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Memorandum

Revised 5/4/2023

TO: MCO Health Plan Leadership

From: Tammy Driscoll, Senior Advisor, Director's Office

CC: Tammy Whitlock, Deputy for Complex Care
Adrienne Fegans, Deputy for Programs and Operations
Dan Plain, Director of Health Care Services Division
Jason Rachel, Director of Integrated Care Division

DATE: May 4, 2023

SUBJECT: Compliance with 21st Century Cures Act for MCO Network Providers

This memorandum clarifies the Department's requirements for compliance with the 21st Century Cures Act federal regulations for screening and enrollment of MCO Network providers. DMAS will incorporate these provisions as necessary in the next revision of the Department's MCO contract.
Unless stated otherwise, the following provisions are effective with dates of service on and after July 1, 2023.

1. Prior to finalizing any Virginia Medicaid provider contract, the MCO must ensure its Virginia Medicaid and FAMIS network providers enroll in the DMAS Provider Services Solution (PRSS) system. This does not require the MCO's network provider to render services to FFS members.
2. Effective with dates of service on and after 7/1/23, MCOs must suspend/terminate an existing provider's Medicaid / FAMIS network participation status until the network provider enrolls in PRSS.
   Two Exceptions:
   1) MCOs should delay payment suspension/contract termination for any providers with pending application status, until notified otherwise by DMAS.
   2) MCOs should delay payment suspension/contract termination for unenrolled pharmacy providers (not PRSS enrolled), until 9/1/2023. MCO pharmacy benefit managers should send warning notices at point of sale to encourage unenrolled pharmacy providers to enroll. Also see #14 for delay of claim denials for missing prescribers.
3. The MCO's providers participating within an MCO's D-SNP network that only provide Medicare services are not required to enroll in PRSS.
4. MCO's must continue to pay for care using out of network providers in accordance with federal rules and MCO contract standards. ***Out-of-network providers, including out of network pharmacy providers, are not required to enroll in PRSS*** but must be registered by the MCO using the non-par provider registration (NPPR) file; this includes non-par providers billing the MCO for cost sharing, e, g., TPL coinsurance and deductibles. Exception: registration for non-par providers is not required if the MCO's non-par provider is already PRSS enrolled, e.g., par with FFS or another MCO. Non-emergency

transportation providers must also be registered by the MCO using the NPPR file. (Registration supports data quality for the DMAS federal reporting.)

5. MCOs may execute network provider agreements for up to 120 calendar days, pending the provider's completion of the DMAS enrollment process, but must terminate the provider's Virginia Medicaid/FAMIS network participation status immediately upon notification that the network provider cannot be enrolled, or the expiration of the 120-day period without enrollment of the provider. Upon such termination, the MCO must notify affected members. ***Given the backlog of pending provider applications, this 120-day timeframe will be extended until further notice.*** The MCO must register these providers using the NPPR process while the provider's PRSS application is pending.
6. DMAS will allow retro-enrollments for up to 120 days prior to the provider's PRSS application date, when requested by the provider in PRSS, and where the provider satisfies federal screening and enrollment criteria.
7. Other than exceptions noted in # 2 above, effective with dates of service on and after 7/1/23, MCOs must not pay claims to network providers unless/until the billing/rendering provider NPI (or for facility claims, the billing and attending NPI) is PRSS enrolled with an active status that covers the claim dates of service. ***Exception: until further notice, MCOs should not deny claims for network providers with a pending application in PRSS. MCOs should not deny claims for unenrolled network pharmacy providers until 9/1.***
8. MCOs must not submit encounters for paid claims to an <u>out of network provider</u> (NPI), until the MCO registers the NPI using non-par provider (via NPPR file) during claim dates of service. (Exception: not required if the non-par provider is already PRSS enrolled in FFS or with another MCO).
9. MCOs must not submit paid encounters for claims that are not consistent with 7 & 8 above.
10. MCOs must deny (versus reject) claims where the reason for the denial is because the network provider is not enrolled with the state in PRSS.
11. MCOs must ensure that members are not held liable for any claims denied to providers for the provider's failure to enroll in PRSS.
12. Suspended/terminated providers cannot be included in the MCO's provider directory and cannot be counted in the network for network adequacy.
13. MCOs will update the par status for their network providers who are PRSS enrolled using the PRN file and MCO portal.
14. MCOs must not deny claims for missing ordering, referring, or prescribing providers until notified otherwise by DMAS. MCOs must notify and encourage any non-billing ordering, referring, and prescribing providers to enroll as ORP providers in PRSS. See *areas to be implemented in the future*, below.
15. MCOs must meet network adequacy requirements and must transition members who are impacted by provider terminations in a manner that mitigates adverse impact to members and preserves the member's continuity of care, per federal and contract standards. See section 3 on the next page for additional details.
16. When pharmacy claim denials are implemented, the MCO is required to cover a 72 hour emergency supply per current contract standards, as follows: *A seventy-two (72) hour emergency supply of a prescribed covered pharmacy service must be dispensed if the prescriber cannot readily provide authorization and the pharmacist, in his/her professional judgement consistent with the current standards of practice, determines that the Member's health would be compromised without the benefit of the drug. For unit-of-use drugs (i.e., inhalers, eye drops, insulin, etc.), the entire unit should be dispensed for the seventy-two (72) hour supply.*

Areas to be implemented in the future.

1. Ordering, Referring, and Prescribing (ORP) Non-Billing Providers
   - DMAS will work with MCOs to develop a process and timeline to apply NPI claim edits to ORP providers, including missing prescribers: dentists (e.g., enrolled with DentaQuest), hospitalists, interns, etc. Process may include pharmacy point-of-sale over-rides and exceptions identified by the workgroup, based on other state processes, federal allowances, etc.
   - MCOs should not send notices to dental providers asking them to enroll in PRSS. Dental providers are not enrolled in PRSS; dentists are screened and enrolled per Cures Act requirements by the DMAS dental benefits administrator (DBA), DentaQuest.
   - Out of network ORPs are not required to enroll. See MPEC page 43, and page 99.
   - Many states have not implemented claim edits for non-billing ORPs. TMSIS edits for missing ORPs are currently at the medium level (not critical/ high).
2. Encounter Edits – DMAS will continue to use informational edits at this time. DMAS will transition to pass/fail edits in the future, following resolution of any start-up concerns and post implementation of necessary systems changes.

Related Federal, State, and Cardinal Care MCO Contract References:

- Federal regulations 42 CFR §438.608(b), and 42 CFR §455.100-106, 42 CFR §455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, PUBL255.PS (congress.gov)
- Federal provisions for continued services to members and network adequacy and access to care standards – 42 CFR §§ 438.62, 438.68, 438.206, and 438.207
- Federal member notification requirements for terminated providers - 42 CFR §438.10(f)(1)
- CMS Medicaid Provider Enrollment Compendium (MPEC) – sub regulatory guidance on provider enrollment.
- April 22, 2019, CMS Memo - Clarification of Medicaid provider enrollment provisions for services provided by integrated D-SNPs and MMPs (cms.gov)
- Cardinal Care MCO Contract, Sections: 5.7.1, 5.13, 5.15, 7.1, 7.2, 7.3, 8, 8.11, 11, 12.1, 13.3.

Gainwell NPPR and PRN Guides:
Provider Downloads | MES (virginia.gov) (scroll to the end of the page).

Department's Overall Strategy and Timeline

1. **Enhanced communications and outreach (January – March 2023)**
   - MCO "Act Now" notices sent to ALL network providers not PRSS enrolled,
   - MCOs continue to message providers in a variety of ways, i.e., fax blasts, point of sale messages, and email notices to providers.
   - Dedicated webpage launched that includes source of truth file of enrolled providers, information on how to check enrollment status and enroll any missing NPIs, service locations, etc.
2. **Network analysis and targeted outreach to enroll providers needed for network adequacy (February – June 2023)**
   - ✓DMAS shares enrollment files and pending enrollment files with plans weekly.
   - ✓MCOs conduct data analysis to identify any network providers not enrolled in PRSS.
   - ✓MCOs provide high-touch outreach to providers needed for network adequacy and to avoid member disruption.

3. **Transition of care planning activities are underway and will be launched in (May – June 30, 2023, to impacted members)**
   - MCOs will transition members to available Cures Compliant network providers, using outreach, member services, and care management activities to ensure timely member access,
   - MCOs must identify members with potential impact.
   - For members who receive primary care from or were seen on a regular basis by the terminated/suspended provider, MCOs will send written notice of termination to the Member within thirty calendar days prior to the effective date of the termination.
   - MCO transition plans will:
     - Transition each impacted member to a new provider within at least thirty (30) calendar days prior to the effective date of provider termination.
     - Ensure the member retains access to services consistent with the access they previously had and is permitted to retain their current provider during the transition.
     - Continue services with the member's current provider (out of network) when necessary to ensure continuity of care, until the member can be transitioned to an in-network provider.
     - Ensure the Member's new provider can obtain copies of the member's medical records.
     - Transition any authorizations to the new provider(s), and
     - Obtain DMAS approval on transition plans for any terminations that impact high risk members.
   - MCOs should ensure sufficient staffing is in place to handle increased volume of transitions based on impact to be identified in the MCO data analysis. Plans will provide data to DMAS on 4/20 (per instructions sent 4/13 by email from Katie Linkenauger.) Data will include metrics on providers who will be terminated or suspended by region and type of provider, provider PCP assignments, specialty care in progress, and any high-risk members served by these providers.
4. **Hierarchical, phased, provider terminations (April through June 30, 2023)**
   - Providers with no claims/not needed for network adequacy will be terminated/suspended first.
   - Pharmacies and any providers needed for network adequacy or to mitigate member disruption will be terminated/suspended by June 30,2023, following aggressive activities to promote participation.
5. **Ongoing monitoring of provider enrollment, terminations, network adequacy, encounters, and TMSIS reporting, and work to address the future areas identified above. (July – December 2023)**