ACAP
Association for Community Affiliated Plans

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Donald Berwick
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
File code: CMS-6028-P

Submitted electronically via: *http://www.regulations.gov*

Dear Dr. Berwick:

The Association for Community Affiliated Plans (ACAP) appreciates this opportunity to provide comments on the proposed rule regarding provider screening and enrollment and related program integrity issues provisions of the Affordable Care Act (ACA).

ACAP is an Association of 53 not-for-profit and community-based Safety Net Health Plans. Our member plans provide coverage to over 7 million individuals enrolled through Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dual eligibles. Nationwide ACAP plans serve one of every four Medicaid managed care enrollees. The strong support and participation of Safety Net Health Plans has played a critical role in the expansion of health coverage.

As stewards of public funding for Medicaid, CHIP, and Medicare, our member plans take very seriously their responsibility for detecting and preventing waste, fraud and abuse. They understand that these functions and development of new tools are essential for protecting and delivering high quality care to their enrollees and ensuring the integrity of the Medicaid, CHIP and Medicare programs. However, ongoing efforts to meet these goals must be pursued using approaches that minimize the administrative burden on providers – and thus on Safety Net Health Plan networks – and that do not adversely impact beneficiaries' access to medical care.

As required by federal and state statutes, Medicaid Safety Net Health Plans have instituted administrative and management arrangements and procedures, for example many have compliance plans designed to guard against waste, fraud and abuse. Further, many plans have developed additional compliance policies to both address new problems and avert potential challenges that may arise.

In response to the proposed rule, we offer the following comments related to Medicaid managed care organizations and recommendations to address those provisions which could reduce enrollees' access to care. Our comments focus on the following three themes:

1 Leverage the existing waste, fraud and abuse procedures and approaches currently utilized by Medicaid managed care organizations.
2 Adopt policies and options that minimize the administrative burden on low-risk providers for enrolling and participating in the Medicaid and CHIP programs.
3 Provide explicit authority for exceptions to recognize circumstances specific to managed care organizations.

General Provider Screening – Medicaid and CHIP

The NPRM states that all providers must be enrolled with the State Medicaid agency. However, as noted in the Preamble to the rule, not all providers participating in a Medicaid managed care organization's (MCO) network are enrolled in the state's fee-for-service (FFS) program. In fact, many providers prefer to contract exclusively with the Medicaid managed care organization because of the support and resources plans provide which are not otherwise available in some state FFS programs.

In response to your request for comments on screening requirements as they relate to managed care entities, ACAP urges CMS to ensure that the regulations preserve the option for providers to choose whether they wish to enroll with the state Medicaid/CHIP agency's FFS program, a Medicaid/CHIP managed care organization, or both. That is, ACAP strongly recommends that Medicaid MCOs serve as the default screeners for providers that participate in a plan's network but who do not wish to participate in the Medicaid FFS program.

"Limited Risk" Medicare-screened providers

For medical providers and suppliers designated as "Limited" categorical risk who participate in the Medicare program but do not participate in the state Medicaid FFS program, we recommend that a MCO be permitted to rely on the results of the screening conducted by a Medicare contractor to meet the Medicaid provider screening requirements. This would be consistent with the proposed rule that would allow state Medicaid agencies to rely on the results of screening conducted by a Medicare contractor.

If there are specific requirements established by Medicaid that are not addressed by Medicare screening, a MCO could be charged, through their contract with the state Medicaid agency, to screen for those specific requirements. For oversight purposes, a MCO could be required to have their screening policies and procedures reviewed and approved by the state Medicaid program and to annually certify its compliance with those requirements.

Verification of Medicare provider screening

The proposed rule states the screening conducted by a Medicare contractor will meet the provider screening requirements for Medicaid and CHIP. We are seeking clarification from CMS regarding the publicly available information and process MCOs should utilize to verify screening by a Medicare contractor, including if a "Limited" categorical risk provider is enrolled exclusively with a Medicaid MCO. Identification and development of a reliable verification process is needed to minimize the burden for providers, plans, and states.

"Limited risk" Medicaid MCO-only provider

For medical providers and suppliers designated as "Limited" categorical risk who do not participate in the Medicare or the state's Medicaid FFS program, we recommend that a MCO conduct the screening using the identical screening requirements as proposed in the regulations. This would include verification of any specific requirements established by Medicaid; license verification and database checks. Per our recommendation in the previous paragraph, to ensure that a MCO meets the minimum requirements of the regulation, a MCO could have their screening policies and procedures reviewed and approved by the state Medicaid program with annual certification of its compliance with these requirements.

Preserve provider flexibility

ACAP strongly supports allowing a MCO to conduct the screening for "Limited risk" providers who participate exclusively in Medicaid managed care. However, if CMS is statutorily restricted from permitting this option, such providers should be permitted to enroll with the state solely for the purpose of complying with this regulation's provider screening requirements. We urge CMS to ensure that providers are not required to participate in the state Medicaid FFS program, at their request. Without this option for providers, we are concerned that the screening requirement will create a disincentive to provider participation in Medicaid MCO networks and in turn will compromise care for enrollees.

In the absence of flexibility for states and plans, we have serious concerns that the screening requirement will create a disincentive to provider participation in Medicaid MCO networks and undermine access to care for beneficiaries.

Deactivation and Reactivation of Provider Enrollment

As proposed, a Medicaid/CHIP provider that has not submitted claims for a period of 12 consecutive months will be "deactivated" from the Medicaid/CHIP program. ACAP requests that CMS clarify the application of this provision to MCOs. In doing so we urge the agency to consider the unique situations or reasons for gaps in a provider's submission of claims. For example, a provider may not submit claims to a state's Medicaid FFS program within this time

period, but the provider may still be actively participating in a Medicaid MCO's network. In this case, we recommend that such a provider not be "deactivated."

Further, as an alternative to the proposed 12 month time period, ACAP recommends using a minimum of 18 or 24 months as the time period for submitting claims to maintain "active" Medicaid provider status. The longer time period is more appropriate when considering the participatoin patterns of specialists. For example, MCOs work with specialists that may agree to see Medicaid patients only under special circumstances or on a basis that results in submission of claims beyond the proposed 12 month threshold. "Deactivating" a provider in these situations and requiring the provider to reenroll and pay the application fee is likely to create a significant disincentive for ongoing participation and to undermine the MCO's recruitment efforts. In turn, this threatens access to medical care for enrollees, especially specialty care services.

Temporary Moratoria on Enrollment of Medicare Providers, Medicaid and CHIP Providers

As required by the statute, the proposed regulation states the Secretary can impose and the states must comply with temporary moratoria on enrollment of new Medicare, Medicaid and CHIP providers and suppliers for purposes of preventing waste, fraud and abuse. ACAP requests clarification from CMS regarding whether this requirement applies to Medicaid FFS and Medicaid MCOs.

While we appreciate that the proposed rule grants states the authority to make exceptions if a temporary moratorium would adversely impact beneficiaries' access to care, this will be insufficient to address timely needs of MCOs. As such, ACAP requests that the CMS regulation provide for a specific exception to temporary moratoria for MCOs where contracting with the provider or supplier is necessary to newly meet or maintain the plan's network adequacy standards. In the absence of this explicit exception, we are concerned the regulation's ambiguity would lead to contracting delays and confusion for states and plans and in turn impede access to medical care for beneficiaries.

Application Fee – Medicare, Medicaid and CHIP

In response to your request for comments regarding appropriate exceptions to the application fee, ACAP recommends that CMS provide a comprehensive exception for out-of-state providers providing emergency services to a MCO's members. Such an exception would allow for timely access to critical services for MCO enrollees.

Termination of Provider Participation Under the Medicaid Program and CHIP if Terminated Under the Medicare Program or Another State Program

ACAP requests that CMS clarify the process for identifying the reason for termination from a

program. That is, we ask that CMS provide a way for MCOs to determine if a provider is terminated from a public program due to inactivity or due to allegations of fraud, waste and abuse.

We appreciate your consideration of our comments which seek to ensure the regulation does not compromise care for enrollees. We recognize that CMS must strike a careful balance in protecting the integrity of our nation's major public health care programs while ensuring that individuals have timely access to care in their communities. ACAP is prepared to assist the agency with additional information as needed.

Sincerely,

Margaret A. Murray
Chief Executive Officer