



Center for Medicaid and CHIP Services

CMCS Informational Bulletin

DATE:

FROM: Cindy Mann
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Center for Medicaid, CHIP and Survey & Certification (CMCS)

SUBJECT: Medicaid/CHIP Provider Screening and Enrollment Guidance

This informational bulletin provides guidance as part of a series of implementation activities for the Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted on March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted on March 30, 2010) (collectively referred to as the Affordable Care Act). Specifically, this informational bulletin provides guidance on Section 6401 – *Provider Screening and Other Enrollment Requirements under Medicare, Medicaid, and CHIP*.

Section 6401(a) of the Affordable Care Act, as amended by section 10603 of the Affordable Care Act, amends section 1866(j) of the Social Security Act (the Act) adds a new paragraph “(2) Provider Screening.” Section 1866(j)(2)(A) of the Act requires the Secretary, in consultation with the Department of Health and Human Services’ Office of the Inspector General, to establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under Medicare, Medicaid, and CHIP. Section 1866(j)(2)(B) of the Act requires the Secretary to determine the level of screening to be conducted according to the risk of fraud, waste, and abuse with respect to the category of provider or supplier. Section 1866(j)(2)(C) of the Act requires the Secretary to impose a fee on each institutional provider of medical or other items or services or supplier, to be used by the Secretary for program integrity efforts. Section 6401(b) of the Affordable Care Act amends section 1902 of the Act to add paragraph (a)(77) and (kk), which include requirements for States to comply with the process of screening providers and suppliers and imposing temporary enrollment moratoria for the Medicaid program as established by the Secretary under 1866(j)(2) and (7) of the Act. CMS implemented these requirements with Federal regulations at 42 CFR Part 455 subpart E. These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011.

Submission of State Plan Amendments

States must submit a State plan amendment (SPA) to CMS for review and approval by January 1, 2012 to provide assurances that they will comply with the Federal regulations at 42 CFR 455

subpart E. We have provided a draft Medicaid State Plan preprint for State convenience to assure compliance with and implementation of section 6401 at Enclosure A. States must submit the transmittal and Notice of Approval of the State Plan Material, Form CMS -179, with the SPA template to assure compliance with these Federal requirements. The submissions are to be sent to the SPA Mailbox for review and approval. While the template in Enclosure A includes 42 CFR 455.416 on the termination or denial of enrollment, additional guidance on this regulatory provision was issued on May 31, 2011, see <http://www.cms.gov/CMCSBulletins/downloads/6501-Term.pdf>).

Enrollment and Screening of Providers

Federal regulations at 42 CFR 455.410 and 455.450 require that all participating providers be screened according to their categorical risk level, upon initial enrollment and upon re-enrollment or revalidation of enrollment. In addition, section 455.410 requires that all ordering and referring physicians or other professionals providing services under the State plan or under a waiver of the Plan be enrolled as participating providers.

For purposes of these requirements, only those physicians and other professionals recognized by the State Medicaid agency as providers are required to enroll in the State Medicaid program. As discussed more fully below, the new enrollment requirements for ordering and referring providers do not apply in the risk-based managed care environment, i.e., if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

All participating providers must be screened upon initial application, including applications for a new practice location, and any applications received in response to a request for re-enrollment. Screening is also performed for a provider who is revalidated for enrollment. The required screening measures vary according to the provider's categorical risk level of "limited," "moderate" or "high." State Medicaid agencies may rely on the results of screening performed by Medicare contractors, other State Medicaid agencies or other CHIP programs. Additional guidance regarding screening levels is detailed in the "Frequently Asked Questions" provided as Enclosure B.

It should be noted that 42 CFR 455.452 allows the State Medicaid agency to establish provider screening methods in addition to, or more stringent than, those required by 42 CFR 455 subpart E.

The Federal regulation at 42 CFR 455.414 requires States, beginning March 25, 2011, to complete revalidation of enrollment for all providers, regardless of provider type, at least every five years. Based upon this requirement, States must complete the revalidation process of all provider types by March 24, 2016. Providers that initially enrolled after March 25, 2011 will not have to be revalidated until five years from the date they were initially enrolled. Note that as part of this required revalidation process, States must revalidate the enrollment information and collect updated disclosures from all providers; however, States are not required to rescreen these same providers so long as the providers have been screened by Medicare or another State's

Medicaid program or CHIP within the previous 12 months. No application fee is required for providers that the State is not required to rescreen.

In order to administer the provider screening, application fee, and revalidation requirements successfully as specified in Federal regulations at 42 CFR 455.410, 42 CFR 455.414, 42 CFR 455.450 and 42 CFR 455.460, we believe States must have access to Medicare enrollment data to determine if a provider is currently enrolled in the Medicare program, or has been denied enrollment in the Medicare program, and/or is currently enrolling in the Medicare program. We believe this is important since States can rely on the results of the Medicare screening process and this access will eliminate additional screening and enrollment requirements for Medicaid and CHIP providers, and eliminate additional costs and burdens to State Medicaid programs and CHIP.

Toward that end, CMS has established a process by which States will have direct access to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). Each State will be given “read only” access and will be granted access for a maximum of four users. CMS is requesting that within 30 days from the date of this Informational Bulletin States submit the contact information including name, telephone number and email address, for each of the designated users to Mr. Michael Berger at michael.berger@cms.hhs.gov. Instructions on accessing the PECOS system will be provided to each of the designated users. Users will also be provided with a PECOS User Guide detailing how to log into the PECOS system and how to search PECOS. Further, users will also be provided with “screen shots” to assist in locating the information necessary to verify if a provider is currently enrolled or is enrolling in the Medicare program.

Since there is no national enrollment database for Medicaid providers, in order to ensure that States do not complete unnecessary screening or collect application fees inappropriately, States should request information from providers as to whether they have submitted an application to enroll or if they are currently enrolled in another State’s Medicaid program or CHIP. If a provider informs the State that it is enrolled or has applied for enrollment in another State’s Medicaid program or CHIP, the State should contact the other State to confirm if the provider has been enrolled and therefore, screened, or if the provider is currently enrolling and/or if the State has collected an application fee. Federal Regulations at 42 CFR 455.460 require that only one application fee be collected for a Medicaid enrolling provider. Consequently, if providers are simultaneously enrolling in two separate State Medicaid programs, States are encouraged to work together to determine which State will collect the application fee and conduct the required screening. Additionally, there may be situations in which a State has been granted a waiver of the application fee for a particular category of providers so that the State is not collecting an application fee. Thus, if a provider is simultaneously enrolling in two separate Medicaid programs, the other State must collect the application fee or also request a fee waiver.

Further, for State convenience, we have provided, at Enclosure B, a document entitled “Frequently Asked Questions for the Implementation of the Medicaid Provider Screening and Enrollment Requirements.” This document will provide States with additional information on the implementation and operation of provider screening and enrollment.

Please feel free to contact Donna Schmidt, Deputy Director, Division of State Systems, of my staff, at 410-786-5532, or by email at Donna.schmid@cms.hhs.gov if you have any questions. We look forward to continuing our work together as we implement this important provision of the Affordable Care Act.

Sincerely,

Cindy Mann
Director

Enclosures (2)

A – State Plan preprint

B – Frequently Asked Questions for Implementation of the Medicaid Provider Screening and Enrollment Requirements

cc:

CMS Regional Administrators

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ENCLOSURE A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

4.46 Provider Screening and Enrollment

Citation

1902(a)(77)
1902(a)(39)
1902(kk);
P.L. 111-148 and
P.L. 111-152

The State Medicaid agency gives the following assurances:

42 CFR 455
Subpart E

PROVIDER SCREENING

_____ Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.

42 CFR 455.410

ENROLLMENT AND SCREENING OF PROVIDERS

_____ Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq.

_____ Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.

42 CFR 455.412

VERIFICATION OF PROVIDER LICENSES

_____ Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.

42 CFR 455.414

REVALIDATION OF ENROLLMENT

_____ Assures that providers will be revalidated regardless of provider type at least every 5 years.

42 CFR 455.416

TERMINATION OR DENIAL OF ENROLLMENT

_____ Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

42 CFR 455.420

REACTIVATION OF PROVIDER ENROLLMENT

_____ Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422

APPEAL RIGHTS

_____ Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

SITE VISITS

42 CFR 455.432 _____ Assures that pre-enrollment and post-enrollment site visits of providers who are in “moderate” or “high” risk categories will occur.

CRIMINAL BACKGROUND CHECKS

42 CFR 455.434 _____ Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

FEDERAL DATABASE CHECKS

42 CFR 455.436 _____ Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

NATIONAL PROVIDER IDENTIFIER

42 CFR 455.440 _____ Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

SCREENING LEVELS FOR MEDICAID PROVIDERS

42 CFR 455.450 _____ Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

APPLICATION FEE

42 CFR 455.460 _____ Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

42 CFR 455.470 _____ Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries’ access to medical assistance.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-New . The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Frequently Asked Questions for Implementation of the Medicaid Provider Screening and Enrollment Requirements

A. Screening Process Timeline

Question - Does CMS have a required timeframe for conducting the enhanced screening for new provider applicants, e.g. pre-enrollment site visits?

Answer - While no timeframe for the completion of the screening process is required for a newly or re-enrolling provider by Federal regulations at 42 CFR 455 subpart E, States are encouraged to avoid any unnecessarily lengthy period for completing the provider screening process since it will be important to minimize the impact on access to care.

B. Collection and processing of enhanced provider enrollment/screening information

Question – Are States required to apply the Medicare screening risk levels to Medicaid and CHIP providers?

Answer - Three levels of screening are applicable as described in Federal regulations at 42 CFR 424.518. They are limited, moderate, and high. Section 1902(kk)(1) of the Social Security Act (the Act) requires States to comply with the process for screening providers established by the Secretary under section 1866(j)(2) of the Act. Accordingly, 42 CFR 455.450 establishes the same screening levels for Medicaid and CHIP providers. For those Medicaid and CHIP provider types that are also recognized provider or supplier types under Medicare, we expect States to use the same screening levels as apply under Medicare. For those provider-types that are not recognized under Medicare, we expect States to assess the risk of fraud, waste, and abuse using similar criteria to those used in Medicare, as outlined in Federal Register, Vol. 76, dated February 2, 2011, beginning on page 5868.

Question - Do State Medicaid agencies have the flexibility to assign a Medicaid provider to a risk category at a level lower than the level that Medicare has assigned to that provider type?

Answer - No, as noted above, for those provider types that are also recognized as provider or supplier types under Medicare, States must use the same screening levels as apply under Medicare.

Question – Not all provider types are listed in the Federal Register document. For example what is the risk level associated with non-emergency medical transportation providers (not ambulances or commercial providers) and personal care attendants (PCA) not employed through an HHA?

Answer - For those provider types not listed in a categorical risk level, States must assess the risk posed by the particular provider type to determine the appropriate categorical risk level

for that provider type and subsequently follow the applicable screening requirements for that categorical risk level. While the determination to enroll non-emergency medical transportation and/or PCA providers is up to the States, we expect States to assess the risk of fraud, waste, and abuse using the criteria for Medicare, as outlined in Federal Register, Vol. 76, dated February 2, 2011, beginning on page 5868.

Question - If a provider has been screened by the Medicare program, can those screening results be used by the State Medicaid agency and are they sufficient to comply with the Medicaid requirements for screening?

Answer - As provided in 42 CFR 455.410, States can rely on the results of the provider screening performed by Medicare or another State's Medicaid program/CHIP. However, States must allow for the screening to be completed in order to rely on these results. Thus, in order to enroll a moderate risk provider, (e.g. ambulance company) or high risk provider, (e.g., a newly enrolling HHA), the applicable enhanced screening protocols (site visits for moderate and high risk providers with additional criminal background checks and fingerprinting for high risk providers) must be completed by the State or by a Medicare contractor or another State's Medicaid program or CHIP in order for the provider to be allowed to enroll or be revalidated. At the present time, the criminal background check and fingerprinting are not required. Additional sub-regulatory guidance will be issued on criminal background checks and fingerprinting requirements, following which States will have 60 days to implement these enhanced provider screening requirements.

Question – What risk level should be assigned to mental health service providers? Such mental health services include case management, day support, crisis stabilization, intensive in-home services, etc.

Answer - For those provider types that do not have a screening level assigned under Medicare, we expect States to assess the level of risk of fraud, waste and abuse posed by that provider type using criteria similar to those used in Medicare. Mental health service providers may be most similar to the community mental health clinic provider type in Medicare, which is subject to the moderate screening level. However, because States are uniquely qualified to understand issues involved with balancing beneficiary access to medical assistance and ensuring the fiscal integrity of their Medicaid programs and CHIP, States may assign these providers a different screening level depending on the States' assessment of the risk.

Question - Are Medicaid managed care organizations and the individual providers that provide services for the Managed Care Organization considered providers that must be screened?

Answer – The screening required under section 1866(j)(2)(A) and the implementing regulations applies to all providers enrolling in a State's Medicaid program or CHIP. Thus, if a State requires network providers in risk-based MCOs to enroll as participating providers, the screening requirements apply. However, if a State does not require risk-based managed care providers to enroll, the Federal requirement for ordering and referring physicians and

non-physician practitioners to enroll as participating providers does not apply to practitioners that order and refer services in the risk-based managed care context. If a State requires MCOs to enroll as participating providers, the screening requirements apply. However, if a State does not require MCOs to enroll as providers in the Medicaid program, the Federal requirement for screening would not apply to them.

Question - What is the purpose of a site visit?

Answer - Conducting unscheduled and unannounced pre-enrollment site visits helps ensure that prospective providers meet enrollment requirements. Additionally, for revalidations, site visits are a reliable and effective tool to ensuring that current providers remain operational and continue to meet required provider standards. States have the flexibility to determine the activities that constitute a site visit.

Question - Many State licensing entities require an onsite visit prior to issuing a license. Does CMS expect States to make an additional onsite visit for the purposes of Medicaid enrollment if the entity was previously visited by the State licensing entity?

Answer - Site visits may be combined with other site visit activity such as those for State Licensing, Survey and Certification and Clinical Laboratory Improvement Act requirements so long as the verification activity for screening and enrollment is documented separately.

C. Application Fee

Question – Are States required to collect an application fee for all providers that are not dually enrolled (Medicare providers)?

Answer - Section 1866(j)(2)(C) of the Act requires the imposition of an application fee on each institutional provider "with respect to which screening is conducted," whenever the required screening (whether upon initial enrollment, reactivation, or reenrollment) occurs. Under 42 CFR 455.420, following a deactivation of a provider's enrollment for any reason, a State Medicaid agency must rescreen the provider, including collecting the application fee, before reactivating the provider's enrollment. Federal Regulations at 42 CFR 455.460 require that, beginning on or after March 25, 2011, States must collect the applicable application fee for any newly enrolling or reenrolling institutional provider. This requirement does not apply to individual physicians or non-physician practitioners, or providers that are enrolled in Medicare or another State's Medicaid program or CHIP or to those that have already paid the fee to Medicare or another State Medicaid program or CHIP. If Medicare denies enrollment for the provider, the application fee is not to be collected by Medicaid programs or CHIP unless the denial was based on a temporary moratorium. In that situation, Medicare will refund the application fee to the provider. In addition, States should independently review the basis for the denial of enrollment in the Medicare program in their assessment of the provider's application in a State's Medicaid program or CHIP. For newly enrolling providers, States must collect the applicable application fee prior to executing a provider agreement. The application fee increases each calendar year based on the consumer price index for all urban consumers. The application fee for calendar year 2011 is \$505.

Question - If States have concerns that application fees may adversely impact beneficiary access, what is the process for requesting hardship exception waivers? Does the Secretary require both a letter from the provider and a letter from the State Medicaid agency requesting a hardship exception waiver?

Answer - Section 1866(j)(2)(C)(ii) of the Act and Federal regulations at 42 CFR 424.514 allow an institutional provider to submit a request to CMS for a hardship exception providing justification so that the institutional provider is not required to pay the application fee to the Medicare program. For the Medicaid program, section 1866(j)(2)(C)(ii) of the Act requires the Secretary to review and, if appropriate, approve any request for a hardship exception. Such hardship exceptions are for specific providers; we are also interpreting the statute to allow the Secretary to grant a waiver of the application fee on a broader or categorical basis if the State demonstrates that the imposition of the fee would impede beneficiary access to care. As an example, a State could request a fee waiver applicable to a particular group or category of providers so that an entire institutional provider type or all institutional providers in a defined geographic area can be considered exempt from paying the application fee. To achieve this States must submit a formal request to CMS for review and approval. The request must document the basis for the waiver request including a discussion of the impact on beneficiary access to care if the fee is imposed on providers within the specific group or category of providers. States must submit fee waiver requests to Ms. Donna Schmidt at donna.schmidt@cms.hhs.gov.

Question – If a Pharmacy/DMEPOS entity enrolls as a DMEPOS, but not as a Pharmacy in Medicare, and enrolls as a Pharmacy in Medicaid, is the entity subject to an application fee as a Medicaid Pharmacy and subject to an additional Medicaid screening process?

Answer - Entities that are enrolled under multiple provider types must be screened for each provider type. For example, if an entity is enrolling as a DMEPOS provider/supplier for Medicare and a pharmacy for Medicaid, a high risk screening will be performed by Medicare since DMEPOS providers are high risk providers and a limited risk screening will be performed by Medicaid since pharmacies are limited risk providers. Application fees are applicable for both provider types and must be collected as part of the enrollment/reenrollment process. This is appropriate since the example identifies two different provider types. If the example identified only a pharmacy and if the pharmacy was already enrolled as a provider in Medicare and therefore, had already paid the application fee, there would be no need for the pharmacy attempting to enroll in Medicaid to pay the fee again.

Question - Which program takes precedence for collecting the application fee if a provider enrolls in both Medicaid and CHIP?

Answer - There is no precedence and an application fee is required if the provider is not also enrolled in Medicare or another State's Medicaid program or CHIP. However, only one application fee is required to be collected.

Question – Can States collect Federal financial participation (FFP) for administering the provider enrollment and screening requirements and how should States account for revenue associated with the collection of application fees?

Answer – Any application fees collected by States must be used to offset the cost of conducting the required screening. State expenditures incurred for the administration of the program can be reimbursed at 50 percent FFP. This includes both the costs of the screening that exceed the fees collected and the additional costs of administering the State’s program. To report State administrative costs and to request reimbursement, States must report expenditures and revenues on the Medicaid Budget and Expenditure System, form CMS-64. Additionally, if revenue from application fees exceeds the State’s cost of conducting the required screening, States are required by 42 CFR 455.460 to return to CMS the portion of the application fees which exceed State administrative costs. For example, if a State’s costs to conduct the screening required by 42 CFR 455 subpart E are \$100 million and revenue from application fees equals \$60 million, States may request FFP at 50 percent for the remaining \$40 million for the administration of the provider enrollment and screening initiative. Alternatively, if the cost to implement these requirements is \$60 million and the revenue from application fees is \$100 million, States are required to return to CMS the \$40 million in application fees that exceed the costs of the screening. States need to take into account situations in which an application fee was collected in error. This can occur if a provider is enrolled or enrolling in Medicare or another State’s Medicaid program or CHIP and the State was not aware of such enrollment. In these cases, the State must refund the application fee to the provider.

D. Revalidation Process

Question - What actions must be taken by States for the revalidation process? Is a complete re-enrollment required, or is it sufficient to ask providers to revalidate the information they submitted in their original enrollment process?

Answer - Federal Regulations at 42 CFR 424.515 specify that revalidations are conducted in accordance with the screening procedures specified in 42 CFR 424.518. These screening procedures and risk levels apply to enrollments/re-enrollments and revalidations. Thus, the screening requirements for a newly enrolling or re-enrolling provider also apply for the revalidation of a provider, unless the provider has already been screened by Medicare or another State’s Medicaid program or CHIP within the previous 12 months. Revalidations also include the disclosure requirements as specified in 42 CFR 455.104, 455.105, and 455.106. States may ask providers to verify existing disclosure information when complying with these requirements.

E. Enrollment and Screening Information from Federal and State Databases

Question – Are States required to check Federal databases for provider information? Does the Federal Government sponsor any databases that provide identifying information on providers, e.g. Social Security Administration; Internal Revenue Service; National Practitioners Data Bank, the National Provider Identifier (NPI), etc.?

Answer - Federal regulations at 42 CFR 455.436 require States to confirm the identity and determine the exclusion status of providers and any person with an ownership or controlling interest or who is an agent or managing employee of the provider through routine checks of Federal databases. This section also requires that States check the Social Security Administration's Death Master File, the National Plan and Providers Enumeration System, the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any other databases as the Secretary may prescribe. States must consult these databases to confirm the identity of providers seeking enrollment and/or reenrollment in Medicaid programs or CHIP. Section 455.436(c)(2) requires States to review the LEIE and the EPLS no less frequently than monthly for exclusion information for enrolled providers and any person with an ownership or control interest or who is an agent or managing employee of the provider.

F. Enrollment for Ordering and/or Referring Providers

Question - Who is responsible for verifying that a provider is correctly enrolled in a State's Medicaid program? For example, when a patient presents a prescription to a pharmacy, is it the pharmacist's responsibility to ensure the prescribing physician has enrolled in Medicaid in accordance with the Federal requirements at 42 CFR 455 subpart E implementing these provider screening and enrollment requirements?

Answer - Ordering and referring providers are physicians or other professionals that order or refer items or services for Medicaid beneficiaries. Some of these providers do not submit claims for reimbursement of any services provided but are now required to enroll solely for purposes of ordering and referring services for Medicaid beneficiaries. All ordering and referring providers, except those who are members of risk-based managed care organizations, are now required to be enrolled with the Medicaid program if they continue to order and/or refer services for Medicaid beneficiaries. All claims for payment for ordered or referred items or services must include the NPI of the ordering or referring physician or other professional. If the NPI is not provided on claims for payment or the ordering or referring provider is not enrolled in the Medicaid program, States must deny such claims. For claims which include the NPI from the ordering or referring provider, States must review the claim processing adjudication logic in order to make appropriate payment determinations for services ordered or referred. If an ordering/referring provider is not enrolled, States may pend a claim from the provider performing the services which were ordered or referred to allow for the ordering/referring provider to become enrolled and after such enrollment pay the claim. States may, at their discretion, provide access to enrollment information to providers so that they can ensure that ordering and referring providers are enrolled in the Medicaid program.

Question – If a beneficiary has coverage from a health benefit plan in addition to Medicaid and the ordering/referring provider is authorized to accept the payment from the health benefit plan, is not enrolled in Medicaid and does not bill Medicaid, is the claim from the provider that performs the ordered or referred service payable if the claim was not paid by the other health benefit plan?

Answer – The claim from the provider that performs the service ordered or referred is not payable if the ordering/referring provider is not enrolled in Medicaid even if the ordering/referring provider is only receiving payment from the other health benefit plan.

Question - Some charity care providers, who are not enrolled as providers, provide services to Medicaid patients in areas where access to services is limited. These charity care providers are an important part of the safety net, particularly in areas and specialties with low provider participation in Medicaid. Can States continue to pay for prescriptions and other services ordered by non-enrolled charity care providers?

Answer - All ordering and referring providers are now required to be enrolled with the Medicaid program if they continue to order and/or refer services for Medicaid beneficiaries. As we indicated in the final rule, Federal Register, Vol. 76, dated February 2, 2011, to accommodate such charity care providers, States may establish a streamlined enrollment approach for providers whose only relationship with the Medicaid program is ordering and/or referring services. This streamlined enrollment process could be similar to the Medicare CMS-855-O, which allows a physician or non-physician practitioner who does not submit claims for services provided to Medicare beneficiaries to enroll in Medicare solely for purposes of ordering and referring. In some cases the organization where the ordering or referring provider provides services can submit the streamlined enrollment application information on behalf of the ordering or referring provider. This streamlined enrollment process ensures that providers enrolled are not included in a State’s primary enrollment listing and are not accessible from a State’s website. Further, with this streamlined enrollment process, these providers will not receive referrals to provide direct services to beneficiaries from the State Medicaid agency. Since physician and other non-physician practitioners are considered limited risk providers the use of a streamlined enrollment process should not impact the existing process a State is utilizing in enrolling such providers. However, if these providers have been sanctioned for a payment suspension, overpayment, and/or excluded by the OIG or another Medicaid agency, such providers are to be considered high risk.

Question – Many hospitals are staffed with residents who often are not enrolled as individual Medicaid providers but who order/refer services for Medicaid beneficiaries. In these cases, some States allow pharmacies to submit the NPI of the hospital on the prescription or to use a temporary NPI on the prescription. Can States continue to use current mechanisms to pay claims for prescriptions written by residents since such residents are not typically enrolled in the Medicaid program? Many Medicaid-enrolled hospitals employ hospitalists or contracted emergency room physicians who are not separately enrolled as Medicaid providers. Are prescriptions written by enrolled hospital employees or contract staff eligible for coverage under Medicaid? If not, how will patients obtain necessary discharge medications?

Answer - For providers who are permitted under State law to order and/or refer services for Medicaid or CHIP beneficiaries but who do not have NPIs and who are not authorized to enroll as Medicaid or CHIP providers, e.g., residents at hospitals and, in some cases, hospitalists, States must determine which NPI number should be applied to the claim for

payment if such providers order or refer services for Medicaid or CHIP beneficiaries. In this case, a resident of a hospital who orders a prescription for a Medicaid beneficiary on behalf of the hospital could apply the NPI of the hospital or of the supervising physician to the claim. This practice would eliminate the potential of the claim submitted by the provider (pharmacy) performing the ordered or referred service having their claim denied because no NPI was provided on the claim for the ordering or referring provider. States should notify applicable providers of this process and indicate which NPI must be applied in such situations. For providers who are eligible to enroll in the State's Medicaid program or CHIP as a participating provider, they must be enrolled if they order or refer services for Medicaid or CHIP beneficiaries. As previously discussed the streamlined approach can be used to facilitate the enrollment.

Question - Some States do not enroll mid-level prescribing practitioners (physician assistants and advanced practice nurses) separately in the Medicaid program. Are prescriptions written by mid-level practitioners eligible for coverage if the State does not enroll the providers separately?

Answer - We recognize that there are situations in which non-physician practitioners are authorized by a State to order or refer services but are not authorized to enroll in a State's Medicaid program or CHIP. For example, a State may allow physician assistants or nurse practitioners to order prescriptions but not allow such practitioners to be enrolled providers in their Medicaid program or CHIP. These practitioners are typically employed by providers who are eligible for enrollment, e.g., physicians, hospitals, Federally qualified health centers, and/or home health agencies. States may instruct enrolled Medicaid providers to submit orders or referrals using their respective NPI in the event that employees who are non-enrolled practitioners and not permitted to enroll as providers have ordered or referred services for Medicaid beneficiaries on their behalf.

Question - If a patient is out-of-State and receives services in an emergency room or hospital, can the prescriptions written by the out-of-State provider be reimbursed by the patient's Medicaid plan in another State? This type of situation occurs in all States, but is particularly common for rural States that do not have specialized services available in-State. The out-of-State hospital will often enroll with Medicaid to receive reimbursement for the hospital visit by the Medicaid beneficiary, but it is unlikely that the individual physician prescriber will enroll. How are States expected to accommodate out-of-State prescribers?

Answer - Section 1902(kk)(7) of the Social Security Act provides that the State Medicaid agency must require all ordering or referring physicians or other professionals providing services under the State plan be enrolled as participating providers. Section 2107(e)(1) of the Act makes this requirement applicable to CHIP. The statutory reference to "the State plan" means that the provider that ordered or referred the services must be enrolled in the Medicaid program or CHIP in which the beneficiary is eligible. The NPI of the provider ordering or referring the services must be included on the claim for payment from the provider performing the services ordered or referred. Therefore, a provider located in a State different from the one where the beneficiary is eligible who orders or refers services must be enrolled in the State in which the beneficiary is eligible in order for the State Medicaid agency to pay

the claim from the provider who performed the services which were originally ordered or referred. This includes physicians or other professionals employed at hospitals or other healthcare facilities. If the provider who ordered or referred the services is not going to submit claims to the State, the State can utilize the streamlined enrollment process mentioned earlier to enable the ordering/referring provider to become enrolled. This does not mean, however, that the Medicaid beneficiary has liability for payment other than the traditional cost sharing, deductible or co-pay liability that Medicaid beneficiaries sometimes experience. **Question** - A Medicaid patient might have access to a Veterans Administration (VA) or Indian Health Services (IHS) provider that is not a participant in the State's Medicaid program. Does a State have the option to cover prescriptions written by non-enrolled VA or IHS providers?

Answer - Medicaid beneficiaries may receive services from a provider employed at a VA or IHS facility. If the provider from the VA or IHS facility orders or refers the beneficiary for additional services e.g., prescription drugs, the ordering or referring provider must be enrolled in order to ensure that the claim will be paid to the provider delivering the ordered or referred services. If the provider who ordered or referred the services is not going to submit claims to the State, the State can utilize the streamlined enrollment process mentioned earlier to enable the ordering/referring provider to become enrolled.

Question - Patients who are new to Medicaid often have existing chronic conditions for which they are currently taking medications. Can States continue to pay for the refills of these medication regimens if they are written by non-participating providers, or are the patients required to set up appointments with new (enrolled) providers and obtain new prescriptions to ensure Medicaid coverage?

Answer - If, prior to March 25, 2011, a State processed a claim for a service ordered or referred by a non-enrolled provider who would now be required to be enrolled in the State's Medicaid program, as outlined by the regulatory requirements at 42 CFR 455.410(b), the State is authorized to continue to process and approve prescription refills for the ordered items or services after March 25, 2011, until the refill period has lapsed, even if the ordering/referring provider is not enrolled. In addition, if a current beneficiary was not eligible at the time a prescription was filled but becomes eligible while refills are still available, States are authorized to process and approve such prescription refills until the refill period has lapsed.

G. Moratoria

Question – The Secretary has the authority to impose a temporary moratorium on provider enrollment if the Secretary determines that the moratorium is necessary because a provider or a specific provider type has been identified as being at high risk for fraud, waste, or abuse. States can request an exception to a Secretarial imposed moratorium if the State determines that the imposition of such a moratorium would adversely impact beneficiaries' access to medical care. How can States request such an exception to a temporary moratorium?

Answer - Section 1902(kk)(4)(A) of the Act and 42 CFR 455.470(a)(2) and (3) require States to comply with any temporary moratorium imposed by the Secretary unless the State determines that the imposition of such a moratorium would adversely impact beneficiaries' access to care. If a State determines that an exemption is needed from the imposition of a moratorium due to the expected adverse impact on beneficiary access to care, the State must notify the Secretary in writing. While not required, States are encouraged to include in the notification the basis of the concern for beneficiary access to care if the moratorium is to be imposed. Such notifications must be submitted to Ms. Donna Schmidt at donna.schmidt@cms.hhs.gov.

Question – What documentation is required by a State in order to request a decision by the Secretary to impose or extend a moratorium?

Answer - Section 1902(kk)(4)(B) and 42 CFR 455.470(b) also permit State Medicaid agencies to impose numerical caps or moratoria on new enrollment or under their State plans for provider types that have been identified by the State Medicaid agency and the Secretary as being at high risk for fraud, waste, or abuse. Before implementing such actions under its State plan, the State Medicaid agency must determine that the moratoria or caps do not adversely impact beneficiaries' access to medical care. Additionally, States must notify CMS in writing of their intent to impose or extend a temporary moratorium or numerical cap, including all details of the planned moratorium or cap, and obtain CMS concurrence prior to execution. Such notices are also to be sent to Ms. Donna Schmidt at donna.schmidt@cms.hhs.gov. Any moratoria or cap may be imposed by the State Medicaid agency for an initial period of six months. States may also extend the period for moratoria in additional six month increments; however, each time the State chooses to extend the moratorium, the agency must document in writing the necessity for extending the moratorium which must be available to CMS upon request in order that CMS can review the basis for the extension.

H. States/Provider Compliance

Question - Does the State Medicaid agency have to notify providers of the new screening process before denial of applications for any of the screening requirements? Will CMS require that language be added to provider agreements ensuring compliance with these new provider screening and enrollment requirements?

Answer - CMS recommends that States notify providers of the new enrollment and screening requirements. CMS provides States with the flexibility to choose the appropriate method for doing so. Examples could include provider enrollment websites, provider information bulletins and inclusion in provider agreements. States may incorporate, at their discretion, additional information in their respective provider agreements reflecting components of the new provider screening and enrollment requirements.

I. State Funding

Question - Systems and operational costs will be incurred to develop and implement these provider screening and enrollment regulations. Federal Financial Participation (FFP) is available to States that make modifications to their Medicaid management information systems (MMIS) in order to comply with the requirements outlined in the Federal Regulations at 42 CFR 455 subpart E. What are the requirements for FFP?

Answer - Funding for modifications to the MMIS would be available under section 1903(a)(3) of the Act. It should be noted that, in order to be eligible for funding, a State's MMIS must comply with seven standards and conditions (see Federal Register, Vol. 76, No. 75, dated April 19, 2011). Ninety percent FFP is available for the design, development and implementation of the MMIS to accommodate the requirements of Section 1902(kk) of the Act and the Federal regulations at 42 CFR Part 455 subpart E. For continuing operations of the MMIS, States can receive 75 percent FFP. In order to be eligible for enhanced FFP, States must submit an Advanced Planning Document to CMS for review and prior approval.