Department of Human Services Update

Office of Medical Assistance Programs and the Office of Mental Health and Substance Abuse Services

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Enrolling in the PA MA Program

• Providers who need to enroll should visit –
  www.dhs.pa.gov/provider/promise/enrollmentinformation/index.htm

• To apply online via the Electronic Provider Enrollment Portal –
  https://provider.enrollment.dpw.state.pa.us/

• Physician assistants can now enroll online as provider type 10 – mid-level practitioner.

• Office of Developmental Programs providers can enroll online.
Enrolling in the PA MA Program

- Providers enroll in the PA Medical Assistance program based on their provider type (physician, nurse, mental health and substance abuse provider, case manager, etc.)

- Each provider type has different requirements that need to be met for a provider to qualify as a Medical Assistance Provider.

- All providers must be screened according to the ACA requirements.
MA Requirements

• Medical Assistance provider enrollment requirements come from:
  – Federal law or regulations
  – State laws and regulations for example the regulations set for the in the PA Code (55 Pa Code)
  – Medical Assistance Bulletins, Provider Handbooks and other state policy documents
Screening Requirements of the ACA

• Screened in accordance with their risk level (limited, moderate, high). See Medical Assistance Bulletin 99-16-13,

• Verify that the provider is licensed by the state, that the license has not expired and does not have any current limitations
  – Checks against the DOS databases or require copy of the license or certification to be provided
Screening Requirements of the ACA

- Conduct Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.
  - PECOS - Provider Enrollment, Chain and Ownership System
  - Social Security Administration Database
  - OIG – US Office of Inspector General’s List of Excluded Individuals/Entities (LEIE)
  - MEDI-CHECK – PA Precluded Provider Database
  - SAMS – System for Awards Management
  - NPPES – National Plan & Provider Enumeration System
Screening Requirements of the ACA

- Conduct site visits on “Moderate and High” risk providers to verify that the information submitted is accurate and determine compliance with enrollment requirements. See Medical Assistance Bulletin 99-16-13.
- Collect an application fee prior to executing a provider agreement from a prospective or re-enrolling institutional provider. See Medical Assistance Bulletin ACA Enrollment Application Fee.
- Conduct criminal background checks, including fingerprinting on “high” risk providers. See Medical Assistance Bulletin 99-17-03.
The ACA\textsuperscript{1} added requirements for provider screening and enrollment:

- Providers must revalidate their enrollment every 5 years.
- Physicians and other practitioners who order or refer items or services for Medicaid beneficiaries shall enroll as Medicaid providers.

The Department of Health and Human Services regulation implementing this requirement can be found at 42 CFR § 455.410.

\textsuperscript{1} Section 6401(b) 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) (collectively known as the ACA) amended Section 1902 of the Social Security Act, to add paragraphs (a) (77) and (kk).
• 42 CFR § 455.410 Enrollment and screening of providers.
  (a) The State Medicaid agency must require all enrolled providers to be screened under this subpart.
  (b) The State Medicaid agency must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

• 42 CFR § 455.414 Revalidation of enrollment. The State Medicaid agency must revalidate the enrollment of all providers regardless of provider type at least every 5 years.
Background:

- Originally applied only to Medicaid fee-for-service programs.
- The Medicaid Managed Care Final Rule published May 6, 2016 (Federal Register Vol. 81, No. 88) applied the requirement to Medicaid and CHIP Managed Care Organizations (MCOs).
- Section 5005(b)(2) of the 21st Century Cures Act requires MCO compliance by January 1, 2018.
Ordering, Referring and Prescribing (ORP)

In the PA Medical Assistance (MA) Fee-for-Service (FFS) program:

- Released MA Bulletin 99-12-14 – NPI Requirements on All Claim Submission Media issued December 19, 2012 which provided instruction for submitting the NPI of the billing, rendering and referring providers on FFS claims.
- Released MA Bulletin 99-17-02 – Submission of Claims that Require the National Provider Identifier (NPI) of a Medical Assistance enrolled Ordering, Referring or Prescribing Provider on January 31, 2017.
In the PA MA FFS program:

- Bulletin 99-17-02 identifies providers (by provider type) that should check the PROMISe billing guides to determine if claims submitted for services need to have an enrolled ordering, referring, or prescribing provider NPI.
  - Example of providers that need to include the NPI of an ordering, referring, or prescribing provider on the claims:
    - Home Health Agencies
    - Hospice
    - Pharmacy
    - Durable Medical Equipment
All providers, including behavioral health providers should check their billing guides to determine when an NPI is required on the claim: [www.dhs.pa.gov/publications/forproviders/promiseproviderhandbooksandbillingguides/index.htm](http://www.dhs.pa.gov/publications/forproviders/promiseproviderhandbooksandbillingguides/index.htm)

Physical health claims for services that are ordered or prescribed by an non-enrolled MA provider are denying in the MA FFS program.
• Pharmacy claims are submitted at the point of sale – which means that if a prescriber is not MA enrolled, a recipient in the FFS program may have difficulty getting the drug.
  – Pharmacies have been instructed to call the MA FFS Pharmacy call center for assistance if a claim is denying due to the ORP provider not being enrolled.

• Other physical health claims for services that are ordered or prescribed by an non-enrolled MA provider deny when the provider submits claims for payment, usually after the service or item has been provided.
Compliance with the Managed Care Final Rule

- ORP requirements for the Physical Health MA MCOs and CHIP MCOs
  - DHS expectation that by November 2017 MCOs should be applying soft edits to claims for ORP.
  - January 1, 2018 MCOs should deny claims which the ORP is not enrolled in MA.
Medical Assistance Enrolled Provider Portal Lookup

- Enrolled Medical Assistance providers can verify if providers who are ordering, referring and prescribing are enrolled in the Medical Assistance Program.
- Enrolled providers may access the tool by logging into the PROMISSe™ Internet portal at: https://promise.dpw.state.pa.us.
Value Based Purchasing

• Phase in Implementation beginning in January and July 2018 for Behavioral Health over a 3 year period
• Decisions coming soon about
  o Percent required for each year
  o What is included in the percent
  o Required reporting
• Incentives or penalties to the MCOs
Opportunities within Behavioral Health

• Pay for Performance (P4P)
  o Behavioral Health Specific P4P

• Care Coordination
  o Centers of Excellence (COE)
  o Certified Community Behavioral Health Clinics (CCBHC)
  o Physical Health / Behavioral Health Integration

• Episode of Care Payment
  o Assertive Community Treatment (ACT)
  o Inpatient Psychiatric Case Rates
  o First Episode Psychosis (FEP)
Measuring Quality

• Process measures:
  o Follow-up after in-patient stays
  o Engagement in treatment
  o Retention in treatment

• Change in health care usage:
  o Readmission rates
  o Inpatient stays
  o ER utilization

• Social and functional measures:
  o Employment
  o Housing stability
The Mental Health Parity and Addiction Equity Act (MHPAEA) Final Rule was issued March 20, 2016, became effective May 31, 2016 and states are required to demonstrate compliance by Oct 2, 2017.

MHPAEA applies to enrollees in Medicaid Managed Care Organizations, enrollees in Alternative Benefit Plans and all separate CHIP.

When some benefits are carved out of Medicaid MCOs, states are required to complete the parity analysis to determine compliance. In PA, all MH/SUD benefits are carved out of Medicaid MCOs, therefore DHS is responsible for analyzing for Parity.
Parity

- The Commonwealth has pushed forth a thorough and concerted effort to ensure that OMHSAS and OMAP along with the Behavioral Health Managed Care Organizations (BH-MCO) and Physical Health Managed Care Organizations (MCO) are in compliance with the MHPAEA.
Thus far the Commonwealth has:

- chosen the standards by which to define Mental Health/Substance Use Disorder and Medical/Surgical conditions;
- defined the four classifications of outpatient, inpatient, emergency services and prescription drugs;
- identified applicable financial restrictions (FR), quantitative treatment limits (QTL) and non-quantitative treatment limits (NQTL);
- completed document review with OMHSAS and OMAP as well as 2 rounds of data collection with the BH-MCO and the MCOs for all types of limits;
- begun to finalize the FR/QTL analyses.
Parity

- Given the complexity of the service delivery system, the number of NQTL analyses and in light of the extensive efforts made to date to ensure compliance, DHS requested from CMS an extension until December 31, 2017 to firm up the results of the NQTL analysis, conduct additional follow-up with the BH-MCOs and MCOs and resolve any outstanding compliance concerns.
Co-Located Providers

- DHS established process for the enrollment of co-located providers.
- Both providers must sign the co-location attestation form found at http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_228790.pdf
- Providers attesting they are in compliance with the anti-kickback laws and MA regulation at 55 Pa Code § 1101.51, including freedom of choice.