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November 16, 2010

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-6028-P, Proposed Rule: Medicare, Medicaid and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers.

Dear Dr. Berwick:

The Commonwealth of Massachusetts appreciates the opportunity to submit comments on the Proposed Rule regarding the Medicare, Medicaid and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers.

Massachusetts has the following comments and clarifying questions related to the proposed rule.

438.6 Contract requirements

We are concerned that requiring all Managed Care Entity (MCE) providers to participate in the state's fee for service Medicaid program could reduce access to providers for Medicaid enrollees generally. This concern is especially acute with respect to certain specialty providers, such as child psychiatrists. Providers who are not willing to participate in the fee for service Medicaid program are often willing to participate in one or more MCE networks.

Please clarify how this applies to services provided by MCEs under a Demonstration Waiver or Home and Community Based Waiver that authorizes the state to limit the provision of services to MCEs (so that no providers are enrolled in Fee for Service).

455.23 Suspension of payments in cases of fraud

Please clarify the timing of any payment suspension based on a credible allegation of fraud. While the proposed rule allows for good cause exceptions for not suspending payments or suspending payment only in part, for example, when law enforcement officials specifically request a payment suspension not be imposed as it would compromise or jeopardize an investigation, it is important that the Medicaid Fraud Control Unit or other law enforcement officials have sufficient time prior to the state imposing a payment suspension, to carefully review any referral to evaluate whether a payment suspension would compromise or jeopardize an investigation.

Please clarify that states with authority under state law may impose suspensions for reasons other than where there is a credible allegation of fraud. We believe that where such authority exists, it should be made clear that the requirements under §455.23, including those concerning referrals to the Medicaid Fraud Control Unit and duration of suspension, should not apply.

455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control

We are concerned that the universal requirement that the state always obtain an individual's Social Security Number and date of birth might hamper access. We suggest that this information be required when the state deems it appropriate on a case by case basis.

We are concerned about the requirement that disclosures be made to the state within 35 days after any change in ownership of the disclosing entity, fiscal agent or managed care entity. While we support that the state be notified of changes, it places an unfair burden on the state where the consequence is the loss of FFP when the state may have no knowledge of such changes.

455.410 Enrollment and screening of providers

Given that state Medicaid agencies may rely on enrollment screenings done by Medicare, how does CMS plan to share the Medicare provider enrollment information with state Medicaid agencies (for example, verification of limited liability, partnerships, ownership, fingerprinting results, criminal background checks, etc)? Will CMS maintain a web based database that will have this specific information in it?

Do the provider screening requirements listed in these proposed rules also apply to Medicaid waiver providers (e.g. 1915(c))?

The Commonwealth's primary concern about requiring MCEs to implement the same screening requirements as the state is that, depending on the screening requirements that are established, the MCEs' costs may increase, therefore putting pressure on MCE capitation rates.

455.410(b) The state Medicaid agency must require all ordering or referring physicians...to be enrolled as participating providers

Please clarify the timeframe for compliance with 455.410(b), the requirement that the state Medicaid agency must require all ordering and referring physicians to be enrolled as participating providers.

Please clarify whether 455.410(b) requires that each ordering or referring physician or other professional providing services for an institutional provider needs to be enrolled in the state Medicaid program. For example, if a salaried hospital physician is not enrolled as a participating Medicaid provider, does the referral rule still apply to the physician if the hospital that the physician is employed with is a participating Medicaid provider?

Where a Medicaid recipient is covered by other insurance that paid for the office visit with the physician or other professional who made the order or referral, does that physician or other professional need to be enrolled in the state Medicaid program? Many of our recipients are disabled or elderly, have other insurance, and may be referred by physicians who are paid by the other insurance, but are not Medicaid providers.

Does this requirement apply when an order or referral was made prior to the recipient being eligible for Medicaid?

Does this requirement apply to claims crossed over from Medicare?

Please clarify the definition of "other professionals" as the term is used in the proposed regulation, both for purposes of the state plan and 1915(c) waivers.

455.414 Reenrollment

How does CMS plan to share the results of specific information obtained by Medicare during the reenrollment process with the state Medicaid agencies?

455.418 Deactivation of provider enrollment

Please clarify how a state that does not currently track provider referrals can determine whether a provider must be deactivated as a result of having submitted no claims and making no referrals that result in Medicaid claims within the prior 12 months.

455.434 Criminal background checks

We suggest that to the extent CMS decides fingerprinting is necessary for high risk providers, that it be conducted by CMS, regardless of whether the person or entity is enrolled in Medicare. State Medicaid agencies (and managed care entities if this requirement applies to MCEs) do not have the staff or expertise to conduct such checks. In addition, imposing this requirement on MCEs may increase their costs for administering Medicaid managed care plans and put upward pressure on managed care capitation rates as a result.

455.450 Screening categories for Medicaid providers

The proposed rule states that any provider that is publicly traded on NASDAQ or the NYSE is considered to be at limited risk. We believe that all providers of a particular type, publicly traded or not, should be treated equally.

455.470 Temporary moratoria

What is the process that states would use to notify CMS that implementing a moratorium, caps or other limits, would adversely impact beneficiaries' access to medical assistance?

Massachusetts appreciates the opportunity to comment on this proposed rule and looks forward to continuing to work with CMS to strengthen and improve the Medicaid program.

Sincerely,



Terence G. Dougherty
Medicaid Director