# Medicaid Enrollment Update

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This piece is part of a series that will appear in the *RAP Sheet* over its next several issues that summarizes hot topics in Medicaid enrollment on a state-by-state basis. In this issue, we bring you California, Florida, North Carolina, Virginia, and West Virginia.

Largely speaking, the states are in various stages of implementing federal healthcare reform requirements for provider enrollment that were enacted as part of the Patient Protection and Affordable Care Act of 2010 (PPACA) as amended by the Health Care and Education Reconciliation Act of 2010.[1] The Centers for Medicare & Medicaid Services (CMS) issued implementing regulations that began to apply to Medicaid enrollment effective March 25, 2011.[2] These federal requirements expanded the provider types subject to federally required enrollment onsite agency reviews, required the payment of Medicaid enrollment fees, and provided new mechanisms for the establishment of Medicaid enrollment moratoria.[3] In addition, the federal rules introduced fingerprinting to the Medicaid enrollment process.[4] The states we are featuring are in various stages of implementation of PPACA's Medicaid enrollment requirements. In addition, state Medicaid programs are also now required to suspend Medicaid payments if the state agency receives a "credible allegation of fraud"[5] while the investigation is pending.

## California

California recently passed legislation authorizing its Department of Health Care Services (DHCS) to implement the vast majority of PPACA requirements on January 1, 2013.[6] Providers should have expected additional guidance from DHCS about implementation, including Provider Regulatory Bulletins and new enrollment forms, prior to this date.[7]

### Enrollment Screening Levels

DHCS will, consistent with federal law, implement the Medicaid program's requirement to classify providers engaged in enrollment matters as "limited," "moderate," and "high" categorical risks, with varying levels of enrollment scrutiny to be afforded to each provider category.[8] The categorical screening levels assigned by Medicaid will, at a minimum, mirror the screening levels used for Medicare provider enrollment.[9]

California will expand its use of pre-enrollment and post-enrollment site visits to apply to all moderate- and high-risk providers,[10] and collect fingerprints and conduct criminal background checks on 5% direct and indirect owners of high-risk providers.[11] DHCS indicated that fingerprinting would not be implemented on January 1, 2013, until DHCS received additional implementing instructions from CMS. DHCS' Audits and Investigations Division will undertake the site visits.[12]

Beginning in 2013, DHCS will increase a provider's categorical risk level for enrollment purposes from limited or moderate to high if any of the following occur: Medicaid payments have been suspended based on a "credible allegation of fraud, waste or abuse"; the provider has an existing Medicaid overpayment; the provider has been excluded by the U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) or another state's Medicaid program within the previous ten years; or the provider is applying as a provider that would have been subject to a Medicaid enrollment moratorium within the last six months.[13]

### Requirements for Enrollment of Ordering and Referring Physicians

All ordering and referring physicians and other professionals providing services under the Medi-Cal program will need to become enrolled as participating providers and, thus, be subject to the scrutiny of the Medicaid enrollment process.[14] According to DHCS, final forms to so enroll providers were published January 1, 2013, although drafts were distributed in advance at public meetings; thus, Medi-Cal payment edits to preclude payments for services ordered or referred by physicians who are not enrolled in the Medicaid program will not implement right away. DHCS has not, at the time of submission of this article, published a date at which time these edits will apply.

### Revalidation

In addition, Medicaid programs are currently required to screen all providers at least every five years.[15] DHCS will be able to use CMS Medicare enrollment revalidation data to fulfill these obligations when it is available.[16] For those providers that do not have such information on file, DHCS is developing a short-form application for this purpose.

### Enrollment Application Fees

DHCS began collecting Medi-Cal enrollment application fees from healthcare providers seeking to enroll (except for physicians, other individual practitioners, providers enrolled in the Medicare program or another state's Medicaid programs, or providers that have paid the applicable application fee to a Medicare contractor or another state Medicaid program) commencing January 1, 2013.[17]

### Enrollment Moratoria

California has a longstanding tradition of implementing moratoria on the enrollment of new providers into the Medi-Cal system—it has had in effect for some time moratoria on enrollment for clinical laboratories, adult day healthcare centers, durable medical equipment providers, and certain pharmacies.[18] California will, effective in 2013, additionally implement enrollment moratoria for providers that HHS identifies as risky to the Medicaid program; DHCS will implement these requests unless DHCS identifies that the moratoria will adversely impact Medi-Cal beneficiary access to care.[19]

### Payment Suspension Based Upon Credible Allegation of Fraud

Effective January 1, 2013, DHCS began suspending Medi-Cal payments to providers if DHCS received a "credible allegation of fraud" while the investigation is pending.[20] DHCS is required to notify the provider of the payment suspension between five and 90 days after the payment suspension begins.[21]

## Florida

Like many states, Florida has implemented new Medicaid provider enrollment rules in light of the PPACA requirements. In April 2012, the Florida Agency for Health Care Administration (AHCA) amended its Medicaid provider agreements to incorporate many of the Medicaid changes required under PPACA. Under the new provider agreements, institutional providers must undergo re-enrollment every three years and non-institutional providers now must undergo re-enrollment every five years (previously, it was every 10 years).[22] Re-enrollment packets are automatically mailed approximately 90 days prior to the expiration date of the Medicaid provider agreement.

The Florida Medicaid provider agreement requires the enrolling provider to attest that all statements and information furnished by the prospective provider are true and complete. Filing a materially incomplete, misleading, or false application renders the enrollment application and provider agreement voidable at the option of AHCA and is cause for immediate termination of the provider from the Medicaid program and/or revocation of the provider number.[23] On its face, the provider agreement does not mandate automatic termination for failure to meet this requirement.

Florida now requires criminal history background screening for enrolling and re-enrolling Medicaid providers which involves a fingerprint check of state and federal criminal history information conducted through the Florida Department of Law Enforcement and the Federal Bureau of Investigation. The following individuals must submit to a criminal history check unless otherwise exempt: (1) all partners or shareholders with an ownership interest of 5% or more; (2) all officers; (3) all members of the board of directors; (4) the financial records custodian; (5) the medical records custodian; (6) all billing agents who are employees of the provider; (7) all managing employees or affiliated persons, including pharmacy managers; and (8) all individuals authorized to sign on the account used for electronic funds transfer. These rules became effective in August 2011.[24]

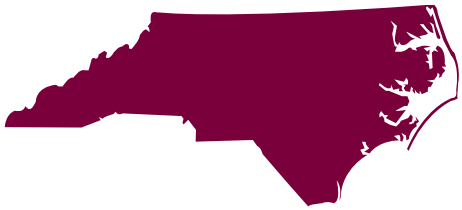
AHCA is required to deny an application for Medicaid enrollment or re-enrollment if one of the individuals has a criminal history of a disqualifying offense.[25] The statute does offer an exemption process, but providers with a problematic criminal history should be proactive and seek an exemption prior to enrollment or re-enrollment.

Medicaid providers must notify AHCA within five business days after a Medicare suspension or disenrollment, and failure to do so may result in sanctions,[26] and the provider may be required to return funds paid to the provider during the period of time that the provider was suspended or disenrolled as a Medicare provider. If a provider has been suspended or terminated from participation in the Medicaid program or the Medicare program, Florida statutes require AHCA to "immediately suspend or terminate, as appropriate, the provider's participation in this state's Medicaid program for a period no less than that imposed by the federal government or any other state, and may not enroll such provider in this state's Medicaid program while such foreign suspension or termination remains in effect."[27] Florida law requires AHCA to immediately suspend or terminate, as appropriate, a provider's participation in Florida Medicaid if the provider participated or acquiesced in any action for which any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5% or greater, was suspended or terminated from participating in the Medicaid program or the Medicare program.

The Florida Medicaid provider agreement requires the enrolling provider allow the government to access "all Medicaid-related information . . . and other information pertaining to services or goods billed to the Medicaid program."[28] The provider agreement does not mandate automatic termination for failure to meet this requirement.

## North Carolina

There are many recent developments in the North Carolina Medicaid program (NC DMA). The two biggest are: (1) the incongruence of the current Medicaid enrollment applications



with state Medicaid policy as it relates to changes of ownership (CHOWs) and as it relates to the completion of the "Exclusion/ Sanction Information" section; and (2) implementation of new processes mandated under PPACA.

### CHOWs

There are inconsistent definitions of what constitutes a CHOW under various North Carolina policy pronouncements. Basic Medicaid and N.C. Health Choice Billing Guide[29] and instructions to In State/Border Organization Provider Enrollment Application[30] (Documents) are out of synch with NC DMA policy as to which transactions constitute CHOWs. Specifically, the current Documents define CHOWs to include, among other things, stock purchases. However, Session Law 2011-399/Senate Bill 496, which added Chapter 108C to the North Carolina General Statutes, specifically excludes such stock transfers from the definition of CHOWs.[31] Following recent conversations with the NC DMA Recipient and Provider Services Department regarding a specific stock purchase transaction, it was confirmed that in fact, NC DMA does not consider these changes to constitute CHOWs. Instead, similar to the Medicare program, NC DMA considers such changes to be changes of information that are reportable as simple file updates.[32]

Rather than require the new shareholders in a stock purchase transaction to submit a new enrollment application, and the previous shareholders to submit a Medicaid Provider Change Form terminating participation due to a CHOW, all that was required at least in one recent instance was to provide NC DMA with a detailed letter describing the relevant changes and providing copies of the relevant pages from the NC DMA provider enrollment application depicting such changes. These documents would then be maintained in the provider's file.

While NC DMA did indicate that both Documents will undergo revision, no indication as to when to anticipate such changes was provided. More importantly, because the current Documents reflect an entirely different process, anyone undergoing a CHOW for a Medicaid provider in North Carolina should discuss the transaction with Provider and Enrollment Services well in advance in order to receive the most up-to-date process and requirements.

### Exclusion/Sanction Information

As with CHOWs, the questions currently posed in the Exclusion/ Sanction section of the In State/Border Organization Provider Enrollment Application[33] are out of synch with current NC DMA policy. Notably, the current questions embodied in the Exclusion/ Sanction Information section exceed what is needed by NC DMA.

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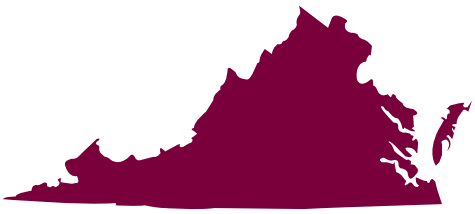
As it stands today, the Exclusion/Sanction Information section of the provider enrollment application asks questions relating not only to the applicant, but also to the applicant's agents, owners, managing employees, etc. However, unlike the Medicare program, NC DMA's questions go a step further and also inquire as to any entity such individuals are or were either an agent, owner, or managing employee of, back to the beginning of time. Responding to questions such as these can be extremely difficult when the applicant is owned and operated by a provider with nationwide or even multi-state operations and with owners, agents, and managing employees with ties to such providers.

Following conversations with the NC DMA Provider and Recipient Services Department we were recently informed that NC DMA does not expect multi-state or national providers and their owners, agents, managing employees, etc., to respond to these questions beyond North Carolina. Instead, they indicate that a global statement with regards to their knowledge of matters with former entities, but then respond in depth, to the extent necessary, with regards to the providers' operations in North Carolina. Unfortunately, as with the current policies regarding CHOWs, the policy with regards to the Exclusion/Sanction Information questions is not yet reflected in the Documents and no indication was provided as to when to anticipate such changes.

### PPACA Mandates

With regards to PPACA mandates, the NC DMA program has begun instituting a wide variety of new measures. Just to name a few, NC DMA has instituted a three-year provider re-credentialing validation program that is currently underway.[34] Similar to the Medicare revalidation program, failing to timely respond to requests for re-credentialing can result in termination of enrollment.[35] In another instance, NC DMA is requiring enrolling providers to undergo screenings and attend trainings for things such as: common billing errors and how to avoid them; audit procedures; how to identify beneficiary fraud; how to report suspected fraud or abuse; and beneficiary due process and appeal rights.[36] Lastly, NC DMA has instituted an enrollment fee for initial enrollments and re-credentialing.[37]



## Virginia

The Virginia Department of Medical Assistance Services (DMAS) has not formally announced changes to its Medicaid provider enrollment and screening requirements. Nevertheless, DMAS recently sought input from a small group of affected parties, asking whether mandatory web-based electronic submission of provider enrollment applications, and other enrollment-related documents, would be appropriate and supported by Virginia Medicaid providers. In response, one affected party discouraged DMAS from making web-based enrollment mandatory. Though many providers are embracing optional web-based Medicare enrollment through the Provider Enrollment, Chain, and Ownership System (PECOS), the alternative paper application reduces provider anxiety with the new system and accommodates the few providers who do not have the technology or know-how to submit electronic applications. Providers have expressed that a similar arrangement would be ideal for Virginia Medicaid enrollment.

Also, a 2012 Virginia budget amendment[38] indicates that "[i]t is the intent of the General Assembly that [DMAS] exercise the full extent of federal flexibility in excluding and removing providers as needed to ensure Medicaid program integrity in compliance with federal and state statutes." The amendment also required DMAS to develop a plan to implement programmatic changes that comply with the heightened federal screening requirements, and to report on the plan to the House Appropriations and Senate Finance Committees by December 1, 2012.

More details about Virginia Medicaid provider enrollment should be issued soon.

## West Virginia

West Virginia has made significant strides toward updating its Medicaid provider enrollment procedures and screening requirements. Molina Medicaid Solutions (Molina) and the West Virginia Bureau for Medical Services (BMS) offered a provider workshop in March of 2012 to announce upcoming changes,[39] and BMS recently placed a draft of its Provider Participation Requirements manual online for comment.[40] The following topics outline the announced changes:

### Reenrollment Under PPACA

Molina is finalizing its web-based Provider Enrollment Application (PEA) that will accommodate newly enrolling and re-enrolling providers. PEA is currently undergoing testing and was slated to be available in 2012.

BMS also confirmed that it currently has access to PECOS, the web-based Medicare enrollment system. With this access, BMS will determine which providers and suppliers have paid the Medicare enrollment application fee and will waive the Medicaid screening fee for providers whose payment has been confirmed. BMS has, and will continue to have "read-only" access to PECOS.

This means BMS may only view the information available on PECOS. It may not edit the information.

### Reenrollment Timeline

To initiate re-enrollment for an *existing* provider, BMS will mail the provider a general notice 60 days prior to its re-enrollment start date. Within those 60 days, BMS will mail the provider another letter that will contain a unique reenrollment access code for the new PEA. The provider will then have 30 days from the scheduled re-enrollment start date to complete the re-enrollment. Providers who fail to timely submit their re-enrollment application may be placed on pay hold by BMS.

To initiate enrollment for a *new* provider, the provider will be required to contact Molina for a PEA access code.

### Risk Levels

Re-enrollment will be phased-in by provider type and risk level based on the federal determinations (e.g., home health and DMEPOS are considered high-risk provider types). A schedule of provider types with risk levels and re-enrollment dates will be placed on the Molina web portal and banner pages when it is finalized.

### Screening Requirements

Screening of high-risk level provider types will include criminal background checks and fingerprinting of each person with an ownership or control interest or who is an agent or managing employee of the provider.

Screening of high-risk and moderate-risk providers will require unannounced pre- and post-enrollment site visits. BMS is currently working on the site visit survey form, which providers may request once it is completed.

For all providers, BMS will conduct regular checks of federal and state databases to confirm the identity and determine the exclusion status of providers and any person with an ownership or controlling interest. Molina has updated its web portal to include links to the West Virginia list of excluded providers and OIG's List of Excluded Individuals and Entities.[41]

Also, it is important to recognize that the above screening requirements are the minimum required by federal law. It is possible that BMS will choose to subject all provider types to site visits and/or other screening procedures.

The PEA system was expected to be available before the end of 2012, along with an updated Medicaid manual for Provider Participation Requirements.

**If you practice in the Medicaid enrollment area and your state is not represented in this article, please share any interest you may have in contributing to a future piece by emailing Accreditation, Certification, and Enrollment Affinity Group Chair Jeanne Vance at jvance@salemgreen.com.*

1 Pub. L. No. 111-148 (2010); Pub. L. No. 111-152 (2010).
2 76 Fed. Reg. 5862 (Feb. 2, 2011).
3 *Id.*
4 42 C.F.R. § 455.434.
5 42 C.F.R. § 455.23.
6 S.B. 1529, ch. 795 (approved by the Governor Sept. 29, 2012; filed with the Secretary of State Sept. 29, 2012); also, Tanya Homman, Chief, Provider Enrollment Division, Comments to author Sept. 14, 2012 (hereinafter *Homman Comment*).
7 DHCS confirms that enrollment applications that are pending will continue to be processed on the pre-January 1 forms so long as they are received by DHCS during 2012. Providers applying in 2013 will need to do so on the new forms. *Homman Comment*.
8 42 C.F.R. § 455.518; Cal. Welf. & Inst. Code § 14043.38 (forthcoming Jan. 1, 2013).
9 *Id.*
10 Cal. Welf. & Inst. Code § 14043.38(b) (forthcoming Jan. 1, 2013).
11 *Id.*
12 *Homman Comment.*
13 Cal. Welf. & Inst. Code § 14043.38 (forthcoming Jan. 1, 2013).
14 42 C.F.R. § 455.410; Cal. Welf. & Inst. Code § 14043.1(b) (forthcoming Jan. 1, 2013).
15 42 C.F.R. § 455.414 (forthcoming Jan. 1, 2013).
16 *Homman Comment.*
17 Cal. Welf. & Inst. Code § 14043.55(d) (forthcoming Jan. 1, 2013).
18 *See* http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp#Forms.
19 Cal. Welf. & Inst. Code § 14043.55 (forthcoming Jan. 1, 2013).
20 Cal. Welf. & Inst. Code § 14107.11(a) (forthcoming Jan. 1, 2013).
21 *Id.*
22 *See* Florida Medicaid Provider Agreement § 4.
23 *See* Florida Medicaid Provider Agreement § 5(o).
24 *See* Fla. Stat. § 409.907(8)(a).
25 *See* Fla. Stat. Chapter 435.
26 *See* Florida Medicaid Provider Agreement § 5(q); Fla. Stat. § 409.908(24).
27 Fla. Stat. § 409.913(14).
28 *See* Florida Medicaid Provider Agreement § 5(e).
29 *See* Basic Medicaid and N.C. Health Choice Billing Guide, § 4
30 *See* In State/Border Organization Provider Enrollment Application, *available at* www.nctracks.nc.gov/provider/providerEnrollment/DownloadAction?SessionIndex=begin&title=Download%20Provider%20Enrollment%20Applications.
31 *See* North Carolina Session Law 2011-399/Senate Bill 496, adding N.C. Gen. Stat. § 108C-10(a) (providing in relevant part, " . . . Transfer of corporate stock . . . shall not constitute change of ownership.").
32 By way of contrast, it should be noted, that in the case of LLCs, the withdrawal or removal of a member or acquisition of a membership interest will constitute a CHOW. *See* North Carolina Session Law 2011-399/Senate Bill 496, adding N.C. Gen. Stat. § 108C-10(a) (providing in relevant part, "In the case of a Limited Liability Company (LLC), the withdrawal or removal of a member, or when a person acquires a membership interest from the LLC . . . ").
33 *See* In State/Border Organization Provider Enrollment Application, *available at*: www.nctracks.nc.gov/provider/providerEnrollment/DownloadAction?SessionIndex=begin&title=Download%20Provider%20Enrollment%20Applications.
34 *See* Basic Medicaid and N.C. Health Choice Billing Guide, § 4; *see also*, Medicaid Bulletin, December 2011.
35 *See Id.*
36 *See Id.*; *see also*, North Carolina Session Law 2011-399/Senate Bill 496, adding N.C. Gen. Stat. §§ 108C-3, 108C-9(d).
37 *See* North Carolina Session Law 2009-451, § 10.58A; *see also*, Medicaid Bulletin, December 2011; *see also*, www.ncdhhs.gov/dma/provenroll/index.htm.
38 Budget amendment 310 #1h is *available at* http://leg2.state.va.us/WebData/12amend30.nsf/0/b61f461cde8d74e3852579ab0057ff56?OpenDocument&Click=.
39 Materials from the workshop are *available at* www.dhhr.wv.gov/bms/news/Pages/pw.aspx (log-in information required).
40 Only certain sections of the manual are open for comment, and the comment period closed on October 26, 2012. The Provider Participation Requirements Manual Section 300 is *available at* www.dhhr.wv.gov/bms/news/Documents/Chap300ProvPartReq30day.pdf.
41 The list of excluded providers is *available at* www.wvmmis.com/provider_enrollment.screen.