fees*, was inadvertently omitted. The inclusion of this citation is indicated by bold, bracketed type.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the March 2012 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Title XIX Medicaid State Plan regarding *Medicaid Provider and Enrollment* is adopted and shall be final effective May 10, 2012.

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATION #12-17
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:
1902(a)(77) 1902(a)(39) of the Act adds 1902(kk); P.L. 111-148 and P.L. 111-152	
42 CFR 455 Subpart E	PROVIDER SCREENING __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 __X__ Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq. __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

__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

__X__ Assures that providers will be revalidated regardless of provider type at least every 5 years.

4.46 Provider Screening and Enrollment Continued

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 a provider.

[42 CFR 455.460

APPLICATION FEE

___X__ Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.]

42 CFR 455.470

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

__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.