

Provisions of the *Affordable Care Act* Create New Medi-Cal Provider Application Screening and Enrollment Requirements

On January 1, 2013, California Senate Bill 1529, which implements sections of the *Affordable Care Act* of 2010 that pertain to Medicaid provider screening and fraud prevention, becomes effective as state law. At such time, the laws that the Department of Health Care Services (DHCS) must follow when reviewing provider applications for participation in the Medi-Cal program will change. A summary of the provider screening and enrollment changes in the California *Welfare & Institutions Code* that become effective January 1, 2013, follows, in alphabetical order by topic.

Application Fees Required for Some Provider Applicants

Section 14043.25 is amended by adding subsection (d), which adds the requirement to submit an application fee for some providers as specified in the federal Medicaid regulations. DHCS is developing new processes and procedures to implement this application fee requirement, which will be published in a regulatory provider bulletin, effective January 1, 2013.

Section 14043.75 is amended to grant DHCS expanded authority to issue provider bulletins specific to the new application fee requirement as stated in section 14043.25.

Denial and/or Termination of Enrollment

Section 14043.26 contains two new causes for the denial of a provider application under subsection (f)(4), failure to submit fingerprints when requested by DHCS **and** failure to submit an application fee when required according to federal regulations. Subsections (h) and (i) are also amended to permit deactivation or termination of enrollment when deficiencies identified in a provider's application are not remediated as requested by DHCS.

Section 14043.28 subsection (a) is amended to specify that DHCS may not impose a three-year reapplication bar in cases when a provider's enrollment is terminated based on that provider having been terminated by Medicare or any other state's Medicaid or Children's Health Insurance Program (CHIP); subsection (b) is amended to grant authority for DHCS to deactivate or terminate enrollment when an application is denied because a provider failed to submit fingerprints as required and as requested by DHCS.

Section 14043.36 at subsection (b) contains an additional cause for the denial of a provider application or deactivation of a currently enrolled provider based on the applicant or provider having been terminated under Medicare or the Medicaid or CHIP of any State.

Section 14043.4 is amended to authorize deactivation of all business locations of an enrolled provider when "material" discrepancies are not remediated.

Section 14043.7(a) is amended to specifically require providers to permit DHCS access to any and all of their provider locations to conduct onsite visits; if a provider does not permit DHCS to access their business location, the provider applicant is subject to denial and deactivation of enrollment.

Disclosure Requirements

Section 14043.2 is amended with additional provider disclosure submission requirements. Individuals with ownership or controlling interest in a provider or applicant must submit their date of birth for identification purposes and corporations with ownership or controlling interest in a provider or applicant must submit their taxpayer identification number, and all business address locations and all P.O. Box addresses. These additional requirements on the provider disclosure forms were implemented by DHCS via a regulatory provider bulletin in November 2011, and beginning January 1, 2013, they will be codified in state law.

Fingerprint Submission and Criminal Background Checks

Section 14043.38 is a new section and adds authority for DHCS to require fingerprints from providers who are screened at the "high" categorical risk level. This new section also outlines specific criteria that

would require a provider's application to undergo a "high-risk" review. DHCS is developing new processes and procedures to implement the fingerprint requirement, which will be published in a regulatory provider bulletin within 60 days of the date on which DHCS receives written federal guidance on this new requirement.

Section 14043.75 is amended to grant DHCS expanded authority to issue provider bulletins specific to the new fingerprint requirement as stated in 14043.38.

"Ordering, Referring or Prescribing Only" Providers Must Enroll

Section 14043.1 amends the definitions of "applicant" and "provider" to include ordering, referring and prescribing individuals. Some healthcare providers will be required to enroll in the Medi-Cal program for the sole purpose of ordering, referring and/or prescribing for Medi-Cal beneficiaries, even though these providers do not send claims directly to Medi-Cal for the services they furnish. DHCS is developing a new application and enrollment process exclusively for "Ordering, Referring and Prescribing Only Providers" which will be published in a regulatory provider bulletin, effective January 1, 2013.

Section 14043.15 is amended at subsection (b)(3) to specify that an ordering, referring or prescribing provider is to be identified on the Medi-Cal claim for reimbursement of any ordered, prescribed or referred goods or medications or services by including the legal name and the National Provider Identifier on such claims.

Screening Risk Levels

Section 14043.38 is new and states that provider types are designated as "limited," "moderate," or "high" categorical risk by the federal government and that DHCS shall, at minimum, utilize the federal regulations in determining a provider's or applicant's categorical risk during screening of applications. This new section also adds authority for DHCS to require fingerprints from providers who are screened in the "high" categorical risk level and outlines specific criteria that would require that an application undergo a "high risk" review. DHCS is developing new processes and procedures to implement the new federal application screening risk levels, which will be published in an informational provider bulletin before January 1, 2013.

Temporary Moratoria

Section 14043.55 is amended to add subsection (b) which authorizes DHCS to establish enrollment moratoria to correspond with any federally-issued moratoria on the enrollment of providers, covering the same period and provider types as the federally-issued moratoria, even if those provider types would not ordinarily be subject to a moratorium under this section. DHCS has discretion when imposition of such moratoria would adversely impact beneficiaries' access to medical assistance.

The following is also a requirement of the *Affordable Care Act* implementation, but was not part of the SB 1529 amendments for the W&I Code sections pertaining to Medi-Cal provider enrollment because the requirements for continued enrollment already exist in State law.

Revalidation of Enrollment Information Every Five Years

The *Affordable Care Act* of 2010 and 42 Code of Federal Regulations, Section 455.414 requires DHCS to revalidate enrollment information for all providers at least every five years. DHCS will initiate a new ongoing process for providing written notice to providers enrolled in the Medi-Cal program that they have been identified for continued enrollment and that they are therefore subject to *California Code of Regulations*, Title 22, Section 51000.55. Details about the new DHCS process for revalidating information and notifying providers of continued enrollment will be published in an informational provider bulletin before January 1, 2013.