

MEDICAID PROVIDER ENROLLMENT

MARCH 2019





Poll Question

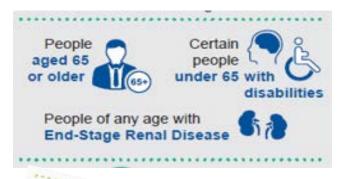


What is Medicaid?

Medicare vs. Medicaid

Medicare

Federal Health Care Coverage

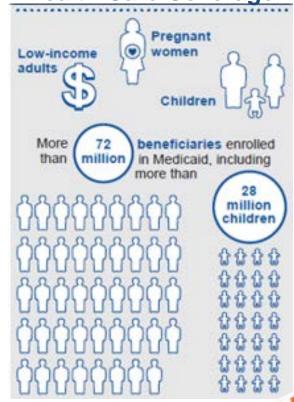






Medicaid

Cooperative Federal and State
Health Care Coverage



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?

Medicaid Provider 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): https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf
 - 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

FCBC

High

Site Visits

Moderate & High

Limited, Moderate, & High

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

Medicaid-Medicare Differences

- The Company of the Co
- 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"

	Medicaid Risk Category	Name	TIN	Practice Location(s)	5 % or more owners
Institutional Organizational	"Limited"	X	X		X
Provider	"Moderate"	X	X	X	X
	"High"	X	X	X	X

^{*}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

This criteria is different between Medicare and Medicaid

increased to "high" from "limited" or "moderate"

- 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

Providers Are "High" Risk When:	Risk Remains "High"	
State imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse in the past 10 years	10 years beyond date of payment suspension	
Provider has an existing Medicaid overpayment* at initial enrollment or revalidation	For any enrollment or revalidation that the provider continues to have an existing overpayment*	

^{*}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

Providers Are "High" Risk When:	Risk Remains "High"
Provider has been excluded by the OIG or another State's Medicaid program within past 10 years	For 10 years beyond date of exclusion
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.	State stops looking at this beginning 6 months and 1 day after a moratorium is lifted



What If I am or will be a Dually Enrolled Provider?



Poll Question



States <u>may</u>, but <u>are not required</u> 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



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

- The provider has been <u>screened in the past 5 years</u>
- The provider is <u>"approved"</u> in Medicare
- The provider is the <u>same risk level</u> in both Medicare and Medicaid
- The provider is verified as the <u>"same" provider</u>

What is the "same" provider?

Risk Category	Name	NPI	SSN (Last 4 digits)	TIN	Practice Location(s)	All 5% or more owners
"Limited" Individual	X	X	X			
"Moderate" Individual	X	X	X		X	
"High" Individual	X	Χ	X		X	
"Limited" Organization	X			Χ		X
"Moderate" Organization	X			X	X	X
"High" Organization	X			X	X	X



- 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

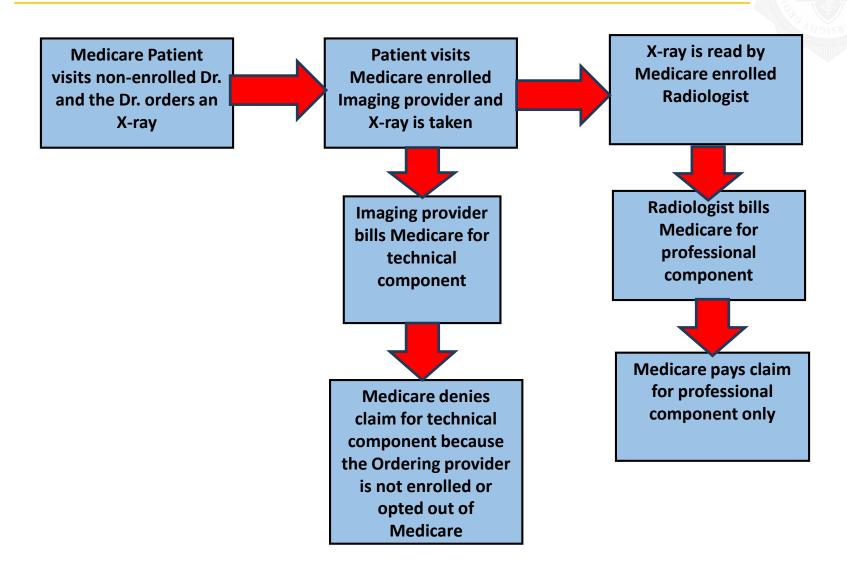
Ordering and Referring

Is enrollment of the O/R provider required?

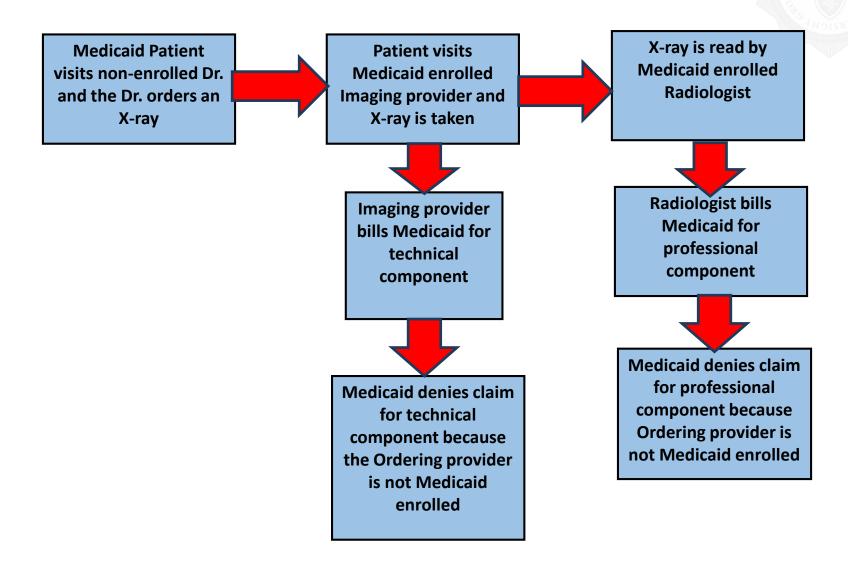
Service	Medicare	Medicaid
DMEPOS	All Items	All Items
Home Health Services	All Services	All Services
Clinical Lab Services	Technical Component Only* Unless Billed Globally	Both Technical and Professional Components
Imaging Services	Technical Component Only* Unless Billed Globally	Both Technical and Professional Components

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

Medicare



Medicaid



Ordering, Referring, and Prescribing

- States are required to enroll <u>all</u> 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

- THOIS WALLS
- 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 <u>discretion</u> to revoke the provider from Medicare
- A provider who is first revoked from Medicare, <u>must</u>
 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