



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES


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MEMORANDUM

DATE: September 26, 2013

TO: Ms. Sharon L. Summers, DMMA
Planning & Policy Development Unit

FROM: 
Kyle Hodges, Director
State Council for Persons with Disabilities

RE: 17 DE Reg. 282 [DMMA Proposed Medicaid Provider Screening]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMA) proposal to adopt regulations implementing §§6401 and 6501 of the Affordable Care Act. In a nutshell, CMS adopted regulations in 2011 which: 1) require states to adopt certain screening and enrollment standards for Medicaid providers; 2) collect an enrollment fee for institutional providers; 3) authorize a temporary Medicaid provider enrollment moratorium when directed by CMS; 4) terminate provider participation in Medicaid and CHIP if another state has terminated the provider's participation on or after January 1, 2011; and 5) adopt provider screening standards at enrollment, reenrollment and revalidation. The proposed regulation was published as 17 DE Reg. 282 in the September 1, 2013 issue of the Register of Regulations. Given time constraints, SCPD has not conducted an exhaustive comparison of the proposed regulation to extensive federal statutory, regulatory, and subregulatory ACA standards. However, Council did identify two (2) areas of concern.

First, §§1.39.2.4 and 1.39.2.5 authorize providers terminated from program participation to invoke full appeal rights compiled in the General Policy Provider Manual. In contrast, the attached CMS Bulletin (CPI-B 11-05) contains the following limitation on provider appeal rights:

...When subsequent States terminate based on that initial termination, the scope of their appeals should only review whether the provider was, in fact, terminated by the initiating program. The subsequent appeals process should not review the underlying reasons for

the initiating termination. The appeal process in subsequent States does not provide a new forum in which to litigate the basis of termination by another State Medicaid program, Medicare, or CHIP.

DMMA may wish to incorporate this limitation into §1.39.2.5.

Second, §1.39.2.4 recites that DMMA will check federal databases monthly and “will terminate providers and disclosed entities or individuals who do not meet ACA screening guidelines.” This is a “no-exceptions” standard. In contrast, the attached CMS Bulletin (CPI-B 11-05) clarifies that termination is not the invariable result of identification of termination of a provider by another state:

Q. Are there any exceptions to the requirement to terminate a provider that was terminated by Medicare or another State Medicaid program or CHIP?

A. Yes. The statute provides for the same limitations on termination that apply to exclusion under §§1128(c)(3)(B) and 1128(d)(3)(B) of the Social Security Act. Thus, a State may request a waiver of the requirement to terminate a particular provider’s participation. State agencies may submit such waiver requests to their respective CMS Regional Offices.

DMMA may wish to consider the following amendment to the last sentence in §1.39.2.4:

DMAP will terminate providers and disclosed entities or individuals who do not meet ACA screening guidelines unless DMAP, in its sole discretion, solicits and secures a waiver from CMS.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations and recommendations on the proposed regulation.

cc: Mr. Stephen Groff
Mr. Brian Hartman, Esq.
Governor’s Advisory Council for Exceptional Citizens
Developmental Disabilities Council

17reg282 dmma-medicaid provider screening 9-26-13

CPI – CMCS INFORMATIONAL BULLETIN

DATE: May 31, 2011 **CPI-B 11-05**

FROM: Peter Budetti
Director
Center for Program Integrity (CPI)

Cindy Mann
Director
Center for Medicaid, CHIP and Survey & Certification (CMCS)

SUBJECT: ***Affordable Care Act Program Integrity Provisions - Guidance to States --
Section 6501 - Termination of Provider Participation under Medicaid if
Terminated under Medicare or other State Plan***

This Informational Bulletin is part of a series of bulletins intended to provide guidance regarding implementation of certain provisions of the Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, together called the “Affordable Care Act.” Specifically, this bulletin provides guidance on the following program integrity provision in the Affordable Care Act that was included in the final rule CMS-6028-FC, published in the Federal Register on February 2, 2011:

- Section 6501 regarding termination of participation in Medicaid and the Children’s Health Insurance Program (CHIP) upon termination from Medicare or another State’s Medicaid program or CHIP.

Termination of Provider Participation Under Medicaid and CHIP

Section 6501 of the Affordable Care Act, Termination of Provider Participation Under Medicaid if Terminated Under Medicare or Other State Plan amends section 1902(a)(39) of the Social Security Act and requires States to terminate the participation of any individual or entity if such individual or entity is terminated under Medicare or any other Medicaid State plan.¹ On February 2, 2011, the Centers for Medicare & Medicaid Services (CMS) published the final rule implementing this provision, applicable to terminations occurring on or after the statutory effective date of January 1, 2011. See <http://edocket.access.gpo.gov/2011/pdf/2011-1686.pdf>.

¹ Although Section 6501 of the Affordable Care Act does not specifically include terminations from CHIP, CMS has required CHIP, through Federal regulations, to take similar action regarding termination of a provider that is also terminated or had its billing privileges terminated under Medicare or any Medicaid State plan.

Termination

“Termination” occurs when the Medicare program, a State Medicaid program, or CHIP has taken an action to revoke a provider's billing privileges, a provider has exhausted all applicable appeal rights or the timeline for appeal has expired, and there is no expectation on the part of a provider or supplier or the Medicare program, State Medicaid program, or CHIP that the revocation is temporary. The requirement for termination based upon a termination in another program applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include reasons based on fraud, integrity, or quality.

Reporting of Terminations

As discussed above, States are required to terminate the participation of any individual or entity if such individual or entity is terminated under Medicare, or any other State's Medicaid program, or CHIP on or after January 1, 2011. In order to help States identify those providers whose billing privileges have been revoked by Medicare or who have been terminated by other State Medicaid programs or CHIP, CMS has established a secure web-based portal that allows States to share information regarding terminated providers. Using this web-based portal, a State is able to download information regarding terminated providers in other States and Medicare and to upload information regarding its own terminations. States are not required to report information on those providers who were terminated prior to January 1, 2011. The web-based portal, however, is designed to accept information regarding terminations that have occurred as early as January 1, 2010. Access to the information-sharing portal is limited to users approved by CMS. CMS has already provided guidance and training regarding the web-based portal to States.

To assist States, we are in the process of developing a Medicaid State plan preprint that may be used when submitting a State plan amendment (SPA) to implement this and other program integrity provisions and anticipate distributing the preprint to States in the near future.

The provisions of section 1902(a)(39), as amended by Section 6501 of the Affordable Care Act, are effective January 1, 2011.

Questions and Answers

Attached to this Informational Bulletin is operational guidance in the form of “Frequently Asked Questions” regarding Section 6501 of the Affordable Care Act.

Thank you for your continued commitment to combating fraud, waste and abuse in the Medicaid program and CHIP. We look forward to our continuing work together as we implement this important legislation. Questions regarding this information can be directed to Angela Brice-Smith at 410-786-4340 or via email at Angela.Brice-Smith@cms.hhs.gov.

Enclosure

Frequently Asked Questions
Section 6501 of the Affordable Care Act
May 2011

Section 6501 of the Affordable Care Act requires each State Medicaid program to terminate any provider who has been terminated under Medicare or by another State Medicaid program. On February 2, 2011, CMS issued final Federal regulations implementing this provision, including defining “termination” and extending the requirements of this provision to include providers participating in the Children’s Health Insurance Program (CHIP) as well. See <http://edocket.access.gpo.gov/2011/pdf/2011-1686.pdf>. CMS has 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, supplier or eligible professional has exhausted all applicable appeal rights or the timeline for appeal has expired. The requirement to terminate only applies in cases where providers, suppliers or eligible professionals have been terminated or had their billing privileges revoked “for cause.” CMS will facilitate the sharing of information to States through a secure web-based portal about terminated Medicaid and CHIP providers as well as Medicare providers who have had their billing privileges revoked. The information contained in the portal about Medicaid and CHIP providers who were terminated for cause will be provided by the States reporting such information. Information reported by States will not be independently verified by CMS.

Q. What does “for cause” mean for Medicaid or CHIP providers?

- A. For cause may include, but is not limited to, termination for reasons based upon fraud, integrity, or quality. For cause does not include cases where a State terminates a Medicaid or CHIP provider as a result of a failure to submit claims due to inactivity.

In addition, for cause does not include any voluntary action taken by the provider to end its participation in the program, except where that “voluntary” action is taken to avoid sanction. For example, if a provider submits a request to the State to “voluntarily” terminate its provider agreement in an effort to avoid sanctions due to non-compliance, then this does not qualify as voluntary action.

Q. How will States know of terminations by other State Medicaid programs?

- A. CMS has established a secure web-based portal to facilitate the sharing of information by States regarding terminated Medicaid and CHIP providers. Using this web-based portal, States are able to upload their own information as well as view information regarding terminated providers that is reported by Medicare and other States and use this information to help protect their respective programs from potential fraud, waste, and abuse. CMS has already provided guidance and training regarding the web-based portal to States. Access to the information-sharing portal is limited to users approved by CMS.

**Frequently Asked Questions
Section 6501 of the Affordable Care Act
May 2011**

- Q. Do the terms “termination” and “exclusion” mean the same thing?**
- A.** No. For purposes of section 6501, a “termination” occurs when the State terminates the participation of a Medicaid or CHIP provider from the program or the Medicare program has revoked a Medicare provider or supplier’s billing privileges, and the provider has exhausted its appeal rights or the timeline for appeal has expired. Generally, “exclusion” from participation in a federal health care program, including Medicare, Medicaid, and CHIP is a penalty imposed on providers and suppliers by the Department’s Office of Inspector General (HHS-OIG). Individuals and entities may be excluded from participating in federal health care programs for misconduct ranging from fraud convictions to patient abuse to defaulting on health education loans. We recognize, however, that certain States give the same meaning to the terms “exclusion” and “termination” and these actions; therefore, ultimately result in the provider’s involuntary departure from the Medicaid program or CHIP.
- Q. Are States expected to report information on providers who are excluded by HHS-OIG from participation in the Medicaid and/or CHIP program?**
- A.** States should report information on providers they have terminated from participation in their respective Medicaid programs and CHIP regardless of any action taken against such providers by any other entity including exclusion by HHS-OIG.
- Q. When will States be expected to start reporting terminations?**
- A.** States are expected to report those providers who were terminated on or after January 1, 2011. In addition, reporting of terminations must not occur until after the timeline for appeal has expired or the provider has exhausted all applicable appeal rights. States are not required to report those providers who were terminated prior to January 1, 2011.
- Q. What are the timeframes for States reporting provider terminations?**
- A.** There is no specified timeframe for reporting terminations. However, at a minimum, States should report terminations on a monthly basis in order to assist other States with protecting themselves from providers who pose an increased risk to government health care programs.
- Q. If a State notifies the HHS-OIG under 42 C.F.R. § 1002.3(b)(3) of actions the State takes to limit a provider’s participation in the program, must the State also report terminations to the portal under section 6501?**
- A.** Yes. A State should still report terminations under section 6501.

Frequently Asked Questions
Section 6501 of the Affordable Care Act
May 2011

- Q. What is the duration of State provider terminations and denials of enrollment in other State Medicaid programs or CHIP as a result of a termination?**
- A. The duration of a termination should be consistent with the terminating State's law. For example, State A terminates a provider and the length of termination is 3 years. A termination action is triggered in State B with regard to that same provider as a result of the State A termination action. State B's length of termination is 1 year. The provider is not allowed to re-enroll in State B's Medicaid program for a 1-year period as opposed to State A's 3-year bar to re-enrollment. Similarly, the State should follow its own State law with regard to the length of the denial of enrollment period for providers who are seeking to enroll in a State Medicaid program or CHIP that were previously terminated by other State programs or had their billing privileges revoked under Medicare.
- Q. What is the scope of appeals by terminating programs?**
- A. The scope of appeals for the original terminating program, *i.e.*, Medicare, Medicaid, or CHIP, should include a full appeal on the merits with regard to the basis of the termination. When subsequent States terminate based upon that initial termination, the scope of their appeals should only review whether the provider was, in fact, terminated by the initiating program. The subsequent appeals process should not review the underlying reasons for the initiating termination. The appeal process in subsequent States does not provide a new forum in which to litigate the basis of termination by another State Medicaid program, Medicare or CHIP.
- Q. Will managed care organizations be able to access provider termination information?**
- A. CMS will not provide managed care entities with direct access to the web-based portal reflecting provider termination information.
- Q. When is a Medicaid or CHIP termination triggered under section 6501?**
- A. A Medicaid or CHIP termination is triggered when a provider is terminated by Medicare or terminated by Medicaid or CHIP for cause and the provider has either exhausted all applicable appeal rights or the timeline for appeal has expired.
- Q. What if existing State law is inconsistent with the requirements of section 6501?**
- A. A State may delay implementation of the requirements of section 6501 if the Secretary determines that State legislation is required. Accordingly, CMS will work with those States that require statutory, regulatory, or administrative changes. If this applies to your State, send an email to providerterms@cms.hhs.gov with the word "Termination" in the subject line.

**Frequently Asked Questions
Section 6501 of the Affordable Care Act
May 2011**

- Q. Are there any exceptions to the requirement to terminate a provider that was terminated by Medicare or another State Medicaid program or CHIP?**
- A.** Yes. The statute provides for the same limitations on termination that apply to exclusion under §§ 1128(c)(3)(B) and 1128(d)(3)(B) of the Social Security Act. Thus, a State may request a waiver of the requirement to terminate a particular provider's participation. State agencies may submit such waiver requests to their respective CMS Regional Offices.
- Q. When is the web-based portal going to be available for use by the States?**
- A.** The web-based portal is currently available for use by States. Several State users have already been trained on how to use the portal. For additional information regarding access to the web-based portal please provide your name, email address, agency, and telephone number via email to providerterms@cms.hhs.gov.