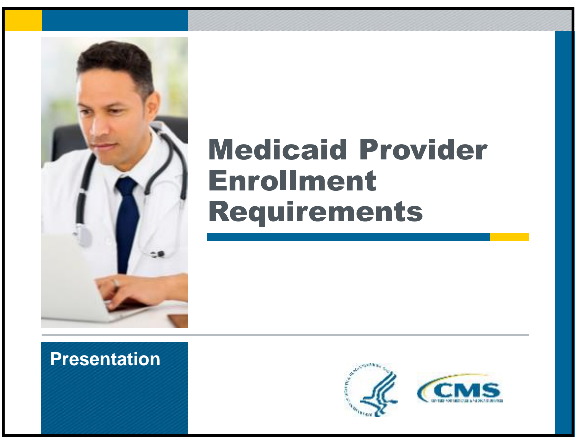


Purpose

To educate providers and State Medicaid agencies (SMAs) on the requirements to enroll in the fee-for-service (FFS) Medicaid program and Children's Health Insurance Program (CHIP), the enrollment process, and the benefits of the new requirements.

Objectives

At the end of this presentation the learner should be able to:

- Identify the responsibilities of the SMA during the provider enrollment process
- Recall the provider categorical risk levels
- Identify the new requirements that apply to all providers enrolling in the FFS Medicaid program or CHIP
- Recall which providers are required to submit fingerprints
- Recall the types of providers on which SMAs must perform criminal background checks
- Identify what a provider's rights are if enrollment is denied or terminated

Vulnerabilities in the Provider Enrollment Process

Before the Affordable Care Act, providers were not required to disclose:

- Ownership and control information regarding:
  - Fiscal agents
  - Managing employees
  - Family members
- Date of birth (DOB) and Social Security Number (SSN) (for individuals)
- Tax identification number and every business location (for corporations)

Vulnerabilities Before the Affordable Care Act

A convicted dentist who had been excluded from Medicare and Medicaid by HHS-OIG was able to:

- Enroll dental clinics he owned and controlled in Medicaid
- Bill Medicaid millions of dollars

A convicted former owner of a durable medical equipment (DME) company who had been excluded by HHS-OIG was able to:

- Enroll new DME companies he controlled
- Bill Medicaid over a million dollars

New Enrollment Requirements Help Prevent Fraud

The Affordable Care Act prevents fraud by requiring:

- All providers, including ordering or referring physicians or other professionals, to enroll
- All providers other than individual practitioners to disclose information about ownership, control, and management of the provider
- SMAs to verify the information disclosed by all providers and perform screening based on the categorical risk of fraud
- Provider enrollment revalidation every 5 years

The Application Fee

Enrollment application fees:

- Do not apply to individual physicians, non-physician practitioners, medical clinics, or group practices
- Do apply to institutional providers such as hospitals and skilled nursing facilities
- Are adjusted annually
- Are set at $554 for 2016

Provider Screening Requirements

For all providers, SMAs must:

- Verify the provider meets applicable Federal regulations and State requirements
- Conduct licensure verifications
- Check nationwide databases

For moderate- and high-risk category providers, SMAs must complete these and additional steps.

Protecting Medicaid Through Enrollment

Information providers must disclose includes, but is not limited to, the following:

- DOB and SSN
- Ownership and control interests
- Criminal convictions

SMAs must confirm information disclosed, including information about:

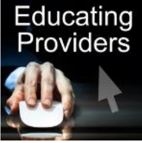
- Identity and ownership
- Licensure
- Exclusion status

Database Checks

For all providers, SMAs must check the:

- List of Excluded Individuals/Entities (LEIE)
- System for Award Management (SAM) Advance Search—Exclusions Database
- Social Security Administration's Death Master File
- National Plan and Provider Enumeration System (NPPES)
- Other appropriate databases to confirm identity upon enrollment and re-enrollment

Ownership Disclosures—Educating Providers



SMAs can educate providers on ownership disclosure requirements by using:

- CMS' Toolkit on Disclosures of Ownership and Control
- CMS' Medicaid Provider Enrollment Compendium
- Provider enrollment websites
- Provider information bulletins
- Specific language in enrollment applications and provider agreements

Ownership Disclosures—Implementation by SMAs

SMA enrollment application forms and contracts should include dedicated space for disclosure of:

- SSNs
- DOB
- Multiple addresses
- Percentage of direct and indirect ownership interests

SMAs should also require collaboration between SMA enrollment personnel and program integrity personnel.

Knowledge Check

SMAs are responsible for: (select all that apply)

- A. Obtaining disclosure information
- B. Obtaining a signature on a provider agreement
- C. Checking eligibility against Federal databases
- D. Collecting a fee from each applicant

Moderate-Risk Category Providers

Must meet all requirements for limited-risk category providers and pass on-site visits to:

- Verify compliance with enrollment requirements
- Ensure previously enrolled providers:
  - Remain operational
  - Continue to meet standards

High-Risk Category Providers

SMAs are required to conduct all limited- and moderate-risk category screening plus:

- Collect fingerprints of the provider and all individuals with a 5 percent ownership interest
- Conduct fingerprint-based criminal background checks using Federal and State databases

Setting Categorical Risk Levels for Provider Types Not Recognized by Medicare

SMAs should consider whether the provider type is:

- Highly dependent on government health care programs
- Not subject to additional government or professional oversight, or
- Especially vulnerable to improper payments

The SMA should consider additional information such as previous experience with the provider type, agency reports and testimony, and law enforcement appraisals.

Changes to Provider Categorical Risk Level

SMAs are required to adjust a provider's categorical risk level from limited or moderate to high if:

- A payment suspension based on a credible allegation of fraud has been imposed in the last 10 years
- There is an existing and qualifying Medicaid overpayment
- The provider has been excluded by HHS-OIG or a State within the last 10 years
- The provider is enrolling within 6 months of the date of the lifting of a temporary moratorium that would then have prevented the provider's enrollment

Knowledge Check

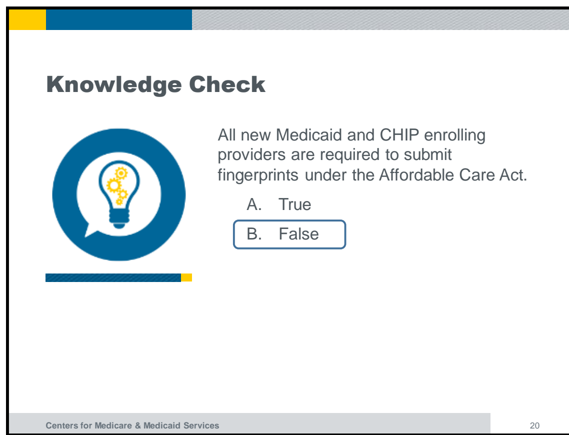
CMS classifies providers into one of three categorical risk levels based on their risk of fraud, waste, and abuse. Which of the following is not one of the three risk levels?

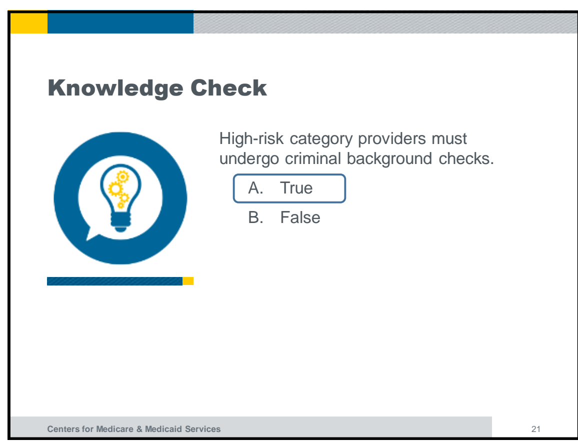
A. No risk
B. Limited risk
C. Moderate risk
D. High risk

Knowledge Check

Which new requirements apply to all providers enrolling in Medicaid? (select all that apply)

A. Disclosure of names and addresses of all individuals or entities
B. Verification that licenses are in good standing
C. On-site visits
D. Submission of fingerprints





Coordination of Medicare and Medicaid Enrollment

SMAs are able to:

- Verify provider information through access to the Medicare enrollment database
- Rely on previous screening of the same provider by Medicare or another State's SMA

Medicare Enrollment
Welcome to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)
CMS

State Screening Requirements

Enrollment requirements in different States include:

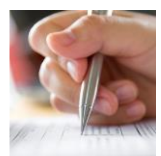
- Additional disclosure requirements
- Additional basis for denial
- Additional basis for raising the categorical risk level
- Criminal background checks for all providers at moderate risk or above
- Expanded site visits

State Screening Regulations—Examples

Some State screening regulations require:

- Added screening steps
- Assignment of a higher categorical risk level than under Federal regulations
- Added screening for all provider types, including fingerprints and criminal background checks

Other State Enrollment Requirements



Some States:
- Require additional disclosures
- Deny enrollment for reasons not in Federal regulations

Mandatory Terminations and Denials

SMAs must deny or terminate enrollment for:
- Failure of a person with 5 percent or greater ownership to submit timely and accurate information
- Termination by Medicare or another State on or after January 1, 2011

Denial and Termination

With certain exceptions, SMAs must deny or terminate enrollment for:
- Conviction of the provider or an owner for a program related criminal offense in the last 10 years
- Failure of a person with any ownership interest to submit timely or accurate information
- Failure of a 5 percent or more ownership interest holder to submit fingerprints
- Denial of an on-site visit

Knowledge Check

If a provider's Medicaid enrollment is denied or terminated, which of the following is true?

A. There are no appeal rights available to the provider

B. The provider can appeal directly to CMS

C. The provider can appeal under any procedures available under State law or regulations

D. None of the above

CMS Authority to Impose Temporary Moratoria

CMS may impose temporary moratoria on enrollment to prevent fraud, waste, or abuse.

Moratoria may be based on:

- Providers of a specific type
- Providers located in specific geographic areas

Temporary Moratoria Imposed by CMS

CMS has imposed moratoria on enrollment of the following providers in Medicare, Medicaid, and CHIP:

- Home health agencies (HHAs) subunits, and branch locations, and
- Ground non-emergency ambulance suppliers

In Florida, Illinois, Michigan, Pennsylvania, New Jersey, and Texas

States' Authority to Impose Moratoria

State-imposed moratoria have included:

- Alaska moratorium on personal care services providers
- California moratorium on clinical laboratories
- South Carolina moratoria on Medicaid targeted case management and behavioral health providers

Benefits of the New Medicaid Enrollment Process

The new Medicaid enrollment process helps protect Medicaid and CHIP by ensuring:

- Providers that have defrauded Federal health care programs in the past are not allowed to:
  - Defraud Medicaid again
  - Compete with legitimate providers
- Providers will stay compliant by meeting regular re-validation requirements in the future

Questions

Please direct questions or requests to: MedicaidProviderEducation@cms.hhs.gov

To see the electronic version of this presentation and the other products included in the "Medicaid Provider Enrollment" Toolkit posted to the Medicaid Program Integrity Education page, visit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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