Attachment: AHIP-NAMD Proposal
Medicaid Managed Care Provider Enrollment Requirements

I. Proposal

The proposal would provide an option for states and other entities needing additional time to comply with the screening and enrollment requirements for providers contracted with Medicaid managed care plans, as set forth in the May 2016 Medicaid Managed Care Final Rule and the 21st Century Cures Act. The proposal consists of the following elements:

1. CMS could adopt a "targeted enforcement discretion" approach for the first year commencing January 1, 2018. With CMS approval, the Agency would use its discretion to target enforcement based on some or all of the following elements:
    a. A notice from state Medicaid agencies to their Medicaid managed care organizations (MCOs) describing the state's plan for notifying contracted MCO providers of the screening and enrollment requirements. States may employ several different processes for screening and enrollment, for example:
        i. The State may instruct MCOs to notify their contracted providers of the screening and enrollment requirement and include information on how to enroll, including instruction on how providers may enroll through the MCO in instances where the state chooses to delegate some of this function.
        ii. The State may direct MCOs to submit their rosters of contracted providers to the state or a designated contractor. Following receipt, the State or its contractor will send out notices notifying each MCO's contracted providers of the screening and enrollment requirement and information on how to enroll.
        iii. The State may notify MCOs that its screening and enrollment process routinely applies to all contracted/network providers as a condition of contracting with Medicaid MCOs.
        iv. The State may identify certain types of providers for which it wishes to conduct additional verification of information, and may request Medicaid MCOs to assist in providing supplemental information.
    b. State-required model language to be included in notices to contracted/network providers.
    c. A mechanism for MCOs to attest to the State that they have made notification to their Medicaid contracted providers, or have provided the State with complete rosters of their contracted providers, as appropriate.
    d. The process for the State to notify CMS that the State, its contractor or its contracting Medicaid MCOs have made the required notifications to all Medicaid MCO contracted providers.
2. A State would commit to developing a work plan (as outlined below in Item II) describing the State's major steps in adapting or implementing systems for screening and enrollment of MCO network providers, whether through the state's existing process or through new processes using vendors and/or by delegating the screening and enrollment functions to the state's Medicaid MCOs; and to providing CMS with periodic updates on milestones completed and progress toward implementation.
3. We request that CMS provide detailed implementation guidance to clarify whether states are expected to screen and enroll only plan network providers, or all providers paid by an MCO.

CMS should also address the applicability of requirements to certain providers, such as those described in Part III, including traditional providers (e.g. dentists, pharmacists) and non-traditional providers (e.g. Meals on Wheels, attendants in consumer-directed programs, wheelchair ramp installers). This guidance should also provide states clarity on CMS's expectations for editing MCO encounters to reflect Ordering, Referring, and Prescribing (ORP) enrollment status. Such guidance would help ensure uniform implementation of the regulation, as well as minimize cases of non-compliance and the need to dedicate state and CMS resources for mitigation efforts.

II. Model Work Plan

Below is a proposed model work plan that a state could develop, for approval by CMS, outlining the steps it will take and projected completion dates to adapt or implement systems for screening and enrollment of MCO network providers.

The State of [State Name] commits to developing and submitting for review a work plan that addresses the following elements:

a. The State will screen and enroll, and periodically revalidate, all network providers of MCOs, PIHPs, PAHPs, and PCCM entities as required by part 455, subparts B and E of this chapter. (§438.602 (b)). The state may also delegate these functions to the MCOs.

b. At state option, the State will permit MCOs, PIHPs, and PAHPs to execute network provider agreements pending the outcome of the screening and enrollment process for up to 120 days, provided that the managed care or PCCM entity will terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider, and notify affected enrollees. (§438.602 (b))

c. The State (or its contractor) will review ownership and control disclosures submitted by a managed care or PCCM entity, and any subcontractors. (§438.608(c))

d. The State (or its contractor) will conduct routine checks of Federal databases to confirm the identity and exclusion status of the managed care or PCCM entity, any subcontractor, and any person with an ownership or control interest, or who is an agent or managing employee of managed care or PCCM entity. Such databases will include: Social Security Administration's Death Master File, National Plan and Provider Enumeration System (NPPES), List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), and any other databases determined by the Secretary or required by state law. The State (or its contractor) will check these databases upon contracting and no less frequently than monthly thereafter. If the State finds a party that is excluded, it will promptly notify the managed care or PCCM entity and take appropriate action. (§455.436, §438.610(d))

e. The State [has][will have] conflict of interest safeguards in place and will comply with requirements applicable to contracting officers, employees, or independent contractors. (§438.610(h), §438.58, 1902(a)(4)(C))

f. The State will ensure that its contracted managed care and/or PCCM entities are located inside the United States and that no claims paid by a managed care or PCCM entity to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates. (§438.610(i))

III. Applicability of Requirements to Certain Providers

Discussions with states and Medicaid MCOs have identified questions about the applicability of the provider screening and enrollment requirements to various kinds of providers, such as those listed below. Having a clear understanding of the providers to which the requirements apply will help ensure appropriate implementation of the requirements. We request that CMS provide guidance regarding applicability to these provider types.

As part of this guidance, CMS should clearly articulate that several non-traditional provider types are exempt from the screening and enrollment requirements, including:

- Home improvement or repair service providers, such as carpenters and handymen making home modifications, or installing wheelchair ramps or bathroom safety bars; pest control services and providers of "in lieu of" benefits.
- Interpreters providing interpretive services at medical visits – foreign language, ASL
- Physicians and other providers and suppliers providing Medicare Part B covered services to dual eligibles, where the provider's only interaction with the state Medicaid program may be through the State's payment of a portion of the dual eligible individual's Medicare cost sharing
- Meals on Wheels organizations
- Non-medical transportation (NMT) providers, such as buses, taxis, ridesharing service drivers (Uber, Lyft, etc.), and friends and family of the beneficiary providing such transportation.
- Dentists providing services not covered by the State's Medicaid plan, but incidental to those services, such as prescribing a medication that is covered by Medicaid (this example may be addressed in the Ordering, Referring, and Prescribing providers discussed below).

CMS should also ensure that its guidance provides clarity and consistency with applicable FFS Medicaid screening and enrollment requirements, in instances where such guidance has been variable or inconsistent in the past. We encourage CMS to consider the operational feasibility and administrative burden of state and plan implementation of screening and enrollment for these provider types, as well. Providers which fall under this category include:

- Ordering, referring or prescribing providers who:
    - practice outside the state,
    - order, refer or prescribe services covered by Medicaid, whether or not the providers themselves are paid by the Medicaid program,
    - are hospital-based specialists subcontracted with or employed by a contracted hospital (whether in state or out of state); e.g. emergency physician, anesthesiologist, radiologist, nuclear medicine, pathologist, or
    - are school-based and provide or refer for Medicaid-covered services
- Parents who are caregivers of children with complex needs who are enrolled in Medicaid

Lastly, CMS should be explicit in identifying providers who are subject to the screening and enrollment requirements. A non-exhaustive list of such providers could include:

- Dentists providing Medicaid-covered services
- Pharmacists – employed and independent
- Pharmacies
- Contracted providers of non-emergency medical transportation services

- Providers of in-home services in consumer-directed programs, such as personal care, chore/homemaker services, or companion care, who are 1) employed directly by the enrollee; and 2) who are employed through a home care agency
- In the case of health departments, county agencies or other local governmental agencies through which Medicaid enrollees receive public health or behavioral health services, specific applicability to 1) the governmental agency itself; 2) professionals employed by the agency; and 3) professionals contracted by the agency
- Centers, agencies and their staff, including non-licensed staff, providing services such as peer supports, pre-vocational services, supportive employment, habilitative services, or housing services
- Personal emergency response system providers