EXTERNAL REVIEW COMMENTS – Chapter 388-502
5/6/10

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Some stakeholder's offered and/or requested to meet with representatives of the Department in order to discuss the proposed rules and alternative approaches to meeting shared goals of providing quality health care in an effective and efficient manner.	**Department's Response:** The rule-making process provides for a formal process for comments and input. The Department is required to review every comment/suggestion and respond accordingly. The informal review process (known as "External Review") was the first opportunity for stakeholders to review and comment on the proposed rules. This table is a compilation of the comments received along with the Department's response. The Department plans to file the revised rules for Public Hearing. The Public Hearing provides stakeholders with another opportunity to review and comment on the rules.
WAC 388-502-0005(4) and (5) **Core Provider Agreement (CPA)** Both subsections relate to the effective date of the Core Provider Agreement and impact the timing of when the Department will reimburse providers. Stakeholders are concerned with the backlog in the provider enrollment workload and stated that the impact of the rule change would be that licensed providers would not be paid for any Medicaid-covered services that are provided prior to HRSA staff processing the enrollment/credential. One stakeholder recommended: "…the effective date be established as the date the proper materials are received by HRSA, or at a minimum, that the policy require exceptions and modification of the effective date when a backlog situation exists."	**NO CHANGE WAS MADE AS A RESULT OF THESE COMMENTS.** The proposed rules will not be implemented until the inventory is reduced to within 30 days of receipt (also see the Department's response to the next comment – and addition of "exceptions" to the proposed text). Until the Department's inventory is within 30 days from the date of receipt of the application, applications that have been determined eligible as a medical assistance provider are being approved effective the date the application was received.

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WAC 388-502-0005 Core Provider Agreement (CPA) Retroactive payment is required under the Medicaid program. Even under the new rules, there must be exceptions to allow DSHS to honor specific requests for retroactive enrollment effective dates if: a recipient has been granted retroactive eligibility; an emergency service was provided; or medically necessary services were rendered and the provider's credentials, licensure, certifications, etc. were active and in good standing for the earliest requested date of service. Another stakeholder commented: "The Department should consider language consistent with the Medicare program (and many state Medicaid programs) which provide that the effective date for certain providers is the later of the date of filing its enrollment application or the date the provider begins furnishing services, but which also provide that the provider may retrospectively bill for services prior to their effective date of circumstances precluded enrollment in advance of providing the services. See e.g., 42 CFR § 424.420(d); 42 CFR § 424.521(a) and Medicare Program Integrity Manual § 6.1.4.	A CHANGE WAS MADE AS A RESULT OF THESE COMMENTS The Department's retroactive rules pertain to eligibility. See WAC 388-416-0015(9). The Department does not intend to adopt the standards of Medicare. However, the Department has made the following change to the proposed text, to include exceptions: NEW SECTION WAC 388-502-0005 Core Provider Agreement (CPA) (5) ~~When the department approves a CPA, the effective date of the CPA is the date of approval.~~ ~~When the department approves a CPA, the effective date of the CPA is the date of approval.~~ Enrollment of a Medicaid provider applicant is effective no earlier than the date of approval of the provider application. (a) For federally-qualified health centers (FQHCs), see WAC 388-548-1200. For rural health clinics (RHCs), see WAC 388-549-1200. (b) Any other exception to this policy must be requested in writing to the department by providing justification as to why the applicant's effective date should be back dated. Exceptions will only be considered for emergency services, department-approved out-of-state services or if the client was given retroactive Medicaid eligibility. The requested effective date must be noted and must be covered by any applicable license or certification submitted with this application. This also applies to healthcare practitioners who join an established group or clinic as a performing provider, when the established group or clinic has an existing CPA.

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WAC 388-502-0005 **Core Provider Agreement (CPA)** (5) When the department approves a CPA, the effective date of the CPA is the date of approval." This provision would be patently unfair to those physicians who would be providing services to Medicaid clients only to have those claims denied, in situations where DSHS-HRSA did not complete the processing of those physicians' applications in a timely manner. This provision creates no incentive for DSHS-HRSA to complete the processing of CPAs in a timely manner and that it actually creates an incentive to not do so.	**NO CHANGE WAS MADE AS A RESULT OF THESE COMMENTS** Although there is no specific timeframe within federal law that mandates how soon the Department is to process applications for new Core Provider Agreements, the Department's goal of responding to completed CPA applications, that include all supporting documentation, is within 30 days. See also the Department's response on the page 1 of this packet (first two comments and responses).
WAC 388-502-0005(5) **Core Provider Agreement (CPA)** When the department approves a CPA, the effective date of the CPA is the date of approval." Stakeholder suggested that Medicaid should adopt a similar standard as Medicare, reflecting both the need for timely enrollment but also balancing the impact of DSHS operational challenges such as staffing and budgeting shortfalls on physicians and other practitioners. In adopting a standard that accepts the filing date as the effective date of privileging, the Medicare program "addressed the public's concern regarding contractor processing timeliness while appropriately ensuring that Medicare payments are made to physician and NPP organization and to individual physicians and NPPs who have enrolled in a timely manner.	**NO CHANGE WAS MADE AS A RESULT OF THESE COMMENTS.** The Department does not intend to adopt the standards of Medicare. However, a change to the proposed text has been made. Please see the Department's previous responses on page 1.
New Section WAC 388-502-0010(2)(a) **When the department enrolls** "Be currently licensed…" As a possible long term solution, stakeholders suggested that the Department examine ways to streamline the enrollment process. For example, if a physician has already gone through the credentialing process with Medicare and is approved, then that approval might satisfy some activities that are duplicative of DSHS-HRSA's efforts.	**NO CHANGE WAS MADE AS A RESULT OF THESE COMMENTS.** The single state agency (the Department) has an obligation to administer Medicaid and is careful not to delegate it out to anyone else (including Medicare). Having said that, the Department does give due consideration to Medicare certification, when appropriate, as reflected in FQHC and RHC rules.
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WAC 388-502-0010(2)(b) When the department enrolls "Have current professional liability coverage, individually or as a member of a group, through a commercial carrier." Many physicians are insured as members of a self-insured group, one that does not buy insurance through a commercial carrier, such as is the case with many large multispecialty clinics and with hundreds of physicians now employed by hospitals that self-insure. Recommend that the draft language should be amended to reflect the legitimate professional liability coverage arrangement affecting that section of physicians.	A CHANGE WAS MADE AS A RESULT OF THESE COMMENTS. Department made the following change to the proposed text: (2)(b) "Have current professional liability coverage, individually or as a member of a group, ~~through a commercial carrier~~;"
WAC 388-502-0010(2)(e) When the department enrolls Requires that a provider "Sign, without modification, a core provider agreement (CPA) and Debarment form (DSHS 09-048) or a contract with the department." Debarment is not required by federal law, therefore the debarment form should not be required as part of the Core Provider Agreement process.	NO CHANGE WAS MADE AS A RESULT OF THESE COMMENTS. Debarment is required by federal law – 45 CFR 74.13, Executive Order 12549 and 12689 Debarment and Suspension, and 48 CFR part 9, subpart 9.406 . Federal Executive Order Number 12549 directs federal agencies to ensure that any state or other agency receiving federal funds were not contracting or awarding grants to persons, organizations, or companies who have been excluded from participating in federal contracts or grants. Our state's Medicaid program receives Federal dollars and is therefore bound by this Executive Order. Reference to this Executive Order is contained in the Core Provider Agreement under page 9, Section V. and page 11. http://maa.dshs.wa.gov/ProviderEnroll/New%20Provider.htm
WAC 388-502-0010(2)(g) When the department enrolls States that a healthcare practitioner must "Agree to accept the payment from the department as payment in full." The provision makes no reference to *covered services*, that is, the acceptance does not specifically *exclude Medicaid non-covered services* from this requirement. Recommend language be added that limits this requirement to Medicaid covered services only.	A CHANGE WAS MADE AS A RESULT OF THESE COMMENTS. The proposed language mirrors the CFR language in Title 42: Public Health § 447.15 Acceptance of State payment as payment in full. Department made the following change to the proposed text: (2)(g) Agree to accept the payment from the department as payment in full (in accordance with 42 CFR § 447.15 Acceptance of State payment as payment in full and WAC 388-502-0160 Billing A Client).

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WAC 388-502-0010(2)(i) **When the department enrolls** "Have screen employees and contractors with whom they do business…and on a monthly basis thereafter, to assure that employees and contractors are not excluded from receiving federal funds…" The responsibility of screening employees typically is executed by the administration of the practice, not the provider. The proposed provision would place this requirement on each provider. Requiring of providers that this scrutiny of employees and contractors be conducted "on a monthly ongoing basis thereafter" imposes an excessive and impractical requirement for research and oversight on "providers" and the practice entity. DSHS-HRSA is in a better position to conduct this type of monitoring…	A CHANGE WAS MADE AS A RESULT OF THESE COMMENTS. The Department has changed the proposed text as follows: (2) To enroll as a provider with the department, a healthcare professional, healthcare entity, supplier or contractor of service must, on the date of application: This screening requirement is directed by the Centers for Medicare and Medicaid Services (CMS) to strengthen the integrity of the Medicaid program and help States reduce improper payments to providers. State Medicaid Directors were advised by the Centers for Medicaid and State Operations (CMSO) under SMDL #09-001, dated January 16, 2009, to: 1. *Page 1 – "…direct providers to screen their own employees and contractors for excluded persons."* 2. *Page 4 - "Advise all current providers and providers applying to participate in the Medicaid program to take the following steps to determine whether their employees and contractors are excluded individuals or entities:…"* *4th Bullet – "State should require providers to search the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search."*
WAC 388-502-0012(1)(a)(i) **When the department does not enroll** This subsection permits the department to deny enrollment of a healthcare practitioner when: "there are risk factors that affect the credibility, honesty, or veracity of the healthcare practitioner." Absent further definition, this language is far too broad and offers the department virtually unlimited discretion to deny provider enrolment.	NO CHANGE WAS MADE AS A RESULT OF THESE COMMENTS. The Uniform Disciplinary Act (UDA) outlines what constitutes unprofessional conduct for any Washington State license holder or applicant (RCW 18.130.180). The UDA is used to regulate health professionals and is used in conjunction with the commission's laws and rules in disciplinary cases. The Department's general definition's section is located in WAC 388-500-0005. This section states, "Unless defined in this chapter or in other chapters of the WAC, use definitions found in the *Webster's New World Dictionary.*"

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AC 388-502-0012(5) Stipulates that the "applicant does not have any dispute right within the department." The Department should follow Medicare's example by offering dispute rights within the Department prior to judicial review.	NO CHANGE WAS MADE AS A RESULT OF THESE COMMENTS. Either party to the contract has the right to make a business decision not to contract with the other party without that decision being subject to dispute.
WAC 388-502-0014 Review and Consideration of an applicant's history Subsection (a) simply states the converse of language at **WAC 388-502-0012**. If the criteria in **WAC 388-502-0012** are not currently applicable to a particular provider, that provider – by definition – qualifies for enrollment in the Medicaid program	NO CHANGE WAS MADE AS A RESULT OF THESE COMMENTS. The criteria listed under WAC 388-502-0012 relate to current or pending actions; the criteria listed under WAC 388-502-0014 relate to historical actions.
WAC 388-502-0030 Termination of a provider agreement – For cause This section contains vague language, e.g., "moral turpitude" (1)(a)(i), "inadequate or inappropriate treatment," (1)(a)(vi) without further definition. Such language would afford the Department far too much discretion. Who makes a determination of "moral turpitude" and on what basis? Is "inappropriate treatment" based on a panel's interpretation, community standards, national practice standards, etc.? Language in subsection (b) is likewise vague and global: (ii) Dishonesty or other unprofessional conduct. (xiii) Unnecessary medical/dental or other healthcare procedures. What are the standards and who makes the determination that there has been unprofessional conduct or unnecessary medical/dental procedures?	NO CHANGE WAS MADE AS A RESULT OF THESE COMMENTS. The Uniform Disciplinary Act (UDA) outlines what constitutes unprofessional conduct for any Washington State license holder or applicant (RCW 18.130.180). The UDA is used to regulate health professionals and is used in conjunction with the commission's laws and rules in disciplinary cases. Also, as previously mentioned, the Department's general definition's section is located in WAC 388-500-0005. In this section, it states, "Unless defined in this chapter or in other chapters of the WAC, use definitions found in the *Webster's New World Dictionary.*"

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WAC 388-502-0040(b) Termination of a provider agreement – For convenience Stakeholders expressed concerns that this section would terminate a provider agreement without notice if the provider does not submit a claim for 18 months. It is unreasonable to expect large practices to know when a physician has last submitted a claim to the Department. Medicare recently changed its rule regarding termination due to lack of activity and has agreed to provide notice of deactivation beginning January 1, 2010. http://www.cms.hhs.gov/transmittals/downloads/R532OTN.pdf To ensure that providers/suppliers are notified that their Medicare billing privileges have been deactivated, MCS shall systematically generate a letter when a Part B deactivation occurs and when the Provider Enrollment Chain and Ownership System (PECOS) notifies MCS about a deactivation.	NO CHANGE WAS MADE AS A RESULT OF THESE COMMENTS. While this section is a "new" section, the policy is not new. The Department does not terminate without notice. Similar to Medicare's "One Time Notification," the Department has a long standing practice of notifying providers through written communication prior to terminating for convenience in the absence of any other concerns the Department may have about the provider. The written communication notifies the provider of the Department's intent to terminate the provider's agreement due to billing inactivity and allows the provider a period of time to respond before the termination becomes effective. Termination for convenience, by either party, is a contractual right contained in the CPA. The CPA provides all the process that is due to either party.

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Due Process Considerations **WAC 388-502-0030, -0040 Termination For Cause or Convenience; WAC 388-502-0050 Provider Dispute of a Department Decision; WAC 388-502-0060 Reapplying for Participation; and WAC 388-502-0230 Provider Payment Reviews and Dispute Rights** Concerned that physicians will not have adequate due process protections in dealing with DSHS-HRSA. The physician as "provider" is subject to DSHS-HRSA processes that do not guarantee the right to argue and present information in dispute of the Department's actions or proposed actions. Stakeholders object to the denial of access to the dispute resolution process for providers whose CPA has been terminated for convenience. The proposed rules eliminate rights that providers possess under the current rules and deny providers any means to appeal a decision made without a reasonable basis. Also, in the case of a provider who has not submitted a claim to DSHS-HRSA for 18 consecutive months, the provider should have the opportunity to modify his or her practice pattern before their contract is terminated. Stakeholders recommend that a provider whose CPA was terminated for convenience be afforded an opportunity to challenge the proposed action through proposed WAC 388-502-0060.	NO CHANGE WAS MADE AS A RESULT OF THESE COMMENTS. The proposed rules do not change any contractual rights contained in the current rule or in the Core Provider Agreement (CPA). In the case of a provider who has not submitted a claim to DSHS for 18 consecutive months, the Department does notify the provider prior to terminating for convenience in the absence of any other concerns the Department may have about the provider. Termination for convenience, by either party, is a contractual right contained in the CPA. The CPA provides all the process that is due to either party. Either party to the contract has the right to make a business decision not to contract with the other party without that decision being subject to dispute.

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WAC 388-502-0050 **Provider dispute of a department decision** This section should be applicable to any Department decision related to provider enrollment – denied or terminated enrollment. Upon receipt of HRSA's initial dispute decision, providers should have the right to have an impartial party, from outside HRSA, review the written determination.	**NO CHANGE WAS MADE AS A RESULT OF THESE COMMENTS.** The single state agency (the Department), has an obligation to administer Medicaid and the Department cannot delegate it out to anyone else. As the single state agency, the final decision on ANY dispute MUST be the Department's.
Preliminary Cost Benefit Analysis Under Benefits, the Department listed that the proposed rules "eliminates confusion surrounding the effective date of the Core Provider Agreement and whether or not services provided to clients during the application process are covered." A stakeholder commented that rationale is inadequate and misleading. Current policy is clearly stated in the Core Provider Agreement and Billing Instructions; providers across the state are familiar with it. Contrary to the intent statement, this policy change will lead to confusion and fewer providers willing to accept patients who are Medicaid eligible or potentially Medicaid-eligible.	**NO CHANGE WAS MADE AS A RESULT OF THESE COMMENTS.** Neither the Core Provider Agreement nor current rule state when the CPA becomes effective. The proposed rule eliminates any confusion.

cc: DSHS Rules Coordinator