pennsylvania
DEPARTMENT OF PUBLIC WELFARE

OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES BULLETIN

ISSUE DATE	EFFECTIVE DATE:	NUMBER:
August 1, 2014	March 25, 2011	OMHSAS-14-03

SUBJECT:

Affordable Care Act (ACA) Re-enrollment Guidance for Behavioral Health Providers

BY:

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SCOPE:

- Select Behavioral Health Providers in the Medical Assistance (MA) Fee-for-Service Program
- Select Providers in HealthChoices Behavioral Health Managed Care
- Providers in Consolidated Community Reporting Initiative (CCRI) Delivery System

PURPOSE:

The Office of Mental Health and Substance Abuse Services (OMHSAS) is issuing this bulletin to provide additional guidance to OMHSAS' enrolled providers of behavioral health services, specifically, Community Support Service (CSS) providers. CSS include *Intensive Case Management, Resource Coordination, Blended Case Management, Family Based Mental Health Services, Mental Health Crisis Intervention Services, and Peer Support Services*. In addition to these providers, this guidance also applies to providers of HealthChoices Supplemental Services and providers of base-funded (CCRI) Mental Health services.

BACKGROUND:

On March 7, 2014, Department of Public Welfare's (DPW) Office of Medical Assistance Programs (OMAP) issued Bulletin 99-14-06 to outline the requirements associated with the re-enrollment (revalidation) requirements for continued participation in the MA Program for currently enrolled providers.

As outlined in Bulletin 99-14-01, 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 Affordable Care Act or ACA), amended Section 1902 of the Social Security Act (Act) to add paragraphs (a) (77) and (kk), requiring States to comply with provider screening requirements. The federal Department of Health and Human Services promulgated regulations implementing these provisions of the statute on

March 23, 2011, which are found at 42 Code of Federal Regulations (CFR) 455, Subpart E – Provider Screening and Enrollment.

DISCUSSION:

Revalidation of Enrollment

The Department must revalidate the enrollment of all providers, regardless of provider type, at least every five (5) years. In order to do this, the Department is requiring that all providers re-enroll at least every five (5) years by submitting a fully completed Provider Enrollment Application specific to the program for which they are enrolled, along with any required additional documentation/information based on provider type, for every active and current service location. The Federal regulation at 42 CFR §455.414 (relating to the revalidation of enrollment) requires the Department to complete the initial revalidation of currently enrolled providers by March 24, 2016.

Therefore, the Department is requiring all currently enrolled providers to complete the re-enrollment process as outlined below:

- Providers that initially enrolled on or before March 25, 2011 will have to complete the re-enrollment process by March 24, 2016, and subsequent re-enrollments every five (5) years thereafter.

- Providers that initially enrolled after March 25, 2011 will not have to re-enroll until five (5) years from the date they were initially enrolled. They will also complete subsequent reenrollments every five (5) years thereafter.

As stated in 42 C.F.R. § 455.416, service locations for which the provider has not completed the re-enrollment process by the March 24, 2016 deadline will expire and no longer remain active. If the enrollment is closed, the provider will not be paid for services provided to recipients after the date of the closure. If the provider wishes to re-enroll, the provider must submit a new application. The effective date of the new enrollment will not be made retroactive to cover any lapsed enrollment periods.

After the initial re-enrollment, providers will have to subsequently re-enroll by submitting a complete, up-to-date enrollment application for each service location at least every five (5) years. As with the initial revalidation process, if a provider does not complete the re-enrollment process within five (5) years of the most recent re-enrollment, the provider's enrollment will expire.

OMHSAS Provider Record Update Requirements

It remains the responsibility of the provider to inform the Department/OMHSAS when:

- Demographic changes specific to the service location, which includes contact information, email changes, etc. occur;

- Changes occur in direct or indirect ownership and controlling interest by five (5) % or greater;

- When a provider relocates, the provider must take the appropriate action to keep their information current, which would otherwise render the information in their current provider file inaccurate or incorrect.

PROCEDURE:

1) Providers can determine their next re-enrollment deadline by logging in to the provider portal for each service location. The re-enrollment/re-validation date will be displayed in the masthead of the provider portal for each service location. The date identified is the expiration date for that specific service location based on the most recent application on file with DPW/OMHSAS.

2) Prior to completing an application for re-enrollment/revalidation in the MA Program, providers should review enrollment requirements to assure all requirements are met in order to continue enrollment with the PA Medicaid Program.

3) Providers of CSS services must complete the latest version of the PROMISe™ Provider Enrollment Application including all required accompanying requirements /documentation. Providers of CSS services will obtain their enrollment application and review requirements by accessing the following link:
http://www.dpw.state.pa.us/provider/promise/enrollmentinformation/index.htm

4) CSS Providers will mail the enrollment application/required documentation to:
DPW/OMHSAS
Business Partner Support Unit
112 East Azalea Drive – 2nd Floor
Harrisburg PA 17110

5) Providers of HealthChoices Supplemental Services, enrolled through the Behavioral Health Managed Care Organization will need to meet the requirements set forth by the contracted county/BH-MCO. When the provider has met the contracted county/BH-MCO requirements, the contracted county/BH-MCO will provide the current HealthChoices Supplemental Services Provider Enrollment Application/required documentation and will coordinate and submit the Provider Enrollment Application/documentation along with BH-MCO Attestation Form to OMHSAS at the above address, for processing.

6) Providers of CCRI, enrolled through the County MH will need to meet the requirements set forth by the County. When the provider has met the County requirements, the County will provide the current CCRI Provider Enrollment Application/required documentation and will coordinate and submit the Provider Enrollment Application/documentation along with the County Attestation Form to OMHSAS at the above address, for processing.

OMHSAS requires original hardcopy enrollment documents/supporting documentation, which includes original provider signature/dates.

If you have additional questions regarding *this* information, please contact the Behavioral Health Services Toll-Free Inquiry Line at 800-433-4459.