



## ACA provider screening requirements

### Issue:

- The federal Affordable Care Act (ACA) made numerous changes to the Medicaid, called Medical Assistance (MA) in Minnesota, and Medicare programs to fight fraud, waste and abuse.
- These changes require DHS to screen MA providers to ensure that they are qualified to perform services under state and federal requirements and are eligible to participate in health care programs. The ACA screening provisions require DHS to:
  - Collect an application fee from all providers at enrollment. Individual providers and providers who have already enrolled and paid the fee to Medicare or to another state's Medicaid program are not charged this application fee. The fee revenues must be applied to DHS' costs of conducting the required provider screening activities.
  - Assign provider types to screening categories of limited, moderate or high risk for fraud, waste or abuse.
  - Expand screening of all enrolling providers to include data validation, licensing checks, and checking multiple databases
  - Conduct mandatory rescreening of all providers at least once every five years.
  - Make unannounced site visits to providers considered moderate or high risk before and after enrolling.
  - Perform FBI checks and fingerprinting of high-risk owners.
- DHS has already implemented parts of the screening requirements through policy and through legislation enacted in 2011.

### Proposal:

- Implements the federal provider enrollment requirement to conduct pre- and post-enrollment screening of potential and re-enrolling providers
- Adds six staff for the Office of Inspector General to conduct on-site visits and three staff for enrollment activities
- Provides for the dedication of the federally required enrollment fee, estimated at \$536 per application in 2013 and is expected to generate more than \$500,000 annually.
- Supplements the fee revenue with a General Fund appropriation. The additional resources are necessary because the fee is only paid by newly enrolling providers.

### Impact:

- The provision will help prevent fraud waste and abuse in health care programs and avoid significant "pay and chase" activities by preventing fraudulent or illegitimate providers from enrolling in state health care programs.
- Site visits will allow staff to verify that providers have administrative capacity and are ready to provide services before being enrolled They are operating consistent with Minnesota Laws and requirements after enrollment.

- It will bring Minnesota into compliance with federal law and regulations and provide resources needed to implement the provisions of Minnesota law enacted in 2011.

**Number of people affected**

- Approximately 800,000 Minnesotans are enrolled in state health care programs.
- More than 155,742 providers are enrolled with DHS with approximately 975 new providers expected to enroll each year.

**Fiscal impact:**

- FY2014: \$311,000
- FY2015: \$290,000
- FY2016: \$290,000
- FY2017 \$290,000

**Related information:**

- Minnesota Management & Budget website: <http://www.mmb.state.mn.us/>
- Minnesota Health Care Programs fact sheet:  
<https://edocs.dhs.state.mn.us/lfservlet/Public/DHS-4932-ENG>

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