Medicaid Provider Enrollment

Medicaid Provider Screening and Enrollment Requirements

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Content Summary

The Affordable Care Act gave the Centers for Medicare & Medicaid Services (CMS) the authority to adopt new provider screening and enrollment regulations for all providers and suppliers participating in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). This booklet addresses the provider screening and enrollment provisions that apply to fee-for-service (FFS) Medicaid and CHIP providers. Those provisions address provider screening risk levels, disclosure requirements, application fees, and temporary provider screening and enrollment moratoria.

Under the Affordable Care Act,[1] the Centers for Medicare & Medicaid Services (CMS) adopted new provider screening and enrollment regulations for all providers and suppliers participating in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) based on their assigned risk level. These regulations implemented the Affordable Care Act's requirement that all ordering or referring providers or other professionals reimbursed under Medicaid or CHIP fee-for-service (FFS) arrangements be enrolled in the State Medicaid program or CHIP.[2] CMS implemented the regulations as part of its continuing efforts to prevent the participation of fraudulent providers posing a high risk of fraud, waste, or abuse.

The U.S. Government Accountability Office (GAO) designated Medicaid as a high-risk program due to its vulnerability to fraud, waste, and abuse.[3] The GAO estimated that in fiscal year 2014, the amount of improper payments made by Medicaid for ineligible persons or to providers for services not furnished was $17.5 billion.[4] Improper

payments, defined as "any payment that should not have been made or that was made in an incorrect amount,"[5] are not all the result of fraud. Fraudulent claims, however, are significant enough to threaten the fiscal integrity of the Medicaid program. The new provider enrollment and screening requirements are consistent with CMS' shift from an anti-fraud strategy of "pay and chase" to a strategy of preventing fraudulent providers from enrolling in the program from the beginning. As part of this prevention strategy, CMS implemented new provider enrollment and screening requirements and issued guidance and educational materials discussed later in this booklet. First we will discuss the screening requirements.

Provider Screening Requirements

Any provider or supplier wishing to bill Medicaid or CHIP on an FFS basis must first enroll with Medicaid or CHIP and undergo screening.[6] Under Title 42 of the Code of Federal Regulations (CFR), Section 400.203, CMS defines an FFS Medicaid provider as "any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency."[7] This booklet refers to both Medicaid and CHIP FFS providers as Medicaid providers or simply as providers. Similarly, this booklet refers to both SMAs and the separate agencies that in some States administer CHIP as State Medicaid agencies (SMAs).

The Affordable Care Act expanded the scope of the Medicaid provider screening and enrollment requirements to include providers who order, refer, and prescribe services for patients but do not bill Medicaid directly. Under the new provider screening and enrollment requirements, SMAs "must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers."[8] These provider screening and enrollment requirements apply only to those physicians or other professionals that are provider types eligible to enroll in a State's Medicaid program.

Providers are required to enroll in each Federal health care program they intend to bill, including Medicare, Medicaid, and CHIP.[9] If an enrolling provider is already enrolled in the Medicaid or CHIP program of another State, the SMA may, instead of duplicating that State's screening activities, rely on the results of those activities.[10] Likewise, in instances where an enrolling provider is already enrolled in Medicare, States may in general rely on the results of the screening performed by a Medicare contractor. In order for the SMA to rely on such screening, it must have taken place on or after March 25, 2011, the provider must be in an "approved" status with Medicare, and the Medicare risk category must equal or exceed the Medicaid risk category.[11] To make it easier for SMAs to confirm these conditions, CMS has given dedicated users from each State read-only access to CMS' Medicare Provider Enrollment, Chain and Ownership System (PECOS) since 2012.[12] CMS has also provided sub regulatory guidance for SMAs on how to go about relying on such screenings.[13]

After initial provider screening and enrollment, SMAs must revalidate the provider screening and enrollment of all providers at least every 5 years.[14] The rules and CMS guidance require SMAs to confirm the accuracy of information disclosed during provider screening and enrollment and collect updated disclosures during revalidation.

Providers that enrolled before March 25, 2011, must be revalidated on or before September 25, 2016.[15] SMAs are also required to rescreen providers, deactivated for any reason, when they apply for reactivation.[16, 17] Finally, as stated in 42 CFR Section 455.452, SMAs may establish screening methods "in addition to or more stringent than" those required by the Federal regulations.[18]

Disclosing Entities Defined

The regulations require SMAs to obtain disclosures from "disclosing entities, fiscal agents, and managed care entities."[19] Disclosing entities are defined as Medicaid providers "other than an individual practitioner or group of practitioners" and fiscal agents.[20] Disclosing entities "normally are corporations or partnerships where there are owners, officers, partners, or managing employees who run the company." Typical disclosing entities include hospitals, nursing homes, community mental health centers, and clinical laboratories. The regulations require disclosure of information about owners, officers, partners, and managing employees because these persons will determine how the entity will operate. Without disclosure, these persons would remain "behind the scenes."[21]

Ownership, Control, and Management of Disclosing Entities

To bring to light the behind-the-scenes information about ownership and control of disclosing entities, the regulations require disclosing entities to disclose information regarding managing employees and persons with "ownership or control interests" in the disclosing entity. A managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency."[22] A "person with an ownership interest" is defined as an individual or entity that has direct or indirect ownership interests in the disclosing entity totaling 5 percent or more.[23] Direct ownership interest means possession of equity in the capital, the stock, or the profits of the disclosing entity.[24] Indirect ownership interests are interests in entities other than the disclosing entity that in turn have an ownership interest in the disclosing entity.[25]

The ownership and control information that disclosing entities must disclose includes:

- Names, dates of birth (DOBs), Social Security numbers (SSNs), and addresses of all persons with an ownership or control interest in the disclosing entity;
- For corporate entities, primary business address along with all other business locations and Post Office Box addresses;
- Tax identification numbers (TINs) of any other entity with ownership or control interests in the disclosing entity or in any subcontractor in which the disclosing entity has at least a 5 percent ownership or control interest;
- Names of other disclosing entities in which an owner of the disclosing entity has an ownership or control interest;[26] and
- Family relationships between persons with ownership or control interests in the disclosing entity or persons who have at least a 5 percent ownership and control interest in any subcontractor of the disclosing entity.[27]

The information concerning managing employees that disclosing entities must disclose includes:

- Names;
- Addresses;
- DOBs;
- SSNs;[28] and
- Convictions of criminal offenses related to the managing employee's involvement in any program under Medicare, Medicaid, or Title XX services program since the inception of those programs.[29]

Disclosures of Additional Information by All Providers

The regulations require all providers to disclose certain information regarding business transactions and criminal convictions. All providers must disclose:

- Ownership of, and significant business transactions with, wholly owned suppliers and subcontractors;[30] and
- Convictions of any criminal offense related to the person's involvement in any program under Medicare, Medicaid, or Title XX since those programs began.[31]

The SMA must notify the U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) of persons who have had such convictions within 20 days.[32]

In addition to the information that the regulations specifically require providers to disclose, there are additional disclosures required of individual providers by implication. This is because the rules explicitly require the SMA to verify or use

certain information that logically must be supplied by the provider. This information includes, but is not limited to:

- DOB;
- SSN;[33]
- Licensure;[34] and
- National Provider Identifier (NPI).[35]

When Disclosures Must be Made

All providers, both individuals and disclosing entities, must disclose ownership interests at the following times:

- Upon submission of an application for enrollment;
- When signing the provider agreement;
- When the SMA requests such information on revalidation;
- Within 35 days after any change in ownership of the disclosing entity;[36] and
- Within 35 days of a request from the SMA:
  - The ownership of any subcontractor with whom the provider had business transactions totaling more than $25,000 during the 12 months prior to the request; and
  - Any significant business transactions between the provider and any wholly owned supplier or any subcontractor during the previous 5 years.[37]

Fiscal agents and managed care entities must make disclosures at similar times related to contract proposals and extensions, as well as within 35 days of a change of ownership.[38]

Managed Care Network Providers

The ownership disclosure requirements discussed have been in place for Medicaid FFS providers since 2011. They will be phased in for Medicaid managed care network providers by July 1, 2018.[39]

Guidance for SMAs on Implementing Ownership Disclosure Requirements

Under the regulations, SMAs are required to verify each provider's identity,[40] licensure in the enrolling State and in other States,[41] exclusion status,[42] and compliance with any applicable Federal or State requirements for that provider type.[43] SMAs are also required to check specific databases to confirm identity and exclusion status.[44]

In 2016, HHS-OIG reported that during a sample period from December 2013 through April 2014, most SMAs did not request or verify all required ownership information and did not check all required databases. For example, HHS-OIG found that three-fourths of all State Medicaid programs did not request "all applicable address information for corporate entities with an ownership interest," including the "primary business address, every business location, and P.O. Box address."[45] HHS-OIG recommended that CMS ensure SMAs request and verify all required ownership information, check required databases, and give SMAs guidance on how to verify ownership information.[46]

Before the report was released, CMS took significant steps to assist SMAs with overcoming the implementation issues identified by HHS-OIG. In a 2008 Medicaid Director's Letter, CMS recommended SMAs refuse to process applications that do not appear to be complete or do not "include information on individuals with ownership or control interests in the provider [disclosing] entity, including managing employees, until the State verifies the accuracy and completeness of the information."[47]

In a 2010 compilation of best practices, CMS suggested that SMAs should provide dedicated space in the provider contract and in the enrollment application form for the applicant to use to supply ownership disclosure information. The form should provide space for multiple addresses for corporate entities, require an indication of the percentages of ownership, and instruct the applicant to attach additional pages if needed to identify all parties with ownership or control interests. The contract should include a clause requiring submission of updated ownership information upon a change of ownership. To ensure that these things happen, program integrity staff and enrollment staff need to meet regularly, develop an enrollment policy together, and develop management controls that ensure adherence to policy.[48]

A 2014 CMS toolkit also contains guidance for SMAs on disclosure requirements. Through State program integrity reviews starting in 2009, CMS' Center for Program Integrity has identified problematic enrollment and screening issues and developed and posted the following set of toolkits to help SMAs address these issues.[49] One of these toolkits, published in September 2014, suggests SMAs should request providers submit DOBs for persons with an ownership or control interest in the disclosing entity and SSNs. This makes it easier for SMAs to verify the identity of such persons. Application forms and contracts should contain spaces for both. The toolkit further suggests that the SMA or the contractor responsible for procuring contracts should consult the program integrity staff on contract language. This would help ensure the incorporation of all disclosure requirements. Finally, the toolkit suggests it would be helpful if State program integrity and enrollment staff trained procurement staff on the disclosure requirements.[50]

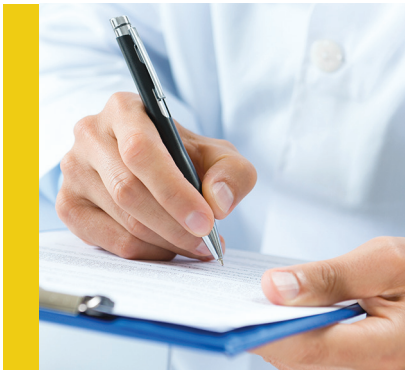
In a 2016 report, HHS-OIG noted that dedicated SMA users had read-only access to PECOS, but found that SMAs did not use PECOS to verify provider ownership

information. HHS-OIG recommended CMS encourage SMAs to do this. HHS-OIG further recommended SMAs report discrepancies between ownership information in PECOS and information submitted by the provider to the SMA.[51] SMAs should also make use of monthly PECOS data-extracts that CMS provides.[52]

To obtain ownership information not found in PECOS, SMAs have a number of other means at their disposal. First, they could check the websites of the relevant States' Secretary of State offices, or the equivalent, where corporations, limited liability companies, and other business entities must register. These sites offer such information as whether the business is still active and whether it operates under other names. These sites also may provide information such as the names of owners, officers, and directors.[53, 54]

To verify physical addresses, SMAs may use the website of the U.S. Postal Service (USPS) or a local assessor. For the USPS, go to the https://www.usps.com website, click the "Look Up a ZIP Code" link, enter an address, and click "Find." If the USPS database recognizes the address, the website will return the address in standard USPS format. SMAs can search addresses on online assessor websites to find ownership information, assessed property value, and current property tax obligations.

Checking address and ownership information by these means can provide additional validation. This would be especially useful in cases where a provider or owner reported the same false information to both Medicaid and Medicare. As noted by HHS-OIG, correlation by other sources is no guarantee the information is correct,[55] but the possibility of error decreases as the number of sources checked increases.



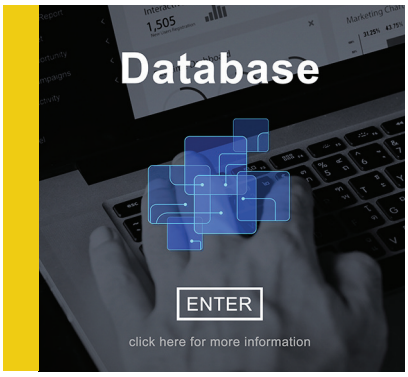
Educating Providers on Ownership Disclosure Requirements

Failure to properly and completely disclose ownership information can have serious effects on providers. For example, providers that fail to submit timely and accurate information for any person with a 5 percent or greater direct or indirect ownership interest in a provider business are subject to mandatory termination.[56] HHS-OIG has recommended that CMS work with SMAs to educate providers on disclosure requirements.[57]

CMS has provided SMAs with multiple resources to help them educate providers. In addition to the recommendations in the Medicaid Director's Letter, the Best Practices report, and the toolkit discussed above, SMAs can also educate providers by referring them to a more recent and comprehensive source. In May 2016, CMS published the Medicaid Provider Enrollment Compendium (MPEC), which explains the regulatory framework in detail and includes sections on the ownership disclosure requirements.

Although the means of educating providers on disclosure requirements are "within the State's discretion," the MPEC suggests examples that "may include enrollment websites, provider information bulletins, and inclusions in provider agreements." CMS plans to update and expand the MPEC, so SMAs and providers should check the website regularly.[58] For other disclosure issues, SMAs can refer providers to the MPEC and the following toolkits:

- Toolkit for Disclosures of Business Transactions;
- Toolkit for Disclosures of Health Care-Related Criminal Convictions; and
- Toolkit for Notifications to the HHS-OIG.[59]



Screening—Database Checks

The Affordable Care Act requires SMAs to conduct pre-enrollment screening checks of various databases to confirm the identities of providers and all associated persons. The SMA also must determine whether providers have been excluded from any Federal health care programs or have been debarred from Federal contracting. SMAs must check the exclusion and debarment databases monthly as long as the provider remains enrolled. These procedures apply to any person with an ownership or control interest in a provider business. In addition, anyone who is an agent or managing employee of a provider business is subject to these database checks.[60] SMAs must perform these database checks regardless of the provider's risk level,[61] must recheck for exclusions monthly, and must check all appropriate databases again upon re-screening and enrollment.[62]

CMS has advised SMAs they should remind providers to screen their contractors and employees against the List of Excluded Individuals/Entities (LEIE) database[63] monthly, even though SMAs are not required by law to give such reminders.[64] Additionally, in 2013, HHS-OIG stated providers should frequently check their employees and contractors for exclusions to avoid potential liability for civil monetary penalties.[65] Providers should check with their SMA for the rules in their States.

SMAs are required to check for debarments. The regulations refer to the Excluded Parties List System (EPLS) replaced by the Advanced Search—Exclusions database, which SMAs and providers can access on the System for Award Management (SAM) website.[66, 67] Medicaid regulations do not explicitly address whether a debarred provider is thereby ineligible to enroll in Medicaid. SMAs should gather as much factual information as possible regarding the reasons for the debarment, evaluate that information, and determine the provider's eligibility for enrollment in light of the facts rather than the debarment.

In addition to performing the required LEIE database checks and the Advanced Search—Exclusion database checks, SMAs are required to check the following databases:

- The Social Security Administration's (SSA's) Death Master File;[68] and
- The National Plan and Provider Enumeration System (NPPES) NPI Registry.[69]

In 2014, the GAO found an SMA and a managed care plan (MCP) reported problems accessing the SSA's Death Master File, which is a subscription-only database. CMS responded that it was working with the SSA to improve SMA access to the Death Master File.[70]

CMS has the authority to designate other databases SMAs must check to determine identity and exclusion status,[71] but has not to date. Pursuant to another recommendation from the GAO, CMS is determining whether to add the additional databases used by States and MCPs to the list of databases SMAs must check.[72]

CMS recognizes States are "uniquely qualified" when it comes to understanding the issues of providing services to beneficiaries and maintaining the fiscal integrity of Medicaid and CHIP. Thus, the regulations give States considerable flexibility in establishing screening and disclosure requirements for all providers, as well as authority to establish requirements "in addition to or more stringent than" those established by CMS.[73] Providers should check with their SMA to ensure compliance with any additional State rules or expectations.

Screening Activities Required by Categorical Risk Level

The Affordable Care Act authorized CMS to establish screening levels for enrolling providers in Federal health care programs, including Medicaid and CHIP. Screening levels for Medicare, Medicaid, and CHIP providers are based on the risk of fraud, waste, or abuse posed by each provider type. The regulations also establish three screening levels: limited, moderate, and high.[74, 75] The types of screening performed depend on the category type of the provider and the associated risk level. The Affordable Care Act requires SMAs to place providers in a risk category not lower than the category applied to the providers if enrolling in Medicare.[76, 77] For Medicaid provider types not recognized by Medicare, the SMA must assign the provider type to a risk category based upon the risk of fraud, waste, or abuse posed by the provider type. CMS guidance on the factors to consider in determining the risk are discussed below.

Examples of SMA activities by categorical risk level are provided in Table 1.

Table 1. SMA Screening Activities by Categorical Risk Level

SMA Activities	Limited Risk	Moderate Risk	High Risk
Obtain disclosures and check databases • Obtain disclosures regarding ownership and criminal convictions • Check exclusion databases • Check other databases to confirm identity and licensure • Verify the provider meets applicable Federal and State "requirements for the provider type"[78]	X	X	X
Conduct on-site visit • Conduct an on-site visit to confirm the accuracy of information submitted in the provider's application[79]	Not Applicable	X	X
Conduct fingerprint-based criminal background check (FCBC) of: • Individual providers, or, • In the case of an institutional provider, every person with a 5 percent or more ownership interest in the institutional provider[80]	Not Applicable	Not Applicable	X

For all risk categories, the SMA must check the following databases:

- The SSA's Death Master File;[81]
- The NPPES NPI Registry;[82]
- The LEIE;[83] and
- SAM's Advanced Search—Exclusion Database Exclusions Extract (replacement for the EPLS).[84]

For moderate- and high-risk category providers, the SMA must also conduct on-site visits.[85] The purpose of on-site visits is to verify the accuracy of the information submitted to the SMA and determine compliance with Federal and State provider screening and enrollment requirements.[86] In addition to the required on-site visits to moderate- and high-risk category providers before and after enrollment, the SMA has discretion to conduct announced or unannounced on-site visits to providers, regardless of risk category. CMS, its agents or designated contractors, or the SMA may conduct these visits.[87]

For high-risk category providers, SMAs must conduct FCBCs in addition to on-site visits.[88] Under the Affordable Care Act, since June 1, 2016, CMS has required SMAs to verify convictions of owners, agents, and managing employees of newly enrolling high-risk category providers and suppliers through a FCBC. Provider types included in the high-risk category pursuant to Medicare regulations are home health and durable medical equipment (DME).[89] SMAs may include other provider types in the high-risk category as appropriate. SMAs that did not implement FCBCs by June 1, 2016, were required to have a CMS-approved plan in place by then of how they will implement such checks.[90]

Risk Levels of Providers Recognized by Medicare

Under the Affordable Care Act, SMAs are required to follow the process established for Medicare providers when determining what risk categories apply to different provider types.[91] This means, as noted in CMS' comments to the provider screening and enrollment rules, that "[f]or the types of providers that are recognized as a provider or supplier under the Medicare program, States will use the same screening level that is assigned to that category of provider by Medicare."[92] Of course, as noted above, a State may apply more stringent criteria, which result in placing provider types in higher risk categories than in Medicare. Table 2 reflects the risk classification of Medicare provider types; many of them are also recognized by Medicaid.

Table 2. Risk Category Levels of Provider Types Recognized by Medicare

Limited-Categorical Risk Provider Types
• Physician or non-physician practitioners (including nurse practitioners, certified registered nurse anesthetists, occupational therapists, speech/language pathologists, and audiologists) and Medical groups or clinics; • Ambulatory surgical centers; • Competitive acquisition program/Part B vendors; • End-stage renal disease facilities; • Federally qualified health centers; • Histocompatibility laboratories; • Hospitals, including critical access hospitals; • Indian and tribal health services facilities; • Mammography screening centers; • Mass immunization roster billers; • Organ procurement organizations; • Pharmacies (newly enrolling/revalidating via the CMS-855B); • Radiation therapy centers; • Religious non-medical health care institutions; • Rural Health Clinics; and • Skilled nursing facilities.
Moderate-Categorical Risk Provider Types
• Ambulance service suppliers; • Community mental health centers; • Comprehensive outpatient rehabilitation facilities; • Hospice organizations; • Independent clinical laboratories; • Independent diagnostic testing facilities; • Physical therapists and physical therapist groups; • Portable X-ray providers; • Revalidating home health agencies; and • Revalidating suppliers of durable medical equipment, prosthetics, orthotics, and supplies
High-Categorical Risk Provider Types
• Prospective (newly enrolling) home health agencies; and • Prospective (newly enrolling) suppliers of durable medical equipment, prosthetics, orthotics, and supplies.

SMA Risk Categorization of Providers Not Recognized by Medicare

For the types of providers Medicare does not recognize, such as non-emergency medical transportation (NEMT) providers and personal care assistants, SMAs should rely on guidance found in CMS' comments on the rules.[93] First, SMAs should identify those non-recognized provider types that present increased risks of fraud, waste, and abuse. "[W]here applicable, [CMS] expect[s] that States will assess the risk of fraud, waste, and abuse using criteria similar to those used by Medicare." In its Notice of Final Rulemaking, CMS discussed those criteria:

> Those provider types that are generally highly dependent on Medicare, Medicaid, and CHIP to pay salaries and other operating expenses and which are not subject to additional government or professional oversight would be considered moderate risk, and those provider types identified by the State as being especially vulnerable to improper payments would be considered high risk.[94]

In addition, SMAs should consider other factors from the Notice, which are paraphrased in CMS' MPEC. These include reports by the GAO and HHS-OIG, law enforcement appraisals, Congressional testimony, level of administrative enforcement actions and oversight by government and accrediting bodies, and the SMA's experience with the provider type.[95]

Using these criteria, and making analogies to the Medicare types categorized in the regulations, it is possible that an SMA might, but is not required to, classify some Medicaid-only provider types as shown in Table 3.

Table 3. Hypothetical SMA Risk Categorization of Provider Types Not Recognized by Medicare

Possible Moderate-Categorical Risk Provider Types
• NEMT suppliers; • Revalidating personal care services (PCS) suppliers; • Revalidating DME suppliers; and • Revalidating dental clinics.
Possible High-Categorical Risk Provider Types
• Prospective (newly enrolling) PCS suppliers; • Prospective (newly enrolling) DME suppliers; and • Prospective (newly enrolling) dental clinics.

These are hypothetical examples that may not apply in a particular State. For provider types that Medicare does not recognize, it is especially important that the

provider find out which screening level applies by contacting the SMA in each State where they do business.

Changes to Provider Risk Level

SMAs are required to adjust the provider risk category from limited or moderate to high if:

- There is an existing qualified Medicaid overpayment;
- The SMA has imposed a payment suspension in the last 10 years based on a credible allegation of fraud;[96]
- HHS-OIG or another SMA has excluded the provider from Medicaid in the last 10 years; or
- CMS or the SMA lifted a temporary moratorium for the particular provider type within the last 6 months and a provider within a provider type that was prevented from enrolling based on the moratorium applies for provider screening and enrollment as a provider at any time within 6 months from the date the moratorium was lifted.[97]

The regulation setting forth these factors does not explain the first three of these factors in any detail, but the other regulations and sub regulatory guidance do. As to Medicaid overpayments, CMS' MPEC gives sub regulatory guidance on which ones "qualify" and thus require raising a provider's risk level to high. Qualifying overpayments are those for over $1,500 and are more than 30 days old, have not been repaid at the time of the application, are not currently the subject of an appeal, and are not part of an SMA-approved extended repayment schedule.[98]

Allegations of fraud are, generally speaking, "credible" under Medicaid regulations if they have indicia of reliability and the SMA has carefully reviewed them and acted judiciously on a case-by-case basis.[99] Although the regulation does not set forth a time limit on the effect of a past suspension on enrollment, CMS' MPEC fixes a time limit of 10 years.[100] To make sure the full period is covered when screening providers for enrollment or reenrollment, SMAs should keep records of payment suspensions longer than the 5-year minimum required by the regulations.[101]

Finally, HHS-OIG has authority to exclude providers from all Federal health care programs for a number of reasons related to criminal convictions or misconduct.[102] SMAs should keep in mind that HHS-OIG is not the only agency with authority to exclude providers. SMAs have authority to exclude providers for any reason HHS-OIG could exclude them.[103, 104] Thus SMAs should check the LEIE database and available records of exclusions by the SMA or other SMAs.

The regulations specifically provide that nothing in the subpart on screening and provider enrollment prohibits States from establishing screening and disclosure requirements for all providers "in addition to or more stringent than" those required by that subpart.[105] Providers should check with their SMA to ensure compliance with any additional State rules or expectations.

Application Fees

The Affordable Care Act requires States to collect an application fee from certain types of providers to offset the costs associated with screening.[106] CMS adjusts the application fee for each calendar year annually based on the consumer price index. The application fee for 2016 is $554.[107]

Individual physicians or non-physician practitioners, and providers already enrolled in Medicare or another State's Medicaid program, are not required to pay this fee. The Affordable Care Act specifies that "institutional" providers, such as "a hospital or skilled nursing facility," are required to pay the fee.[108] In sub regulatory guidance, CMS gives the following additional examples of institutional providers: ambulance services, DME suppliers, hospices, clinical laboratories, and pharmacies. Institutional providers pay one fee upon enrollment, regardless of how many physicians or non-physician practitioners reassign their benefits to the institution or how many practice locations are involved.[109] Furthermore, each provider subject to the fee is required to pay it only once each year, regardless of the number of Federal health care programs it is enrolled in for that year.[110, 111]

As part of the enrollment process, the SMA should ask each provider whether the provider has enrolled or is enrolling in another State's Medicaid program. If it is enrolling or has enrolled, the State should contact the other State to confirm the information. If the provider is not excused from paying the application fee, for example by the grant of a hardship waiver, the SMA should coordinate collecting the fee with the other State.[112]

Under certain circumstances, institutional providers may submit a request to CMS for a hardship exception so the provider is not required to pay the application fee. CMS may also grant a waiver of the application fee on a broader scale if a State demonstrates that the fee impedes beneficiary access to care. More information is posted to https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/paymentadj_hardship.html on the CMS website.

Denials and Terminations

The Affordable Care Act states, providers that have not been screened through the procedures established by CMS are not to be enrolled or reenrolled in Medicaid.[113] Reenrollment is the process a terminated or deactivated provider seeks to again attain enrolled status.[114]

Under the Affordable Care Act, if a provider is terminated from Medicare or the Medicaid program of another State, the SMA shall likewise terminate that provider unless such action would impose a hardship on beneficiaries.[115] By regulation, CMS has limited the reciprocal termination requirement to apply only when the other program terminated the provider on or after January 1, 2011, and the termination was "for cause."[116]

"For cause" terminations, in general, include those based on fraud, other issues concerning integrity, or quality.[117] For example, all terminations under 42 C.F.R. § 455.416, including terminations for falsifying an application, failing to supply identity or ownership information, and for program-related convictions, are considered to be for cause. On the other hand, as pointed out in CMS' MPEC, terminations that are voluntary or based on such things as license expiration, failure to submit claims on a timely basis, or a Medicare-imposed payment suspension, are not. SMAs should look to the Compendium for complete guidance on what constitutes a "for cause" termination that would trigger a reciprocal termination.[118]

To make it easier for SMAs to learn the facts about terminations, the Affordable Care Act requires CMS to "establish a process for making available" to each SMA identifying information on providers terminated by Medicare or CHIP.[119] Although the specific subsection of the law concerning establishment of a process does not mention Medicaid terminations, CMS has included Medicaid terminations in the process. For Medicaid terminations, CMS asks States to email termination information every month to a Provider Termination mailbox. CMS then includes that information in a spreadsheet available to the SMAs through a secure web-based portal.[120] CMS encourages States to report to the database, but does not require it.[121]

HHS-OIG has found that the lack of a requirement to report to the database, and other issues, have impaired implementation of the reciprocal termination requirement. In a 2015 study, HHS-OIG found that SMAs in other States had previously terminated 12 percent of providers participating in Medicaid in 2012, and about half of them continued to participate in 2014.[122] HHS-OIG found that one reason for the failure to terminate these providers was that there was no comprehensive, centralized database.[123] In response to the study, CMS noted it modified the original process in 2014 to request more complete information in SMA submissions and to provide for CMS review and follow up on those submissions.[124] CMS also changed the process to incorporate a web-based portal as mentioned above.

In the 2015 report,[125] and in 2016 Congressional testimony, HHS-OIG urged CMS to "require each State Medicaid agency to report all terminated providers." In its testimony, HHS-OIG advised Congress that CMS had "concurred with all of our recommendations."[126] Although CMS has not made reporting mandatory, SMAs should report because reporting may become mandatory and because it is in the interest of SMAs to have as complete a database as possible when implementing the reciprocal termination requirement.

In addition to terminating providers when they are terminated for cause by another program, an SMA is required to deny or terminate enrollment in certain other situations unless it "determines that denial or termination of enrollment is not in the best interests of the Medicaid program."[127] These situations include:

- Any person with a 5 percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare or Medicaid program in the last 10 years;
- The provider or its owners, agents, or managing directors fail to submit timely or accurate information;
- The provider or any person with a 5 percent or greater direct or indirect ownership in the provider fails to submit fingerprints within 30 days of a CMS or SMA request; or
- The provider fails to permit access to provider locations for any site visits.

If the SMA determines that termination or denial of enrollment for any of these reasons is not in the best interests of the Medicaid program, it must document that determination in writing.[128]

Similarly, the SMA is required to deny enrollment to providers of a type or in a location that is subject to a CMS-imposed moratorium unless the SMA determines that denial "would adversely affect beneficiaries' access to medical assistance." The SMA must notify CMS in writing if it makes such a determination.[129] The SMA is not required to, but may, terminate or deny provider screening and enrollment if a provider falsifies any of the information provided on the application or if the identity of the provider applicant cannot be verified.[130]

SMAs have the option to deny enrollment or reenrollment to a provider if any of the persons or entities disclosed by the provider have a criminal conviction related to Medicare, Medicaid, or Title XX (Social Services and Elder Justice) programs. The SMA may also deny enrollment or terminate a provider if they did not fully disclose individuals or entities with a criminal conviction related to Medicare, Medicaid, or Title XX.[131]

Appeal of Denial or Termination

While there is no Federal right to appeal a Medicaid provider enrollment denial or termination, Federal regulations require that the SMA give denied or terminated providers any appeal rights available under procedures established by State law or regulations.[132]

Moratoria

The Affordable Care Act gives CMS the authority to temporarily prohibit enrolling new providers of services and supplies of a particular type or location in Medicare, Medicaid, or CHIP as necessary to prevent or combat fraud, waste, and abuse.[133] Such prohibitions take the form of moratoria. Before initiating such moratoria, CMS is required to consult with the affected SMA. After consultation, the SMA is required to impose the moratoria unless the SMA finds such action would adversely affect beneficiaries' access to care.[134, 135] If the SMA makes such a finding, it must notify CMS in writing.[136]

CMS and SMAs can initiate moratoria under the Affordable Care Act. SMA-initiated moratoria must be based on the same risk factors that CMS-initiated moratoria are based on, and CMS must agree to the moratoria.[137] As with the CMS moratoria, SMA moratoria may be imposed for up to 6 months initially and may be extended in 6-month increments. The SMA also has the authority to impose numerical caps and other limits on provider screening and enrollment of new Medicaid providers.[138]

Conclusion

The Medicaid provider screening and enrollment and revalidation screening requirements are designed to ensure only qualified providers are allowed to enroll and that providers who have defrauded Federal health care programs in the past are not allowed to participate. As an integral component of CMS' prevention-oriented approach, implementation of the enhanced provider screening and enrollment and screening process will help to reduce improper payments and save Medicaid and CHIP funds for use by beneficiaries that need the care. As partners in integrity, Medicaid and CHIP providers can help make this a reality. Providers are critical partners in delivering quality care to low-income individuals and in maintaining the integrity of the Medicaid program.

Materials Available on the Internet

To see the electronic version of this booklet and 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. SMAs should consult guidance contained in the MPEC, posted to https://www.medicaid.gov/affordablecareact/provisions/downloads/mpec-032116.pdf on the CMS website.

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