

NCIOM ACA Workgroups Legislation

*Provisions are draft and still
being finalized*

January 19, 2011

General Provision

- All ACA activities must be taken into context of federal requirements, impact on existing programs, the Governor's Initiative and current budgetary situation
- Submission of a provision that directs the Dept to move forward with the planning and pricing of all aspects of ACA.
 - Provides for reporting back to GA if CMS issues guidance while the GA is not in session and the Dept has the resources to implement the requirements or activities as recommended by the IOM reports
- Directs the Dept to explore seeking CMS approval in areas that enhance funding
 - Health homes
 - Health Choice
 - Community Based Options

Electronic Transactions

- Builds off the HIT plan and last year's provision of electronic billing and EFT.
- Requires providers to submit Prior authorizations through vendor web portals, receive authorizations electronically and submit provider enrollment applications
 - Directs the Dept to accept electronic/digital signature and not require hard copy submission unless required by federal law/rule.

Eligibility

- Continues the NCFAST funding and process, with modified timelines
- Directs the Dept to implement the simplification actions in planning
- Begins the planning and design of
 - The infrastructure for determining eligibility (MAGI),
 - Transition of business processes and functions for current eligibility activities at the local DSS,
 - Begins to expand others conducting eligibility determination
 - Allows for contracting to accomplish all the documentation and rewriting of manuals
 - Outreach and training of recipients

Innovation Projects

- Directs the Dept to move forward within allowable resources to pilot.
- Examples:
 - Alternative funding/pricing methodologies
 - Pay for performance
 - Psychiatric hospitalization or emergency interventions – IMD
 - Personal responsibility in health care

Fraud and Abuse

Includes changes in enrollment and termination

- Although much was already underway – provision will outline more details and put policy into legislation
 - Screening, Oversight, disclosures
 - Enrollment and disenrollment requirements
 - Criminal history and exclusions, Finger printing, High risk providers
- Education and training of providers
 - Minimum based upon type and specialty but more in the areas of Medicaid rules and requirements – Medicaid 101
- Modifies procedures and outlines prepayment review requirements
- Expands and documents self reporting and payback
- Expands self referral, ownership issues

Fraud and Abuse

Includes changes in enrollment and termination

- Initiates requirements for billing agents and registering with Medicaid
- Establishes procedures and processes for high risk providers and establishes benchmarks for becoming a high risk provider. Once meeting the high risk ranking, outlines the requirements and process for “getting off the list” if not one of the federally mandated categories.

Fraud/Abuse

- Data sharing about payers
- Data sharing and reporting to feds and other states – requires CMS guidance
- Modifies current bond requirements
- Directs the Dept to adopt rules as necessary to meet federal requirements
- Modifies suspension of payment legislation
- Establishes penalties for failure to allow and/or provide timely access to records during review or audit
- Establishes corporate compliance programs for ALL Medicaid providers