Poll Question
What is Medicaid?
Medicare vs. Medicaid

Medicare
Federal Health Care Coverage

Medicaid
Cooperative Federal and State Health Care Coverage

People aged 65 or older
Certain people under 65 with disabilities
People of any age with End-Stage Renal Disease

59 MILLION patients

632.9 BILLION

72 million beneficiaries enrolled in Medicaid, including
more than

552.3 BILLION

Low-income adults
Pregnant women
Children
Medicare vs. Medicaid

- Medicare and Medicaid are separate programs
- Submitting an application to Medicare does not mean you have also submitting an application to Medicaid
- An enrollment approval in Medicare does not necessarily guarantee enrollment approval in Medicaid
What is CMS’ role?
CMS Center for Program Integrity manages Medicare and Medicaid enrollment.

- CMS provides oversight while States administer the Medicaid program

- CMS issues Federal regulations and sub-regulatory guidance that states must adhere to in implementing their Medicaid program

- CMS provides technical assistance to states via phone, email, and in-person visits
Medicaid Provider Enrollment Requirements

• CMS promulgated requirements via regulations at 42 CFR:
  – 455 Subpart B (Disclosures)
  – 455 Subpart E (Screening and Enrollment)

• The federal regulations became effective March 25, 2011 (except FCBC)

• These requirements mirror those implemented in Medicare—with a few exceptions
Sub-Regulatory Guidance

• Medicaid.gov contains all provider enrollment related Medicaid guidance issued to states: 
  https://www.medicaid.gov/medicaid/program-integrity/affordable-care-act-program-integrity-provisions/index.html

• Most importantly, the Medicaid Provider Enrollment Compendium (MPEC): 

  • Updated July 24, 2018
  • Guidance is for State Medicaid Agencies and providers
State-Based Requirements
Poll Question
State Requirements

CMS does not prohibit states from implementing their own provider standards and requirements

**MPEC:** “Under § 455.452, nothing in Subpart E restricts a SMA from establishing provider screening methods in addition to or more stringent than those required by Subpart E.”

- Conduct required screening in a more stringent manner than Medicare or another State conducts the same required screening
- Conduct additional screening activities
- Impose additional requirements on providers
Risk Level and Screening

High

Moderate & High

Limited, Moderate, & High

1. Check Federal or state requirements by provider type
2. Licensure Checks
3. Database Checks
Medicaid-Medicare Differences

- Medicaid has a 5 year revalidation requirement for Suppliers of Durable Medical Equipment and Supplies

- Fingerprinting for Medicaid “high” risk providers required as of July 1, 2018

- Risk categories for Medicaid-only provider types may differ
  - other provider types will have similar risk level as Medicare
  - States have the authority to raise (but not lower) the risk category for any provider type

- Criteria to elevate risk level
How does this impact you and what to expect?
Application Fees

• States are authorized to charge application fees on a per application basis

• If a state requires providers to submit an application for each practice location, the state may charge a fee for each of those applications
  • Some states may permit all locations to be enrolled using one application

• States may charge fees of provider types that Medicare does not
Application Fees

• Medicaid* cannot charge an application fee when the provider is enrolled with Medicare or another State’s Medicaid program

• The provider must be the “same”

<table>
<thead>
<tr>
<th>Medicaid Risk Category</th>
<th>Name</th>
<th>TIN</th>
<th>Practice Location(s)</th>
<th>5 % or more owners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional Organizational Provider</td>
<td>“Limited”</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>“Moderate”</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>“High”</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

*Medicare will charge the fee regardless of enrollment with Medicaid
Site Visits

- Site visits may differ between states and with Medicare’s site visit criteria/protocol

- Some states use site visits not only to confirm the practice location but also compliance with other state policies and requirements

**Examples:**
One state uses site visits to verify the location is wheelchair accessible

Verification that employed staff have required CPR certifications
Fingerprinting

- States, like Medicare, must fingerprint all 5% or greater owners of providers categorized as “high” risk
- States may categorize provider types at higher risk levels than Medicare
- Some states may choose to fingerprint all owners, at least one state fingerprints managing employees
“High” Risk Providers

• Prospective (newly enrolling):
  • Home health agencies (HHA)
  • DMEPOS

• Provider types the State has categorized as “high”

• Providers elevated per 42 CFR 455.450(e)
Increase in Risk Level

- CMS has designated specific criteria for states to use in determining when a provider may need to have their risk level increased to “high” from “limited” or “moderate”

- This criteria is different between Medicare and Medicaid

- While you may be categorized as “limited” or “moderate” risk in Medicare, you may be “high” risk in Medicaid

- The state would be required to conduct “high” risk screening
## Criteria to Increase Risk Level

<table>
<thead>
<tr>
<th>Providers Are “High” Risk When:</th>
<th>Risk Remains “High”</th>
</tr>
</thead>
<tbody>
<tr>
<td>State imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse in the past 10 years</td>
<td>10 years beyond date of payment suspension</td>
</tr>
<tr>
<td>Provider has an existing Medicaid overpayment* at initial enrollment or revalidation</td>
<td>For any enrollment or revalidation that the provider continues to have an existing overpayment*</td>
</tr>
</tbody>
</table>

*Overpayment Criteria on next slide
Criteria to Increase Risk Level

An overpayment that meets the criteria to bump a provider to “high” risk is $1500 or greater and all of the following:

- Is more than 30 days old
- Has not been repaid at the time the application was filed
- Is not currently being appealed
- Is not part of a SMA-approved extended repayment schedule for the entire outstanding overpayment
## Criteria to Increase Risk Level

<table>
<thead>
<tr>
<th>Providers Are “High” Risk When:</th>
<th>Risk Remains “High”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider has been excluded by the OIG or another State's Medicaid program within past 10 years</td>
<td>For 10 years beyond date of exclusion</td>
</tr>
<tr>
<td>State or CMS, in the previous 6 months, lifted a moratorium for the particular provider type and a provider that was prevented from enrolling applies for enrollment within 6 months from the date the moratorium was lifted.</td>
<td>State stops looking at this beginning 6 months and 1 day after a moratorium is lifted</td>
</tr>
</tbody>
</table>
What If I am or will be a Dually Enrolled Provider?
Poll Question
States **may**, but **are not required** to, rely on the results of screening performed by Medicare or its contractors.

- CMS has designed the framework for when states can and cannot rely on Medicare’s screening for dually enrolled providers.
- More detailed guidance on the following is available in the MPEC.
Relying on Medicare’s Screening

A state is able to fully rely on Medicare’s screening when:

• The provider has been **screened in the past 5 years**

• The provider is “**approved**” in Medicare

• The provider is the **same risk level** in both Medicare and Medicaid

• The provider is verified as the “**same**” **provider**
Relying on Medicare’s Screening

What is the “same” provider?

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Name</th>
<th>NPI</th>
<th>SSN (Last 4 digits)</th>
<th>TIN</th>
<th>Practice Location(s)</th>
<th>All 5% or more owners</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Limited” Individual</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Moderate” Individual</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>“High” Individual</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>“Limited” Organization</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>“Moderate” Organization</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>“High” Organization</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Relying on Medicare’s Screening

• If information submitted on Medicaid application does not align with Medicare, the state may not be able to fully rely on Medicare’s screening

• States may choose to perform their own screening and only rely party on Medicare’s screening

• Enrollment with Medicare does not exempt providers from disclosing information requested on Medicaid application

• There may be instances when States can only partially rely on Medicare’s screening
Partially Relying on Medicare’s Screening

**Example:** State receives Medicaid application that lists three 5% or greater owners. Upon checking PECOS the state only sees one 5% or greater owner.

**Next Steps:** The state has two options:

1. Perform screening on the two additional owners and enroll
2. Reach out to CMS to see if a CHOW is pending; await CHOW approval to enroll

• In either case, States are asked to provide these discrepancies to CMS—could result is possible revocation or impact to application
What if I’m enrolled in another state’s Medicaid Program?
Relying on Another State

Similar concept as relying on Medicare

• If a provider was screened and enrolled by another state, any subsequent states may rely on that screening

• Relying is optional

• The same data elements used for relying on Medicare’s screening would need to be confirmed and matched between two states
What if I don’t directly participate with Medicaid?
Poll Question
## Ordering and Referring

**Is enrollment of the O/R provider required?**

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMEPOS</td>
<td>All Items</td>
<td>All Items</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>All Services</td>
<td>All Services</td>
</tr>
<tr>
<td>Clinical Lab Services</td>
<td>Technical Component Only* Unless Billed Globally</td>
<td>Both Technical and Professional Components</td>
</tr>
<tr>
<td>Imaging Services</td>
<td>Technical Component Only* Unless Billed Globally</td>
<td>Both Technical and Professional Components</td>
</tr>
</tbody>
</table>

*Provider performing the professional component must be enrolled in order to be reimbursed but O/R provider does not.*
Medicare

Medicare Patient visits non-enrolled Dr. and the Dr. orders an X-ray

Patient visits Medicare enrolled Imaging provider and X-ray is taken

Imaging provider bills Medicare for technical component

Medicare denies claim for technical component because the Ordering provider is not enrolled or opted out of Medicare

X-ray is read by Medicare enrolled Radiologist

Radiologist bills Medicare for professional component

Medicare pays claim for professional component only
Medicaid

Medicaid Patient visits non-enrolled Dr. and the Dr. orders an X-ray

Patient visits Medicaid enrolled Imaging provider and X-ray is taken

Imaging provider bills Medicaid for technical component

Medicaid denies claim for technical component because the Ordering provider is not Medicaid enrolled

X-ray is read by Medicaid enrolled Radiologist

Radiologist bills Medicaid for professional component

Medicaid denies claim for professional component because Ordering provider is not Medicaid enrolled
Ordering, Referring, and Prescribing

• States are required to enroll all ordering, referring, and prescribing providers

• Unlike Medicare, this requirement applies to all items and services due to statutory language drafted by Congress

• This is typically accomplished via a claims edit which will deny any claim with an unenrolled provider’s NPI

• The NPI for the ordering, referring, prescribing provider must almost always be a Type 1 individual NPI
Ordering, Referring, and Prescribing

- Providers do not have the option of “opting out” in Medicaid as it is not permitted by Medicaid regulations.

- Some states offer a streamlined enrollment approach
  - Ordering, referring, prescribing only

- Crossover claims are also subject to this requirement—some providers may need to enroll with Medicaid in order for a dually eligible beneficiary to receive their Medicaid benefit.
Managed Care Network Providers

• Medicaid Managed Care “In-Network” providers must be screened and enrolled with the state

• If your status is “in-network” with a Medicaid Managed Care plan you must execute a provider agreement with the state

• Your provider agreement with the plan will not fill this requirement

• Some states have allowed MCOs to screen providers
  • Screening must be consistent with ACA requirements
Managed Care Network Providers

• Once again, providers do not have the ability to “opt out”

• The use of a Preclusion List approach is not permitted in Medicaid

• Some states have created an “MCO-only” provider type and separate enrollment process

CMS is not aware of any states that require participation or acceptance of Medicaid patients because you have enrolled with their program
How might a Medicaid termination impact you?
Terminations

• States are required to report terminated providers to CMS
  • This does not include providers who voluntarily terminate their enrollment

• If a provider is terminated from any state, CMS has the discretion to revoke the provider from Medicare

• A provider who is first revoked from Medicare, must be terminated from all state Medicaid programs
Other Key Differences
State-only Moratoria

• States have the authority to implement a state-based (Medicaid only) moratoria

• Requires CMS initial approval and re-approval every six months

• CMS requires states to conduct a thorough access to care analysis

• States are also required to provide strong reasoning as to the need for the moratoria
Enrollment Effective Dates

• States have the authority to backdate an enrollment effective date but are not required to do so

• In most cases, states can backdate to the Medicare certification date but not to exceed one year

• States have the authority to set their own backdating policies

• Some states will not backdate while others may only go as far back as six months
Contacting the State

• Most states include on their website a contact or general inquiry box for enrollment related inquiries

• If you do not have a method for contacting a particular state, CMS can facilitate and have the state reach out to you
Questions?

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If you need more accessibility options for the material, contact providerenrollment@cms.hhs.gov

Centers for Medicare & Medicaid Services