

*(Note: this guidance has been updated, see <https://www.medicaid.gov/affordable-care-act/program-integrity/index.html> for the most recent version)*

## Medicaid Provider Enrollment Compendium (MPEC)

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**Last Updated: March 21, 2016**

**Intended audience:** State Medicaid Agencies (SMA)

**Message to providers:** If you are a provider seeking to enroll to provide services to Medicaid or Children’s Health Insurance Program (CHIP) beneficiaries, these programs are administered by individual states. You’ll need to enroll in each state for which you would like to provide services to that state’s eligible residents. To locate instructions for how to enroll in a specific state’s Medicaid Program or CHIP, please conduct a web search using the terms “state”+ “Medicaid provider enrollment” (replace “state” with the name of the state where you seek to enroll). This will help you to locate information regarding a specific state’s enrollment process.

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## **1.1– Introduction**

### **A. Purpose for Medicaid Provider Enrollment Compendium**

#### 1. Sub Regulatory Guidance

This policy manual contains sub regulatory guidance and clarifications regarding how state Medicaid agencies are expected to comply with the following federal regulations at 42 CFR § 455:

- Subpart B “Disclosure of Information by Providers and Fiscal Agents,” and
- Subpart E “Provider Screening and Enrollment”

The federal regulations at 42 CFR Part 455 include Subparts A through F; however, the information herein addresses only Part 455 Subparts B and E.

#### 2. Applicability to Children’s Health Insurance Program (CHIP)

All references to the Medicaid Program in this compendium are inclusive of CHIP.

Section 6401(b) of the Affordable Care Act amended section 1902 of the Act to require State Medicaid Programs to comply with the procedures established by the Secretary for screening providers and suppliers. Section 6401(c) of the Affordable Care Act amended section 2107(e) of the Act to make the provider and supplier screening requirements under section 1902 applicable to the Children’s Health Insurance Program (CHIP).

Via a final rule published in the Federal Register on February 2, 2011, CMS established and implemented Medicaid provider screening requirements at 42 CFR Part 455, Subpart E. Per 42 CFR § 457.990, these regulations are applicable to CHIP and became effective on March 25, 2011.

### **B. Description of Content**

This manual includes selected definitions, a description of the statutory basis and background for the requirements at Subparts B and E, and guidance for states specific to topics related to compliance with the regulations at Subparts B and E.

### **C. Procedures for Updates to this Compendium**

This document will be updated and expanded. Please refer to the “Last Updated” information to see the date this document was most recently updated. When the document is updated, changes and edits will appear in red font for one update cycle.

#### **1.1.1 - Background**

State Medicaid Plans pay providers for furnishing covered services to eligible beneficiaries, including either on a fee-for-service basis or through risk-based managed care arrangements. If state Medicaid agencies pay fraudulent providers, either directly or through managed care plans, for services that the providers did not furnish or for services they did furnish to beneficiaries they knew had no need for the services: (1) Medicaid funds are diverted from their intended purpose, (2) beneficiaries who need services may not receive them, and (3) beneficiaries who do not need services may be harmed by unnecessary care. Identifying overpayments due to fraud--- and recovering those overpayments from providers that engaged in the fraud---is resource-intensive and can take years. In contrast, keeping ineligible entities and individuals from enrolling in State Medicaid Plans as providers in the first place allows the program to avoid paying claims to such parties and then attempting to identify and recover those overpayments. Provider screening enables states to identify such parties before they are able to enroll and start billing.

#### **1.1.2 – Selected Definitions (§§ 455.2 and 455.101)**

**Agent** means any person who has been delegated the authority to obligate or act on behalf of a provider.

**Conviction** or **Convicted** means that a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending.

**Disclosing entity** means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

**Fiscal agent** means a contractor that processes or pays vendor claims on behalf of the SMA.

**Group of practitioners** means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

**Indirect ownership interest** means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

**Managed care entity (MCE)** means managed care organizations (MCOs), pre-paid inpatient health plans (PIHPs), pre-paid ambulatory health plans (PAHPs), primary case care management (PCCMs), and health improvement organizations (HIOs).

**Managing employee** means 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.

**Other disclosing entity** means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

- (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization (meaning all MCOs) that participates in Medicare (title XVIII);
- (b) Any Medicare intermediary or carrier; and
- (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

**Ownership interest** means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

**Person with an ownership or control interest** means a person or corporation that—

- (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
- (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
- (c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

**Practitioner** means a physician or other individual licensed under state law to practice his or her profession.

**Provider** means either of the following:

(1) For the fee-for-service program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency.

(2) For the managed care program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services.

**Significant business transaction** means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5 percent of a provider's total operating expenses.

**Subcontractor** means—

(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

**Supplier** means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

**Termination** means—

(1) For a—

- (i) Medicaid provider, a State Medicaid Program has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and
  - (ii) Medicare provider, supplier or eligible professional, the Medicare Program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.
- (2)(i) In all three programs, there is no expectation on the part of the provider or supplier or the state or Medicare Program that the revocation is temporary.
- (ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.
- (3) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to—(i) fraud; (ii) integrity; or (iii) quality.

**Wholly owned supplier** means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

## **1.2 – Basic Statutory and Regulatory Framework**

### **1.2.1 - 42 CFR Subpart B**

#### **A. Statutory and Regulatory Background for 42 CFR 455 Subpart B**

Via the February 2, 2011 final rule “Medicare, Medicaid, and Children’s Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers, Final Rule” (Federal Register Volume 76, pages 5862 -5971):

- The federal regulation at 455.104 was finalized adding to the disclosure requirements collection of SSNs and DOBs of persons with an ownership or control interest in the disclosing entity.
- The federal regulation at § 455.104(b)(1)(i) was modified to clarify from whom the name and address must be provided and to require the disclosing entity to supply primary business address as well as every business location and P.O. Box address, if applicable.

- The federal regulation at § 455.104(b)(2) was clarified regarding to whom the spouse, parent, child, or sibling is related.
- The federal regulation at § 455.104(b)(4) was amended to require managing employees to provide SSNs and DOBs.

Section 1902(a)(27) of the Act provides general authority for the Secretary to require provider agreements under the State Medicaid Plans with every person or institution providing services under the State plan. Under these agreements, the Secretary may require information regarding any payments claimed by such person or institution for providing services under the State plan.

Section 2107(e) of the Act provides that certain title XIX and title XI provisions apply to States under title XXI, including 1902(a)(4)(C) of the Act, relating to conflict of interest standards, and 1902(a)(77) and (kk), relating to screening, oversight and reporting requirements.

#### 1. Assuring confidentiality of Personally Identifiable Information (PII)

The “Report to Congress on Steps Taken to Assure Confidentiality of Social Security Account Numbers as required by the Balanced Budget Act” was signed by the Secretary and sent to the Congress on January 26, 1999. This report outlines the provisions of a mandatory collection of SSNs and EINs effective on or after April 26, 1999.

### **B. Compliance with Part 455, Subpart B – State Plan Requirements**

Section 455.103 requires that a State’s Medicaid Plan must provide that the requirements of §§ 455.104 through 455.106 are met.

Under § 430.35(b), if a state fails to change its approved plan to conform to a new federal requirement, the state is subject to withholding of federal matching payments, in whole or in part, until the state’s plan is in compliance with federal requirements.

### **C. Education on Requirements**

CMS recommends that states educate providers regarding the disclosure requirements in Part 455. The means of education are within the state’s discretion; examples may include provider enrollment websites, provider information bulletins, and inclusion in provider agreements.

## 1.2.2 - 42 CFR 455 Subpart E

### A. Statutory and Regulatory Background for 42 CFR 455 Subpart E

Section 6401(a) of the Affordable Care Act (as amended by section 10603 of the Affordable Care Act) amended section 1866(j) of the Social Security Act (the Act) by adding a new paragraph: “(2) Provider Screening”, which sets forth the following:

- 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 (OIG), to establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under Medicare and Medicaid.
- 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 amended section 1902 of the Act to require State Medicaid Plans to comply with the procedures established by the Secretary for screening providers and suppliers. Section 6401(c) of the Affordable Care Act amended section 2107(e) of the Act to make the provider and supplier screening requirements under section 1902 applicable to the Children’s Health Insurance Program (CHIP).

Via a final rule published in the Federal Register on February 2, 2011, CMS established and implemented Medicaid provider screening requirements at 42 CFR Part 455, Subpart E. Per 42 CFR § 457.990, these regulations are applicable to CHIP. These provisions became effective on March 25, 2011.

Section 1902(a)(77) of the Act requires that State Medicaid Plans comply with the provider and supplier screening, oversight, and reporting requirements in section 1902(kk). Section 1902(kk) contains requirements related to screening, provisional periods of enhanced oversight for new providers and suppliers, disclosure, temporary moratoria on enrollment of new providers and suppliers, compliance programs, reporting of adverse provider actions, and enrollment and NPI of ordering or referring providers. Sections 1902(a)(77) and 1902(kk) were added to the Act by section 6401(b) of the Affordable Care Act.

Section 1902(a)(39) of the Act requires that State Medicaid Programs terminate the participation of any individual or entity if that individual or entity is terminated under Medicare

or by any other Medicaid Program. Section 1902(a)(39) was amended by section 6501 of the Affordable Care Act. The federal regulations at Part 455, Subpart E implement the provider screening and enrollment requirements of sections 1902(a)(77) and 1902(a)(39) of the Act.

## **B. Compliance with Part 455, Subpart E – State Plan Requirements**

Section 455.405 requires that a State’s Medicaid Plan must provide that the requirements of §§ 455.410 through 455.450 and § 455.470 are met. To facilitate compliance with these State Plan requirements, a Medicaid State Plan preprint is available as Enclosure A to the December 23, 2011 CMCS Informational Bulletin (<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-12-23-11.pdf>).

Under § 430.35(b), if a state fails to change its approved plan to conform to a new federal requirement, the state is subject to withholding of federal matching payments, in whole or in part, until the state’s plan is in compliance with federal requirements.

## **C. Education on Requirements**

CMS recommends that states educate providers regarding the enrollment and screening requirements in Part 455. The means of education are within the state’s discretion; examples may include provider enrollment websites, provider information bulletins, and inclusion in provider agreements.

## **1.3 Medicaid Providers: Categories and Definitions**

### **A. Medicaid “Providers”**

For Medicaid, we use the terms “providers” or “Medicaid providers” when referring to all Medicaid health care providers, including individual practitioners, institutional providers, and providers of medical equipment or goods related to care. The term “supplier” has no meaning in the Medicaid Program.

### **B. Ordering, Referring, or Prescribing Physician or Other Professional (ORP)**

Federal regulations at §§455.410(b) and 455.440 implement the statutory provisions relating to ordering, referring, or prescribing professionals at § 1902(kk)(7)(A) and (B) of the Act. Under 455.410(b), the SMA 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. Under § 455.440, the SMA must require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services.

We interpret the statutory terms “ordering” and “referring” to include prescribing (either drugs or other covered items) or sending a beneficiary’s specimens to a laboratory for testing or referring a beneficiary to another provider or facility for covered services.

Examples of “ordering or referring” include;

- Prescribing (either drugs or other covered items) for a beneficiary
- Sending a beneficiary’s specimens to a laboratory for testing
- Ordering imaging services for a beneficiary
- Ordering durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for a beneficiary
- Referring a beneficiary to another provider or facility for covered services
- Determining or certifying a beneficiary’s need for a covered item or service (e.g., outpatient drug counseling or home health services or nursing facility services) where the determination or certification by a physician or other professional that a beneficiary needs or qualifies for receipt of an item or service is required for payment of the claim

With respect to the disclosure and screening requirements at Subparts B and E, ORP providers are not exempt.

When enrolling ORPs, a State Medicaid Plan has the discretion to enroll ORPs as a specific provider type for purposes such as, but not limited to, payment, tracking, or reporting.

### **C. Concept of “Institutional” Provider**

Medicaid covers certain inpatient, comprehensive services as institutional benefits. The term "institutional" has several meanings in common use, but a particular meaning for Medicaid. In Medicaid coverage, “institutional services” refers to specific benefits authorized in the Social Security Act. These are hospital services, and certain long-term care services. In some cases there are Medicaid-only provider types that may be considered institutional. The SMA may find it helpful to use the criteria below to determine whether a provider is institutional. These criteria are not fully determinative, as there are other provider types considered to be institutional and to which the application fee applies. See Section 1.8.1.C.1 for more information regarding these provider types. Once a state has determined that a provider/supplier is institutional, they should apply that determination to all providers/suppliers of the same type.

Institutional benefits share the following characteristics:

- Institutions are residential facilities, and assume total care of the individuals who are admitted.
- The comprehensive care includes room and board. Other Medicaid services are specifically prohibited from including room and board.
- The comprehensive service is billed and reimbursed as a single bundled payment. (Note that states vary in what is included in the institutional rate, versus what is billed as a separately covered service; for example, physical therapy may be reimbursed as part of the bundle or as a separate service.)
- Institutions must be licensed and certified by the state, according to federal standards.
- Institutions are subject to survey at regular intervals to maintain their certification and license to operate.
- There may be different Medicaid eligibility rules for residents of an institution; therefore, access to Medicaid services for some individuals may be tied to need for institutional level of care.

Once a SMA has determined that a provider/supplier is institutional, it should apply that determination to all providers/suppliers of the same type.

See section 1.8.1.C.1.a “Institutional Providers” for information concerning “institutional providers” for purposes of application fee payment.

#### **D. Risk Levels for Provider Types Also Existing in Medicare**

##### **1. Regulations Used to Determine Medicaid Risk Categories**

Consistent with section 1902(kk)(1) of the Act, for provider types that exist in both Medicare and Medicaid, the SMA must assign providers to the same or higher risk category applicable under Medicare under 42 CFR § 424.518.

##### **a. Medicare Screening Levels that Apply to Medicaid**

Specifically, the SMA should rely on the following regulatory citations indicating the list of providers assigned to each Medicare risk categories:

- §424.518(a)(1) indicates providers the SMA must assign at a minimum to the “limited” risk category
- §424.518(b)(1) indicates providers the SMA must assign at a minimum to the “moderate” risk category
- §424.518(c)(1) indicates providers the SMA must assign at a minimum to the “high” risk category (please note that, specific to the “high” risk category, the next section describes that there is additional Medicaid-specific criteria a SMA must follow at 455.450(e))

A SMA may not assign a Medicaid provider to a risk category lower than that which Medicare has assigned to that same provider type.

If a provider potentially fits within more than one risk level, the highest screening level is applicable.

## 2. Providers Designated “Limited” Risk

“Limited” -- Section 424.518(a)(1) lists the following provider types under the “limited” risk category:

- 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 (ASCs)
- Competitive Acquisition Program/Part B Vendors
- End-stage renal disease facilities (ESRDs)
- Federally qualified health centers (FQHCs)
- Histocompatibility laboratories
- Hospitals, including critical access hospitals (CAHs), Department of Veterans Affairs hospitals, and other federally-owned hospital facilities

- Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act
- Mammography screening centers
- Mass immunization roster billers
- Organ procurement organizations (OPOs)
- Pharmacies newly enrolling or revalidating via the CMS-855B application
- Radiation therapy centers (RTCs)
- Religious non-medical health care institutions (RNHCIs)
- Rural health clinics (RHCs)
- Skilled nursing facilities (SNFs)

### 3. Providers Designated “Moderate” Risk

“Moderate” -- Section 424.518(b)(1) lists the following provider types under the “moderate” risk category:

- Ambulance service suppliers
- Community mental health centers (CMHCs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Hospice organizations
- Independent clinical laboratories (ICLs)
- Independent diagnostic testing facilities (IDTFs)
- Physical therapists enrolling as individuals or as group practices
- Portable x-ray suppliers (PXRSSs)

- Revalidating HHAs
- Revalidating DMEPOS suppliers

#### 4. Providers Designated “High” Risk

“High” risk can apply to individual or organizational providers. Two federal regulations, §§ 424.518(c) and 455.450(e), are used to indicate the providers and provider types the SMA must categorize as “high” risk. Section 424.518(c)(1) lists the following provider types under the “high” risk category:

- Prospective (newly enrolling) HHAs
- Prospective (newly enrolling) DMEPOS suppliers

Section 455.450(e) lists the provider types that must additionally be elevated to the “high” risk category. As provided in the regulation and prior clarifying guidance, the SMA must adjust the categorical risk level of a particular provider from “limited” or “moderate” to “high” when any of the following four situations occur:

- The SMA imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse. The provider’s risk remains “high” for 10 years beyond the date of the payment suspension.
- A provider that, upon applying for enrollment or revalidation, is found to have an existing State Medicaid Plan overpayment. The risk remains “high” while the provider continues to have an existing overpayment. 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

\*Note: The \$1500 threshold is an aggregate of all outstanding debts and interest, to include the principal overpayment balance amount and the accrued interest amount for a given provider.

- The provider has been excluded by the OIG or another state’s Medicaid Program within the previous 10 years.

- The SMA or CMS in the previous 6 months lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within 6 months from the date the moratorium was lifted.

## **E. Risk Levels for Medicaid-Only Providers**

There are certain provider types recognized by State Medicaid Plans but not Medicare; this means that they are not listed in § 424.518. The SMA is required to assign Medicaid-only categories of providers to an appropriate risk level.

In general, in order to assign appropriate risk levels – the SMA should examine its Medicaid Program to determine which of these provider types present an increased risk of fraud, waste or abuse to its Medicaid Program. The SMA is uniquely qualified to understand issues involved with balancing beneficiaries’ access to medical assistance and ensuring the fiscal integrity of the State Medicaid Program; thus, the SMA has the discretion to make its own risk level determinations concerning these provider types.

- For the Medicare Program, CMS was required under Section 1866(j)(2)(B) of the Act to determine the level of screening applicable to providers and suppliers according to the risk of fraud, waste, and abuse that CMS determined is posed by particular provider and supplier categories. CMS documented what was considered in making these determinations in the discussion beginning on page 5867 of the February 2, 2011 final rule. To review this discussion in the Federal Register, refer to Section II.A.3. “General Screening of Providers” (76 FR 5867). When assigning Medicaid-only providers to risk categories, we recommend the SMA assess risk using similar considerations as CMS used to assess risk in Medicare, potentially including, and not limited to audit reports, such as, but not limited to:
  - GAO or OIG final reports
  - Insight of law enforcement partners
  - Congressional testimony
  - Level of administrative enforcement actions for a particular provider type
  - Assessment of the level of state and federal oversight for a particular provider type
  - Assessment of the level of oversight by accrediting bodies

- Aggregate experience with a particular provider type.

## **1.4– Disclosures**

### **1.4.1-- Ownership and Control Interests (§§ 455.102 through 455.104)**

#### **A. General**

Federal regulatory provisions regarding disclosure of ownership and control interests are at Part 455, Subpart B (§§ 455.100 through 455.106).

Under § 455.103, a state plan must provide that the requirements of §§ 455.104 through 455.106 are met.

#### **B. Parties Subject to Disclosure Requirements (§ 455.104(a))**

Under § 455.104(a), the SMA must obtain disclosures from (1) disclosing entities, (2) fiscal agents, and (3) managed care entities (definitions of these three terms are in section 11.1.2 “Selected Definitions”).

Information on how the disclosure requirements at 455 Subpart B apply to individuals (e.g., owners, individuals in specific roles, etc.) within these parties is described under section “C. Information to Be Disclosed.”

#### **C. Information to Be Disclosed (§ 455.104(b))**

##### **1. Regulatory Requirements**

Under § 455.104(b), the SMA must require that disclosing entities, fiscal agents, and managed care entities disclose the following:

##### **a. Identifying Information regarding persons with ownership or control interests (§ 455.104(b)(1)):**

- The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include, as applicable, primary business address, every business location, and P.O. Box address.

- Date of birth and Social Security Number (SSN) of any individual with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity.
- Other tax identification number (TIN) (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

b. Ownership or control relationships (§ 455.104(b)(2)):

- Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling;
- Whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

c. Name of Any Other Disclosing Entity

- The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest (§ 455.104(b)(3)).

d. Managing Employee Disclosure

- The name, address, date of birth, and SSN of any managing employee of the disclosing entity (or fiscal agent or managed care entity) (§ 455.104(b)(4)).

Note that practitioners and groups of practitioners are not included within the definition of disclosing entities under 455.101 and thus are not required to provide disclosures pursuant to § 455.104.

There are not exceptions to the managing employee disclosure requirement. To the extent any individual meets the definition of “managing employee” under §455.101, their information is required to be disclosed.

## 2. Identifying Information: Individuals/Entities without TINs

### a. Process for Individuals/Entities without TINs

Consistent with Part 455 Subpart B, the TINs (employer identification numbers or social security numbers) of all entities and individuals with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity and all managing employees must be disclosed. If the SMA or its contractor receives an initial, reactivation, revalidation, or change of ownership application from a provider and the provider fails to disclose the TIN of a particular organization or individual, the SMA or its contractor shall follow normal development procedures for requesting the TIN. In doing so, if the SMA or its contractor learns or determines that the TIN was not furnished because the entity or individual in question does not have a TIN, CMS suggests (but does not require) that the SMA or its contractor use the following process:

- The SMA should ask the provider (via any means) whether the person or entity is able to obtain a TIN or, in the case of individuals, an individual taxpayer identification number (ITIN). Only one inquiry is needed.
- If the provider fails to respond to the SMA's inquiry within a state-determined timeframe, the SMA may deny the application.
- If the provider states that the person or entity is able to obtain a TIN or ITIN, the SMA should send an e-mail, fax, or letter to the provider stating that (i) the person or entity must obtain a TIN/ITIN and (ii) the provider must furnish the TIN/ITIN to the SMA.
- If the provider states that the person or entity is unable to obtain a TIN or ITIN, the SMA should send an e-mail, fax, or letter to the provider stating that (i) the provider must submit written documentation (in a form and manner to be determined by the SMA) to the SMA explaining why the person or entity cannot legally obtain a TIN or ITIN.
- If the provider submits the explanation described above, the SMA should determine whether the explanation is satisfactory. The state may choose to vet the entity or individual via other sources. If the explanation is not satisfactory, the SMA may deny the application as described below under b. "Denial of Enrollment for Individuals/Entities without TINs."

## b. Denial of Enrollment for Individuals/Entities without TINs

If the provider fails to timely respond to the contractor's inquiry in (a) or fails to timely furnish the TIN/ITIN, the SMA or its contractor shall reject the application in accordance with the procedures identified in this chapter, unless the SMA determines that termination or denial of enrollment is not in the best interests of the State Medicaid Plan and the SMA documents that determination in writing.

## 3. Ownership Disclosure: Determination of Ownership or Control Percentages

### a. Difference Between Direct and Indirect Ownership

A direct owner has an actual ownership interest in the disclosing entity (e.g., owns stock in the business, etc.), whereas an indirect owner has an ownership interest in an entity that, in turn, has an ownership interest in the disclosing entity. Many organizations that directly own a disclosing entity are themselves wholly or partly owned by other organizations (or even individuals). This may be the result of the use of holding companies and parent/subsidiary relationships.

When disclosures are required, an enrollment record must capture both direct and indirect owners. Indirect owners should not be listed under a separate enrollment. If a SMA uses a system to capture ownership interest information, the system should accommodate multiple layers of ownership within a single record of enrollment. The combination of indirect and direct ownership may be greater than 100 percent.

Consider the following example:

The provider listed on the Medicaid enrollment application is an ambulance company that is wholly (100 percent) owned by Company A. Company A is considered to be a direct owner of the provider (the ambulance company), in that it actually owns the assets of the business. Now assume that Company B owns 100 percent of Company A. Company B is considered an indirect owner - but an owner, nevertheless - of the provider. In other words, a direct owner has an actual ownership interest in the provider, whereas an indirect owner has an ownership interest in an organization that owns the provider.

### b. Determining Percentages of Ownership Interest (§ 455.102)

Under § 455.104(b), the SMA must require that disclosing entities, fiscal agents, and managed care entities disclose information including the name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. "Person with an ownership or control interest" is defined at §455.101 to include individuals or corporations that have a direct, indirect, or a combination of direct and

indirect ownership interest totaling 5 percent or more in a disclosing entity. This interest includes any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity.

The federal regulation at §455.102 describes how the SMA must determine percentages of ownership interest, as follows:

i. Indirect Ownership Interest (§ 455.102(a))

The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

ii. Person with an Ownership or Control Interest (§ 455.102(b))

Ownership interest also includes interests in mortgages, deeds of trust, notes, and other obligations. An organization or individual that has a 5 percent or greater whole or part interest in any mortgage, deed of trust, note, security interest, or other obligation secured (in whole or in part) by the provider or any of the property or assets of the provider must be disclosed under § 455.104(b). This frequently will include banks, other financial institutions, and investment firms.

In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. If B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and needs not be reported.

c. Publicly Traded Entities

There is not an exception for publicly traded entities.

#### d. Non-Profit Entities

Non-profit entities generally do not have owners unless state law permits such ownership. However, if a non-profit entity has managing employees, to the extent these individuals meet the definition of “managing employee” under § 455.101; they would have to be disclosed as such. In addition, as discussed further below, entities, including non-profit entities, that are organized as corporations must provide disclosures regarding their officers and directors.

#### e. Government-Owned Entities

There is not an exception for government-owned entities. Government-owned entities likewise need to disclose anyone meeting the definition of “managing employee,” and would only need to disclose board members if the entity was organized as a corporation or if that individual meets the definition of “managing employee.” See 1.4.C.1.d “Managing Employee Disclosure.”

#### f. American Indian and Alaska Native (AI/AN) Entities

There is not an exception for organizations owned by AI/AN individuals or health care facilities owned and operated by AI/AN tribes and tribal organizations. AI/AN and tribal entities would need to disclose anyone meeting the definition of “managing employee,” and would only need to disclose Board members if the entity was organized as a corporation. See 1.4.C.1.d “Managing Employee Disclosure.”

### 4. Additional Guidance Regarding Individuals with Control Interests

Under § 455.101, a person with an ownership or control interest includes (1) an officer or director of a disclosing entity that is organized as a corporation; and (2) a partner in a disclosing entity that is organized as a partnership.

#### a. Officers/Directors

##### i. Corporations Only

For purposes of Part 455, Subpart B, persons with ownership or control of a disclosing entity includes “officers” and “directors” only if the disclosing entity is organized as a corporation. This includes for-profit corporations, non-profit corporations, closely-held corporations, limited liability corporations, and any other type of corporation authorized under state law.

##### ii. Board Members

In this context, the term “director” refers to members of the board of directors of a corporation. If a corporation has, for instance, a Director of Finance who is not a member of

the board of directors, he/she would not need to be disclosed as a director/board member. However, as discussed in section C., below, to the extent he/she meets the definition of “managing employee” under § 455.101; he/she would have to be disclosed as a “managing employee.”

### iii. Numbers/Volunteers

All officers and directors must be disclosed, regardless of their number (e.g., 100 board members) and even if they serve in a voluntary (e.g., unpaid) capacity. Also, if a non-profit corporation has “trustees” instead of officers or directors, these trustees must be disclosed.

### iv. Indirect Levels

Only officers and directors of the disclosing entity, fiscal agent, or managed care entity must be disclosed as such. Officers and directors (e.g., board members) of the entity’s indirect owners need not be disclosed as such. However, there may be situations where the officers and directors/board members of the enrolling provider’s corporate owner/parent also serve as the enrolling provider’s officers or directors/board members. In such cases – and again assuming that the provider is a corporation – the indirect owner’s officers or directors/board members would have to be disclosed as persons with ownership or control interests in the provider.

## b. Partners

### i. General and Limited Partnership Interests

All general and limited partnership interests must be disclosed, regardless of the percentage.

### ii. Limit on Partnership Interest Disclosure

Only partnership interests in the disclosing entity need be disclosed. Partnership interests in the entity’s indirect owners need not be reported. However, if the partnership interest in the indirect owner results in a greater than 5 percent indirect ownership interest in the disclosing entity, this indirect ownership interest must be disclosed.

## c. Disclosure by Individuals in Other Capacity

It is important to remember that although an individual or entity may not qualify as an officer, director, or partner and need not be disclosed as a person with an ownership or control interest in the disclosing entity, the party may have to be disclosed in another capacity. Using our earlier example concerning the Director of Finance, he/she may not be a corporate officer or director/board member; however, if he/she qualifies as an owner or managing employee (see section 1.4.1.C.1.d “Managing Employee Disclosure”) he/she would have to be disclosed.

#### **D. When Disclosure Is Required (§ 455.104(c))**

Under § 455.104(d), all disclosures must be provided to the SMA, and under § 455.104(e), FFP is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by § 455.104.

##### **1. Providers or Other Disclosing Entities (§ 455.104(c)(1))**

Disclosure from any provider or other disclosing entity is due at any of the following times:

- Upon the provider or other disclosing entity submitting the provider application.
- Upon the provider or other disclosing entity executing the provider agreement.
- Upon request of the SMA during revalidation under § 455.414.
- Within 35 days after any change in ownership of the disclosing entity.

##### **2. Fiscal Agents (§ 455.104(c)(2))**

Disclosures from fiscal agents are due at any of the following times:

- Upon the fiscal agent submitting the proposal in accordance with the state's procurement process.
- Upon the fiscal agent executing the contract with the state.
- Upon renewal or extension of the contract.
- Within 35 days after any change in ownership of the fiscal agent.

##### **3. Managed Care Entities (§ 455.104(c)(3))**

Disclosures from managed care entities (MCOs, Prepaid Inpatient Health Plans, Prepaid Ambulatory Health Plans, and Health Insuring Organizations), except Primary Care Case Managers (PCCMs), are due at any of the following times:

- Upon the managed care entity submitting the proposal in accordance with the state's procurement process.
- Upon the managed care entity executing the contract with the state.

- Upon renewal or extension of the contract.
- Within 35 days after any change in ownership of the managed care entity.

#### 4. PCCMs (§ 455.104(c)(4))

PCCMs must comply with the disclosure requirements applicable to providers or disclosing entities, as described above.

### **1.4.2 – Business Transactions (§ 455.105)**

Under § 455.105(a), A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with 455.105(b).

Under § 455.105(b), a provider must submit, within 35 days of the date of a request by CMS or the SMA, full and complete information about—

- The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request (§ 455.105(b)(1)); and
- Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request (§ 455.105(b)(2)).

Per § 455.105(c), FFP is not available in expenditures for services furnished by providers that fail to comply with a request made by CMS or the SMA under § 455.105(b) or under 42 CFR § 420.205; FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to CMS or the SMA and ending on the day before the date on which the information was supplied.

### **1.4.3 – Criminal Convictions (§ 455.106)**

Under § 455.106, all providers are subject to the SMA's requirement to disclose the identity of certain persons with criminal convictions (see Section 1.4.3.A below). This provision differs from the criminal background check requirement at §455.434. Under §455.434, the SMA is required to require certain persons to consent to criminal background checks and submit a set of fingerprints upon request, for the purpose of conducting a criminal background check. See

1.5.4 “Screening Activities by Category” and 1.5.5.4 “Fingerprinting/Criminal Background Checks” for additional discussion of these requirements.

#### **A. General Disclosure Requirements (§ 455.106(a))**

Under § 455.106(a), the provider must disclose to the SMA any individual who meets both of the following requirements:

- Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
- Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX (Social Services), since the inception of those programs.

This information must be disclosed before the SMA enters into or renews a provider agreement, or at any time upon the SMA’s written request.

#### **B. Notification to Inspector General (§ 455.106(b))**

Under § 455.106(b):

- The SMA must notify the OIG of any disclosures made under § 455.106(a) within 20 working days from the date it receives the information.
- The SMA must also promptly notify the OIG of any action it takes on the provider's application for participation in the program, whether approval or disapproval.

#### **C. Denial/Termination**

Under § 455.106(c):

- The SMA may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or Title XX.
- The SMA may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under § 455.106(a).

## 1. Additional Regulatory Authority for Denials/Terminations Under 455 Subpart E

This section covers the regulatory authority available under 455 Subpart B for a SMA to refuse to enter into a provider agreement. Additional authorities are provided for a SMA to deny or terminate a provider agreement under 455 Subpart E. Refer to §455.416 and Section 1.89 “Denials” and 1.910 “Terminations” of this compendium.

## 2. Regulatory Authority to Set Reasonable Standards Relating to the Qualifications of Providers

Under § 431.51(c)(2), the State Medicaid Plan has the authority to set reasonable standards relating to the qualifications of providers.

### **1.5 –Enrollment and Screening – General Requirements (§ 455.410(a))**

Under § 455.410, the SMA:

- (a) Must require all participating providers to be screened in accordance with the requirements of §§ 455.412 through 455.450.
- (b) Must require all ordering or referring physicians or other professionals, who order, refer, and/or prescribe services for Medicaid beneficiaries under the state plan or under a waiver of the plan to be enrolled as participating providers.
- (c) May rely on the results of the provider screening performed by any of the following:
  - (1) Medicare contractors.
  - (2) Medicaid agencies or Children's Health Insurance Programs of other states.

#### **A. Screening by Medicare or its Contractors**

Under § 455.410(c)(1) “Medicare contractors” can include screening by either CMS or its contractors.

### **1.5.1 Enrollment Requirements for Specific Provider Categories**

#### **A. Enrollment of Providers in Networks of Medicaid Risk-Based Managed Care Plans**

Under current CMS policy, providers participating in the networks of risk-based Medicaid MCOs are not required to enroll in a state’s Medicaid Program. (See 76 FR 5904- 5906, February 2,

2011). Thus, if the SMA does not require risk-based MCO network providers to enroll as participating providers in Medicaid, the Part 455 screening requirements do not apply. However, if a state requires network providers in risk-based MCOs to enroll as participating providers, the Part 455 screening requirements apply to those providers.

## **B. Ordering and Referring Physicians and Other Professionals (ORP)**

### **1. When the SMA Must Enroll ORPs**

The definition of ORP is covered in Section 1.3.

Under § 455.410(b), the SMA 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.

Under this provision, the SMA must require enrollment by all providers that, order, refer, or prescribe services or items for Medicaid beneficiaries that are payable or covered by Medicaid. As discussed below, this requirement only applies to provider types that are eligible to enroll under the State plan.

An individual who is already enrolled in Medicaid as a participating provider does not need to submit a separate application to continue ordering, referring, or prescribing services or items. Conversely, enrollment in Medicaid does not require an ordering, referring, or prescribing physician or other professional to become a rendering provider – i.e., to furnish and bill for services to Medicaid beneficiaries.

Please refer to section 1.6 “Claims Processing” for a discussion of the requirement to deny claims that do not carry the NPI of the ORP as required under § 455.440.

#### **a. Enrollment of Out-of-State ORPs**

The requirement to enroll ORPs and deny claims that do not have the NPI of an enrolled ORP applies equally to out-of-state ORPs.

**EXAMPLE:** A beneficiary receives services from an out-of-state emergency room or hospital, and a physician or other professional at the emergency room or hospital writes a prescription upon discharge. That physician/professional must be enrolled (either as a rendering provider or as an ordering/referring/prescribing one) in the Medicaid Program in which the beneficiary is enrolled in order for the beneficiary’s State Medicaid Plan to cover the ordered/referred/prescribed service/item/drug.

## b. Enrollment of Veterans Administration (VA) or Indian Health Services (IHS) Providers

The requirement to enroll ORP providers and deny claims that do not have the NPI of an enrolled ORP applies equally to providers without respect to their employer.

EXAMPLE: A Medicaid beneficiary receives services from a provider employed by, for example, a VA or IHS facility. If the VA or IHS physician/professional orders, refers, or prescribes the beneficiary additional services or items payable by Medicaid FFS, that ORP must be enrolled in the beneficiary's State Medicaid Plan in order for the claim for the ordered, referred, or prescribed services to be paid.

## c. Enrollment of Contracted Hospitalists or Emergency Room Physicians

Many Medicaid-enrolled hospitals employ hospitalists or contracted emergency room physicians who are not separately enrolled as Medicaid providers. Services/items/prescriptions that are ordered/referred/written by these hospitalists/contracted physicians are ineligible for payment unless the hospitalist/physician is enrolled in Medicaid.

## 2. ORPs Ineligible to Enroll in a Particular State's Medicaid Program

To the extent a provider type is not eligible to enroll in a State's Medicaid Program, the SMA is not required to begin to enroll that provider type for purposes of complying with §§ 455.410(b) or 455.440.

In a situation where an ordering, referring, or prescribing practitioner is eligible to enroll in the state's Medicaid Program, it is not permissible to submit claims with an organizational NPI appearing in place of that individual's NPI. For example, if a hospital submits a claim with the hospital's NPI in the ordering/referring field and the services were ordered, referred, or prescribed by a provider type that is eligible to enroll in the state's Medicaid Program, the claim is not compliant under § 455.440 and must be denied.

## **1.5.2 – When Screening is Required**

### **A. General**

Under § 455.450, the SMA must screen all initial applications, including applications for a new practice location, and any applications received in response to a reenrollment or revalidation of enrollment request based on a categorical risk level of "limited," "moderate," or "high." The SMA has substantial discretion in how it performs and completes each required screening activity.

## **B. Screening Upon New Enrollment**

The SMA must screen providers upon receipt of an initial enrollment application and the SMA must complete all screening activities prior to approving the enrollment.

## **C. Screening for Practice Locations**

### **1. Practice Location - New Enrollment**

The SMA conducts full screening upon new enrollment, including a site visit when the provider is categorized as a “moderate” or “high” risk category provider. See 1.5.3 “Site Visits” and 1.5.4 “Screening Activities by Category.”

### **2. Addition of a Practice Location to an Existing Enrollment**

If the SMA permits a new practice location to be added under an existing enrollment, when the practice location is added to a “moderate” or “high” risk category enrollment, the SMA must conduct a site visit for the newly added location but a full rescreening of the enrollment is not required.

## **D. Screening Upon Revalidation**

The SMA must screen providers upon receipt of an application for revalidation.

Consistent with § 455.414, the SMA (beginning March 25, 2011) must complete revalidation of enrollment for all providers, regardless of provider type, at least every five years (this includes ordering or referring physicians or other professionals). The SMA has the discretion to require revalidation on a more frequent basis.

In revalidating a provider’s enrollment, the SMA must conduct a full screening appropriate to the provider’s risk level. The risk-based screening requirements under § 455.450 that apply to a newly enrolling or reenrolling provider also apply to revalidation. Revalidation includes the disclosure requirements specified in §§ 455.104, 455.105, and 455.106, and, depending on the provider’s risk level, includes site visits and FCBCs.

When revalidating a provider, the SMA may rely on Medicare or another state’s screening as described in the sections below.

## **E. Screening Upon “Reenrollment” or “Reactivation”**

The SMA must screen providers upon receipt of an application for reenrollment or reactivation.

Reenrollment occurs when a provider has been terminated, deactivated, or otherwise removed as a state Medicaid provider and seeks to reestablish/reactivate its enrollment. A reenrollment is essentially a new enrollment; in other words, a SMA reenrolling a provider must follow the same steps that it would if the provider were newly enrolling. The fact that a provider is reenrolling does not lessen the requirements for the SMA to conduct provider screening and enrollment on that provider the same way the state would conduct the screening for any newly enrolling provider.

Reactivation occurs when a provider's enrollment number is deactivated for any reason. As with reenrollment, reactivation requires the SMA to follow the same steps that it would if the provider were newly enrolling. Section 455.420 addresses reactivation of provider enrollment. If a provider's enrollment has been deactivated for any reason and the provider seeks to reactivate its enrollment, the SMA must rescreen the provider using risk-based screening under § 455.450.

#### **F. Screening: Timeliness**

CMS does not have a required timeframe for screening a particular application for enrollment, reenrollment, reactivation, or revalidation of enrollment, or for conducting associated activities (e.g., site visit in the case of "moderate" or "high" risk providers). However, the SMA may *not* enroll, reenroll, reactivate, or revalidate the enrollment of a provider until it has completed all of the screening activities applicable to that provider. SMAs are encouraged to avoid unnecessary delays in application screening.

### **1.5.3 –Screening Process (§ 455.450)**

For a discussion of the components of screening (site visit, etc.) please refer to section 1.5.5, "Principal Components of Screening."

#### **A. Use of Disclosure Information in Screening**

Under 455 Subpart B, providers disclose information to the SMA. The SMA uses the information collected to conduct some of the required screening activities under Subpart E. For example, the SMA uses the SSNs disclosed to complete the required database checks at § 455.436.

As a best practice, CMS recommends screening the information disclosed by an organizational provider under § 455.104 against data available from state business licensure boards.

## 1. Instructions for Relying on Revalidation Conducted by Medicare

Under certain circumstances, the SMA may rely on the screening conducted in connection with Medicare's revalidation or enrollment process in place of its own screening. The SMA remains responsible to collect its own disclosures required under 42 CFR 455 Subpart B; the SMA cannot rely on Medicare to collect disclosures in its stead. The SMA must maintain its own provider agreements.

In general, the SMA may rely upon Medicare screening to the extent Medicare has screened the same provider. To rely on Medicare screening in place of its own, the SMA must verify the following conditions are met:

- The date of Medicare's last screening of the subject provider must have occurred on or after March 25, 2011.
- The provider must be the "same" in Medicaid and Medicare. A provider is the same when the SMA is able to match the applicable data elements shown in Table 1 under the section "Instructions for relying on provider screening conducted by Medicare (42 CFR § 455.410) or conducting additional screening when required."
- The Medicare enrollment must be in an "approved" status.
- The Medicare risk category must equal or exceed the Medicaid risk category for that provider.

## 2. Form and Manner of SMA's Revalidation

The SMA has the discretion to:

- Require or permit paper and/or on-line revalidation
- Pre-populate revalidation applications
- Use any means it chooses to notify providers to revalidate

### **B. Other State Screening Methods**

#### 1. SMA Bears Responsibility for Screening Activities Delegated to its Contractors

For the provider screening requirements under Subpart E and based on the disclosures under Subpart B, to the extent that a SMA delegates responsibility for provider screening and

enrollment to a contractor, the SMA remains fully responsible for compliance with the requirements at Subpart B and Subpart E.

## 2. State Discretion to Apply Higher Risk Level and/or Conduct Additional Activities

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.

For example, a SMA has the discretion to:

- Perform verification activities in addition to (but not in lieu of) those mentioned in Part 455 Subpart E.
- Impose requirements on providers in addition to those outlined in Part 455 Subpart E (assuming they are not inconsistent therewith). For instance, a SMA may require certain providers to obtain liability insurance, have a period of provisional or trial enrollment as a means of ensuring that the provider can remain compliant with state and federal rules, etc.
- Apply a higher screening level than that which Medicare applies. Should a SMA choose to elevate a provider's risk category, all required screening activities according to that category must be completed.
- Conduct additional screening activities beyond what Subpart E requires.
- Conduct required screening activities in a manner more stringent than how Medicare or another SMA conducts the same required screening activity (for example, a more comprehensive site visit).

## 3. Reliance on Screening Performed by Another Agency

### a. Required Database Checks Under § 455.436

The SMA may rely on the enrollment screening conducted by Medicare or another State, but may not rely on Medicare or another State's Medicaid Plan to fulfill its own monthly database checks required under § 455.436(c)(2).

### b. Instructions for Relying on Provider Screening Conducted by Medicare (42 CFR § 455.410) or Conducting Additional Screening When Required

Under federal regulations at § 455.410, SMAs must require all enrolled providers to be screened based on the level of risk of fraud, waste, or abuse to the State Medicaid Plan. In

conducting risk-based screening of providers enrolled in both Medicare and Medicaid, SMAs may, but are not required to, rely on the results of screening performed by Medicare or its contractors. All references to Medicare screening are inclusive of screening by Medicare's contractors. This guidance describes how a SMA may rely on Medicare's screening.

The SMA may rely upon the results of a provider screening performed by Medicare (§ 455.410(c)(1)) using one of the following scenarios:

Scenario 1. Relying on an "approved" Medicare status without verifying each screening activity

To rely on PECOS in this scenario, the SMA verifies:

- A positive match (defined in the "Positive Match" section below) of the provider applying for Medicaid enrollment against the information in Medicare's enrollment record, and
- An "approved" Medicare enrollment status, and
- Medicare's screening risk category for the provider (i.e., "limited," "moderate or "high"), and;
- The date of Medicare's most recent revalidation occurs on or after March 25, 2011.

Under Scenario 1, the SMA can rely on Medicare's screening to include all screening activities up to and included in a particular risk category, regardless of whether Medicare's enrollment record reflects a particular activity was completed.

Scenario 2. SMA verifies that discrete screening activities are reflected in Medicare's enrollment records

To rely upon Medicare's screening activity in this scenario, the SMA verifies, for an individual or organizational provider:

- A positive match of a provider applying for Medicaid enrollment against the information in a Medicare enrollment record, and
- An "approved" Medicare enrollment status, and
- The Medicare enrollment record reflects a specific required screening activity that occurred on or after March 25, 2011.

To rely on Medicare’s fingerprint-based criminal background check (FCBC) result of a 5 percent or more owner under Scenario 2, the SMA verifies:

- A positive match of the 5 percent or more owner applying for Medicaid enrollment within any Medicare enrollment record, and
- The enrollment record listing the 5 percent or more owner is in an “approved” status, and;
- The Medicare enrollment record reflects the FCBC with a “Completed PASS” result.

Under Scenario 2, the SMA can rely on individual screening elements Medicare has completed to the extent those activities are reflected as completed in the Medicare enrollment record.

Table 1: Minimum Required Data Elements to Compare

	Risk Category	Name <sup>1</sup>	NPI	SSN <sup>2</sup> (Last 4 digits)	TIN	Practice Location(s)	All 5% or more owners <sup>2</sup>
Individual Provider	“Limited”	X	X	X			
	“Moderate”	X	X	X		X	
	“High”	X	X	X		X	
Organizational Provider	“Limited”	X			X		X
	“Moderate”	X			X	X	X
	“High” <sup>3</sup>	X			X	X	X

<sup>1</sup> The SMA will use its discretion to determine a name match (John W. Smith vs. John Wilkes Smith, etc.).

<sup>2</sup> For individual providers and each 5 percent or more owner, the SMA must confirm a positive match by comparing name and last 4 digits of SSN.

<sup>3</sup> In Medicare, newly enrolling “high” risk providers (HHA and DMEPOS) subsequently drop to the “moderate” risk category upon successful Medicare enrollment.

In order to rely upon Medicare’s screening, the SMA must make a positive match of the provider applying for Medicaid enrollment against the information in PECOS. Under § 455.452, the SMA can establish methods in addition to or more stringent than those required herein.

To confirm a match, the SMA should use the Table 1 above to identify which data elements are minimally required to match based on provider types and provider risk screening levels. An “X” in the table designates minimum data elements that must match in PECOS for the SMA to consider the provider a positive match. Only when a provider is a positive match may a SMA use the “approved” status and risk category (i.e. “limited,” “moderate” or “high”) information

to determine whether it can rely on Medicare’s screening as described in the two scenarios above.

**"Approved" Medicare enrollment status**

The subject provider must be active in Medicare, as indicated by an “approved” Medicare enrollment status.

**Risk Category confirmation**

The SMA must verify the risk category for a provider’s Medicare enrollment.

Because a risk screening category corresponds to a list of required screening activities for that category, once the SMA confirms the information above, it may rely on Medicare to complete all screening requirements that correspond to the particular risk category. For example, if a provider is in a Medicare “moderate” risk screening category, the SMA may rely on an “approved” enrollment status to fulfill all of its own required screening activities up to and including all those activities that correspond to the “moderate” risk category, regardless of whether or when Medicare conducted the screening activities.

If a SMA enrolls a Medicaid provider in a screening category that exceeds Medicare’s, the SMA must either confirm Medicare or another state has performed the required screening activity based on the incremental increase in risk category or the SMA must itself conduct that incremental screening activity, as indicated in Table 2 below. For example, if a Medicare “moderate” risk provider is enrolled in Medicaid in a “high” risk category, the SMA must confirm Medicare or another state has conducted the additional screening required for a provider in a “high” risk screening category (in this case, an FCBC) or else the SMA must conduct the FCBC itself.

Table 2: Risk Category Differences that Require the SMA to Conduct Additional Screening

<b>Medicaid Risk Category</b>	<b>Medicare Risk Category</b>	<b>SMA required to conduct additional Screening</b>
“Limited”	“Limited”	None
“Limited”	“High”*	None
“Moderate”	“Limited”	State must conduct: Site Visit
“Moderate”	“Moderate”	None
“Moderate”	“High”	None
“High”	“Limited”	State must conduct: Site Visit and FCBC
“High”	“Moderate”	State must conduct: FCBC
“High”	“High”	None

\* Note: this scenario would mainly occur when Medicare imposes a payment suspension on a provider which demands Medicare bump that provider up under §424.518; however, a State Medicaid Plan is not required to bump providers up to “high” risk based on Medicare payment suspensions.

## Examples

Example 1. The SMA receives a new enrollment application from an individual provider. The provider is in a “limited” risk category and is in an “approved” PECOS status. The SMA confirms the provider’s name, NPI, and last 4 digits of SSN match with what is in PECOS. The SMA may rely on Medicare’s screening activities that correspond to the “limited” risk category.

Example 2. The SMA receives a revalidation application from a home health agency (HHA). The SMA revalidates its HHA organizational providers in the “moderate” risk category (as does Medicare). Using the table above, the SMA compares the following data elements in PECOS to establish a positive match: Name, NPI, TIN, Practice Location(s), and 5 percent or more owners.

Because the subject HHA is “approved” in PECOS and the SMA confirms the HHA is in a “moderate” risk category in PECOS, the SMA is able to rely on Medicare’s screening to fulfill its own screening requirements. The SMA would not collect an application fee from the HHA.

Example 3. The SMA receives a new enrollment application for a DME provider. The SMA enrolls new DME organizational providers in the “high” risk category. Using the table, the SMA compares the following data elements to PECOS to establish a positive match: Name, NPI, TIN, Practice Location(s), and 5 percent or more owners. The SMA determines the DME is “approved” in PECOS. Because the DME is in a Medicare “moderate” risk category, the SMA is able to rely on Medicare’s screening activities up to and including those corresponding to the

“moderate” risk category. The SMA is not able to rely on Medicare’s screening to substitute for the screening activity additionally required for a provider in the “high” risk category (i.e., the FCBC), unless the SMA can verify Medicare conducted that screening (FCBC). The SMA checks PECOS to determine whether Medicare conducted a FCBC on the 5 percent or more owners. If no Medicare FCBC activity is reflected in PECOS, the SMA must conduct the FCBC to complete the required screening.

Example 4. The SMA in State A receives a new enrollment application from a DME provider. State A’s SMA finds that it is unable to rely on Medicare’s FCBC; therefore, State A must conduct the FCBC. Because the DME provider is based in another State (State B), State A reaches out to State B’s SMA. State B’s SMA confirms that the DME’s enrollment pre-dated the August 1, 2015 FCBC requirement’s effective date, and the provider is enrolled in State B as a “moderate” risk category provider. Because State B confirms no “high” risk screening activity was conducted for the DME enrollment, State A must therefore impose and conduct the FCBC requirement on all 5 percent or more owners of the newly enrolling DME.

d. Instructions for Relying on Provider Screening Conducted by Another State’s Medicaid Program (§ 455.410(c)(2)) or Conducting Additional Screening When Required

The SMA may, but is not required to, rely on provider screening performed by another state’s Medicaid Program. Specifically, under § 455.410(c), if a provider is enrolled and in good standing with another state’s Medicaid Program, the SMA may rely on that enrollment to meet the screening and enrollment requirements regarding rendering providers (§ 455.410(a)) and ordering or referring providers (§ 455.410(b)).

When relying on another State’s Medicaid Plan, the SMA must:

Document that it confirmed the other state’s Medicaid Program performed each required screening activity.

Confirm the provider is in an approved enrollment status.

Confirm the most recent date the other state’s Medicaid Program enrolled or revalidated the subject provider. If the other state did not enroll or has not revalidated the provider within the previous five years, the SMA may not rely on screening of that provider conducted by the other state’s Medicaid Program.

The enrolling SMA bears the responsibility to fulfill any screening activities required to satisfy its own requirements to enroll a provider based on that provider’s risk level at the time of enrollment or revalidation. For example, if a SMA is enrolling a provider in a “high” risk

category, and another state has already enrolled the same provider but did not conduct an FCBC, it is not appropriate to make a request to the other state that they conduct an FCBC. It is the responsibility of the enrolling agency to conduct any additional screening activities required to fulfill any outstanding screening activities.

A SMA is not required to rely on screening activities performed by another state's Medicaid Program, and may instead choose to conduct its own. Nonetheless, if a SMA chooses to rely on a screening activity conducted by another state's Medicaid Program, there is no requirement for the SMA to evaluate how a particular activity was conducted by another state's Medicaid Program, in order to rely on it. For example, if a SMA confirms another state's Medicaid Program conducted a site visit, but the SMA learns the other state's site visit is comprised of a set of activities that are determined to be less stringent than the SMA's own site visit activities, the SMA may nonetheless rely on that other state's site visit to fulfill its own requirement to conduct a site visit. The regulations at Subpart E leave wide discretion to the SMA in how it chooses to conduct screening activities that fulfill the requirements, keeping in mind the purpose for the requirements are to mitigate the risk of improper payments based on fraud, waste, and abuse.

## **1.5.4 Screening Activities by Category**

### **A. Required Screening Activities in Subpart E**

Required screening activities are based on a provider's risk category, as follows:

#### 1. "Limited" Categorical Risk (§ 455.450(a))

For providers in the "limited" risk category, the SMA must:

- Verify that the provider meets any applicable federal regulations or state requirements for the provider type prior to making an enrollment determination. (§ 455.450(a)(1))
- Conduct license verifications, including state licensure verifications in states other than where the provider is enrolling, in accordance with § 455.412. (§ 455.450(a)(2))
- Conduct database checks on a pre- and post-enrollment basis to ensure that providers initially meet and continue to meet the enrollment criteria for their provider type, in accordance with § 455.436. (§ 455.450(a)(3))

## 2. “Moderate” Categorical Risk

For all providers in the “moderate” risk category, the SMA must:

- Perform the “limited” screening requirements described in § 455.450(a). (§ 455.450(b)(1))
- Conduct on-site visits in accordance with § 455.432. (§ 455.450(b)(2))

## 3. “High” Categorical Risk (§ 455.450(c))

For providers in the “high” risk category, the SMA must:

- Perform the “limited” and “moderate” screening requirements described in (§ 455.450(a) and (b)). (§ 455.450(c)(1))
- Conduct a criminal background check. (§ 455.450(c)(2)(i))
- Require the submission of a set of fingerprints in accordance with § 455.434. (§ 455.450(c)(2)(ii))

### a. Providers elevated to “High” Risk Under § 455.450(e)

The SMA is required to elevate a provider’s screening category in certain circumstances as described in Section 1.3.D, “Risk Levels for Provider Types Also Existing in Medicare.” The SMA must conduct any additional required screening upon increasing the risk level. For example, a SMA should not bump a provider up to a “high” risk screening category and also wait until that provider’s next scheduled revalidation to conduct an FCBC. Upon bumping a provider to high risk, the SMA must, within 90 days:

- Notify the “high” risk provider subject to the FCBC requirement;
- Collect fingerprints and use the fingerprints to verify whether the provider has a state or national criminal history;
- Take any necessary termination action based on the criminal history data, or document in writing why that termination is not in the best interest of the Medicaid Program (documentation must be made upon the state’s determination to not terminate. “Upon” is defined here as within 60 days of the provider’s noncompliance and the SMA’s decision to retain the provider); and,
- Update the provider’s enrollment record to reflect FCBC status.

Note that an approved CMS FCBC Compliance plan under 2016-002, “Sub Regulatory Guidance for State Medicaid Agencies (SMA): Fingerprint-based Criminal Background Checks (FCBC), supersedes the guidance in this section. The guidance in this section is in force upon the date that the State Medicaid Plan is expected to be in full compliance under the CMS-approved FCBC compliance plan.

## **1.5.5 Principal Components of Screening**

### **1.5.5.1 – Licensure Review**

Under § 455.412, the SMA must:

- Have a method for verifying that any provider purporting to be licensed in accordance with state law is licensed by said state, and
- Confirm that the provider's license has not expired and that there are no current limitations on the provider's license in any state in which the provider is licensed.

### **1.5.5.2 - Federal Database Reviews**

#### **A. Compliance**

Under § 455.436, the SMA must do all of the following:

- Confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of federal databases. (§ 455.436(a))
- Check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS) (now known as the System for Award Management (SAM)), and any such other databases that CMS may prescribe through regulation. (§ 455.436(b))
- Consult appropriate databases to confirm identity upon enrollment and reenrollment. (§ 455.436(c)(1))
- Check the LEIE and SAM no less frequently than monthly. (§ 455.436(c)(2))

The purpose of the monthly checks of the LEIE and SAM/EPLS under § 455.436(c)(2) is to ensure that enrolled providers, and any person with an ownership or control interest or who is an agent or managing employee of the provider, has not been excluded from Medicare or Medicaid, and has not been excluded from receiving federal contracts.

As described in Section 3.c. “Required database checks under § 455.436,” the SMA may not rely on Medicare or another state’s Medicaid Program to fulfill its own monthly database checks required under § 455.436(c)(2).

### **1.5.5.3 – Site Visits**

#### **A. Site Visits: General**

Under § 455.432, the SMA must:

- Conduct pre-enrollment and post-enrollment site visits of providers that are included in the “moderate” or “high” screening levels in Medicaid. The purpose of the site visit is to verify that the information submitted to the SMA is accurate and to determine compliance with federal and state enrollment requirements. (§ 455.432(a))
- Require any enrolled provider to permit CMS, its agents, its designated contractors, or the SMA to conduct unannounced on-site inspections of any and all provider locations. (§ 455.432(b))

#### **B. Site Visits: Risk-Based Screening**

The conduct of on-site visits is one element of compliance of the risk-based screening requirement under § 455.450. Under § 455.450(b)(2) and (c)(1), the SMA must conduct on-site visits in accordance with § 455.432 when screening providers that the agency has designated as “moderate” or “high” categorical risk.

##### **1. Combining Site Visits**

Site visits that comply with § 455.432 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.

## 2. Site Visits: Announced Versus Unannounced

A site visit that complies with § 455.432 is **not** required to be conducted unannounced, although States must require enrolled providers to permit unannounced on-site inspections.

### **C. Site Visits: Provider Fails to Permit Access**

Under § 455.416(f), the SMA must terminate or deny enrollment if the provider fails to permit access to a location for a site visit under § 455.432, unless the SMA determines that termination or denial is not in the State Medicaid Program's best interests and documents that determination in writing.

### **D. Site Visits: Physical Therapists in Private Practice**

- Under § 424.518, physical therapists in private practice are in the "moderate" screening category for Medicare enrollment purposes and are thus subject to site visits as part of their screening. However, it should be noted that if an entity is enrolled or enrolling as a physician practice and employs a physical therapist within the practice, the practice itself falls within the "limited" screening category (unless the state determines otherwise or the practice's risk status is adjusted upward). This is because the entity is enrolled as a physician practice, not a physical therapy group in private practice.
- If a newly enrolling private practice physical therapist lists several practice locations under a single enrollment ID, the SMA has the discretion to determine the location at which the state (or state's contractor) will perform the site visit.
- If the SMA chooses a location, from the locations listed on the provider's enrollment or revalidation application that is listed in PECOS, an onsite by the SMA is not required.
- If the private practice physical therapist's practice location is his or her home address and he/she exclusively performs services in patients' homes, nursing homes, etc., no site visit is necessary.

### **E. Activities that Constitute a Site Visit**

#### 1. Background

Per § 455.432(a), a site visit is designed to verify that the information submitted to the SMA is accurate and to determine compliance with federal and state enrollment requirements. Within this broad framework, the SMA has discretion to determine how it conducts site visits.

## **1.5.5.4 – Fingerprinting/Criminal Background Checks**

### **A. General**

#### **1. Background**

Under § 455.434, the SMA:

- As a condition of enrollment, must require providers to consent to criminal background checks (including fingerprinting) when required to do so under state law or by the applicable level of screening. (§ 455.434(a))
- Must establish categorical risk levels for providers and provider categories who pose an increased financial risk of fraud, waste or abuse to the State Medicaid Program. (§ 455.434(b))
- Upon the SMA determining that a provider, or a person with a 5 percent or more direct or indirect ownership interest in the provider, meets the SMA’s criteria for criminal background checks as a “high” risk to the State Medicaid Program, the SMA will require that each such provider or person submit fingerprints. (§ 455.434(b)(1))
- The SMA must require a provider, or any person with a 5 percent or more direct or indirect ownership interest in the provider, to submit a set of fingerprints, in a form and manner to be determined by the SMA, within 30 days upon request from CMS or the SMA. (§ 455.434(b)(2))

### **B. Collection of Fingerprints and Performance of Criminal Background Checks**

#### **1. Providers Subject to the Requirement**

Please refer to Section 1.3.D “Risk Levels for Provider Types Also Existing in Medicare.”

##### **a. Individual “High” Risk Providers**

“High” risk individual providers are subject to the FCBC requirement.

For more information regarding the provider types that are “high” risk, refer to section 1.3.D “Risk Levels for Provider Types Also Existing in Medicare.”

## b. Owners of “High” Risk Provider Types

For more information regarding the provider types that are “high” risk, refer to section 1.3.D “Risk Levels for Provider Types Also Existing in Medicare.”

Five percent or more owners of “high” risk providers are subject to the FCBC requirement.

The 5 percent ownership threshold applies to all forms of organizations, including partnerships. Thus, if an individual has, for instance, a 12 percent general or limited partnership interest in an entity, he or she is subject to an FCBC check. Also, if the SMA permits non-profit entities to have owners and a particular non-profit organization has a 5 percent or greater owner, he or she is subject to the FCBC requirement. Please refer to Section 1.3.D “Risk Levels for Provider Types Also Existing in Medicare.”

## 2. Fingerprints

The SMA may determine the form and manner for submission of fingerprints within the scope of applicable laws and policies.

### a. Cost Responsibility

Application fees are intended to cover the costs of a state’s Medicaid provider screening program, including the cost to conduct FCBCs on “high” risk providers. However, the SMA may — and subject to the discussion in subsection 1.5.5.4.B.2.a “Cost Responsibility” below -- require “high” risk providers to pay the costs associated with collecting fingerprints.

## 4. Failure to Submit Fingerprints Upon Request

If the provider, or any person with a 5 percent or greater direct or indirect ownership interest in the provider, fails to submit a set of fingerprints as prescribed by the SMA within 30 days of a CMS or SMA request, the SMA must terminate or deny enrollment unless the SMA determines that termination or denial is not in the Medicaid Program’s best interests and documents that determination in writing. (See § 455.416(e)) This documentation must happen upon the state’s determination to allow the provider to remain enrolled. “Upon” is defined here as within 60 days of the provider’s noncompliance and the SMA’s decision to retain the provider.

## **1.6—Claims Processing**

### **A. Denial of Claims**

Under § 455.440, the SMA must deny claims that do not contain an NPI for the physician or other professional who ordered, referred, or prescribed such items or services.

### 1. Validating claims

When the NPI of an ORP appears on a claim, the SMA must validate that NPI and deny the claim if the NPI is not for an enrolled provider. The state should allow such a claim to pay only in the event that services were ordered, referred, or prescribed by a professional within a provider type not eligible to enroll under the State plan.

The SMA may provide access to enrollment information to rendering providers so that the latter can confirm that ordering, referring, or prescribing individuals are Medicaid-enrolled. This information facilitates a rendering provider in accepting only those referrals made by providers enrolled in the reimbursing State's Medicaid Plan (i.e. referrals for potentially Medicaid-reimbursable services).

## 1.7– Documentation/Evidence of Completion

### A. General Requirements – Documentation

The SMA must be able to produce documentation to support having met each of the provider screening and enrollment requirements under 455 Subpart E.

When a screening activity is not captured in a form that serves to document that activity (for example, a SMA may capture a site visit in a site visit form or report, whereas a database check may not yield a piece of supporting documentation), the SMA should include a statement to confirm the screening activity was completed, using the following criteria:

- Statements must be stored so they can be produced on request: they can be stored electronically, but they are not required to be stored electronically.
- A statement should explicitly describe what requirement was completed and the date of completion. For example, “all databases checked” is not an acceptable statement of completion. “All databases checked 12/1/2014,” is likewise not acceptable. “Checked the SSA DMF - 12/1/2014” is acceptable to document that the SMA screened a provider against the Social Security Administration Death Master File. Each screening activity should be captured independently.

When a screening activity yields hard copy documentation, such as a site visit summary or copy of a provider's license, the documentation must be stored so that it can be produced upon request.

## 1. Documenting Reliance on Medicare’s Screening

In order to rely on Medicare screening, the SMA is required to check Medicare’s enrollment record (PECOS, Tibco extract file). It is not necessary or recommended for a SMA to print or otherwise capture a screenshot of PECOS as documentation to support that the SMA checked PECOS. We recommend, but do not require, the SMA to document that it checked PECOS and the date.

### a. Medicare Welcome Letters

A letter sent by the Medicare Administrative Contractor (MAC) to a Medicare provider to confirm successful Medicare enrollment (a MAC “welcome letter”) does not provide supporting evidence that a SMA checked PECOS as required. It is not acceptable for a SMA to require a MAC “welcome letter” as a condition of provider enrollment.

## **B. Requirements Regarding Documenting FCBCs**

The SMA must document the date that the FCBC was completed. However, documenting completion of the FCBC has specific considerations related to the sensitivity of criminal history information and the requirements to maintain the privacy and security of criminal history data. State Medicaid agencies must follow state and federal laws and regulations, including, if applicable, the policies and procedures set forth by the FBI when a state conducts a national criminal background check via the FBI. A SMA shall not store criminal history data in an enrollment record, regardless of whether the enrollment record is housed electronically or as a paper file.

## **1.8–Applications**

### **A. Form and Manner**

The SMA has the discretion to establish the form and manner of its application process.

### **B. Electronic Signatures**

Electronic signatures of enrollment applications are permitted to the extent authorized under state law.

## **1.8.1 – Application Fees**

### **A. Background**

## 1. General Requirement

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.

States must collect the applicable application fee prior to executing a provider agreement from a prospective or reenrolling provider other than the following:

- Individual physicians, non-physician practitioners, or other non-institutional providers.
- Providers that are enrolled in Medicare or in another State's Medicaid Plan. (§ 455.460(a)(2)(i))
- Providers that have paid the applicable application fee to CMS (i.e., a Medicare contractor) or to another state. (§ 455.460(a)(2)(ii))

### **B. Fee Amount**

The application fee amount is the same as the application fee that applies to Medicare enrollment. The application fee increases each calendar year based on the consumer price index for all urban consumers.

CMS notifies stakeholders of the fee that applies to a subsequent calendar year, by:

- Issuing a "Notice" action in the Federal Register
- Issuing guidance to the State Medicaid Directors
- Issuing CMS provider and supplier listserv messages
- Making announcements at CMS Open Door Forums, and
- Placing information on the CMS Provider/Supplier Enrollment Web page (<http://www.cms.gov/MedicareProviderSupEnroll>)

### **C. Collection**

An institutional provider should pay one fee, at an enrollment level, regardless of how many physicians reassign their benefits to that institution. An institutional provider pays a fee on a

per application basis. For example, if a provider submits a single application containing multiple practice locations, the provider pays a single fee.

## 1. Affected Providers

### a. Institutional Providers

Any providers who are considered institutional in Medicare are also considered institutional in Medicaid. Medicare does not use a broader definition of institutional than Medicaid. Medicare defines the following provider types as “institutional” for purposes of the application fee:

- Ambulatory surgical centers
- Ambulance service suppliers
- Community mental health centers (CMHCs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Competitive Acquisition Program/Part B Vendors
- DMEPOS suppliers
- End-stage renal disease facilities
- Federally qualified health centers
- Health programs operated by an Indian health program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian health service pursuant to Title V of the Indian Health Care Improvement Act
- Histocompatibility laboratories
- HHAs) (including HHAs that must submit an initial enrollment application pursuant to § 424.550(b)(1))
- Hospices
- Hospitals

- Independent clinical laboratories
- Independent diagnostic testing facilities
- Mammography screening centers
- Mass immunization roster billers
- Nursing Facility (other)
- Outpatient physical therapy/outpatient speech pathology providers enrolling via the Form CMS-855A
- Organ procurement organization (OPO)
- Pharmacies that are newly enrolling or revalidating via the Form CMS-855B application
- Portable x-ray suppliers (PXRS)
- Radiation therapy centers
- Religious non-medical health care institutions (RNHCI)
- Rural health clinics
- Skilled nursing facilities

With respect to Medicaid-only provider types, the applicability of the fee depends on whether the provider type is “institutional.” A SMA should use its knowledge of Medicaid-only provider types to make this determination. The criteria in Section “C. Concept of Institutional” may assist the SMA to determine whether a provider is institutional. However, these criteria are not determinative, as there are other provider types considered to be institutional and to which the application fee applies. For example, in the preamble to the February 2, 2011 final rule, in addition to the providers and suppliers in the bulleted listed above, for purposes of Medicaid and CHIP, we stated that a State Medicaid Plan may impose the application fee on any institutional entity that bills the State Medicaid program or CHIP on a fee-for-service basis, such as, but not limited to: personal care agencies, non-emergency transportation providers, and residential treatment centers, in accordance with the approved Medicaid or CHIP State plan.

Once a state has determined that a provider/supplier is institutional, they should apply that determination to all providers/suppliers of the same type.

## 2. Enrollment as Different Provider Types

Entities that are enrolled as multiple provider types must be screened separately for each enrollment.

If an entity is enrolling as two separate institutional provider types, two fees will apply, unless the SMA is able to rely on Medicare or another state's Medicaid agency's collection of the application fee as described in the section below.

### **D. When Not to Collect: Exemptions and Waivers**

#### 1. Non-Institutional Providers –

Non-institutional providers such as individual practitioners and group practices are exempt from the application fee.

There is confusion about the statute regarding whether application fees apply to individual providers because there is an error in the online text for the Social Security Act at §1866(j)(2)(C)(i) reflecting language for an individual app fee. However, the provision for an application fee for individual providers was removed in the reconciliation process for the Affordable Care Act (ACA), by section 10603(a). The mistake online is not reflected in the correct "Yellow Book" of the ACA. No individual fee is authorized by the statute or CMS regulations.

#### 2. Relying on Medicare to Collect the Application Fee

Under § 455.460, the SMA must not collect an application fee from a provider that has paid an application fee to Medicare or another state's Medicaid Program.

Additionally, under § 455.460, the SMA must not collect an application fee from a provider that is enrolled in Medicare or another state's Medicaid Program.

To ensure that the requirements of § 455.460(a) are met and that there is the least duplication of fee payment collections by Medicaid and Medicare, the SMA shall follow the guidance in this subsection.

##### a. Medicare/Medicaid Dually Enrolled Providers:

The SMA should follow the guidance in this section to determine whether it shall rely on Medicare to collect the application fee instead of the SMA.

This guidance applies when an institutional Medicaid provider submits an enrollment application to the SMA for:

- New enrollment
- Revalidation
- An update to the enrollment that adds a practice location
- An update to the enrollment that adds an ownership interest

Similar to the process the SMA uses to determine whether it may rely on Medicare’s screening activity, if the provider is in an “approved” Medicare enrollment status, the SMA should compare the Medicaid enrollment application to the Medicare enrollment information using the data elements shown in Table 1 below.

If any of the data elements noted in the Table 1 below do not match, the SMA should charge an application (see note) fee to process the application and the SMA should proceed to conduct required screening activities based on those data elements that differ.

If all the required elements are a positive match, the SMA should not charge an application fee, regardless of when or whether the provider last paid any application fee to Medicare. The SMA should not charge a fee even when there is a difference between the Medicaid and Medicare risk levels that requires the SMA to conduct additional screening activities, as described under Section 1.5.3.A.1 “Instructions for relying on provider screening conducted by Medicare (§ 455.410) or conducting additional screening when required.”

Table 1

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

Example 1.

An Ambulatory Surgical Center submits a new enrollment application to the SMA. The provider’s Medicaid risk category is “limited.” The provider is dually enrolled in Medicare, with the same name, TIN, and 5 percent or more owners as what is reflected on the provider’s Medicaid application. The SMA processes the application without requiring a fee. The SMA is able to rely on Medicare’s screening meet its own screening requirements.

A HHA submits a new enrollment application to the SMA. The provider’s Medicaid risk category is “high.” The provider is dually enrolled in Medicare in a “moderate” risk category with the same name, TIN, practice location, and 5 percent or more owners as what is reflected on the provider’s Medicaid application. The SMA processes the application without requiring a fee. Based on verifying the matching provider’s “approved” Medicare status, the SMA is able to rely on Medicare’s screening activities up to and including the risk screening activities corresponding to the “moderate” risk category. The SMA must verify Medicare conducted a FCBC or conduct a FCBC itself.

b. Verification of Medicare Fee Payment

If a SMA may rely on Medicare’s screening to fully satisfy its own screening requirements, and Medicare’s enrollment record does not reflect the provider paid an application fee, the SMA must not collect a fee.

c. Refunds

If an institutional provider is enrolled in Medicaid and has paid an application fee, and the provider subsequently enrolls in Medicare, the provider must pay a duplicate application fee to Medicare. Unlike Medicaid, in Medicare there is no regulatory provision that allows Medicare to not collect a fee, outside of a hardship waiver. The provider may request a refund from the SMA. The SMA may not ask the provider to supply proof that the fee was paid to Medicare,

because the information is available in PECOS. The SMA, in this situation, refunds the application fee to the provider, upon the provider's request.

### 3. Provider Is Enrolled in Other Medicaid Plan

Since there is no national enrollment database for Medicaid providers, the SMA should ask the provider whether it is enrolling or has enrolled in another State's Medicaid Plan. If the provider responds in the affirmative, the SMA should contact the other SMA to confirm this information. States are encouraged to work together to determine which SMA should collect the application fee (and conduct the required screening) if the provider is enrolling in multiple states. Similarly, if a state operates separate Medicaid Programs, the programs should coordinate to ensure that there is no duplication of fee payments if a provider is enrolling in both programs.

### 4. Individual Hardship Exceptions

#### a. Relevant Statutory and Regulatory Provisions

- Section 1866(j)(2)(C)(ii) of the Act permits the Secretary (i.e., CMS) to grant, on a case-by-case basis, exceptions to the application fee for institutional providers and suppliers enrolled in the Medicaid Program if the Secretary determines that imposition of the fee would result in a hardship.
- Under § 424.514(f), a hardship exception request must contain a letter that describes the hardship and why the hardship justifies an exception to the application fee requirement.
- Under § 424.514(h), CMS has 60 days in which to approve or disapprove a hardship exception request.

#### b. Hardship Exception Process

##### i. SMA Submission Process

The application review process follows:

- The SMA requires a letter from the provider describing the hardship and why the hardship justifies an exception to the application fee requirement. The provider submits the letter and supporting documentation to the SMA in accordance with the state's policy for submission.

- The state evaluates the documentation and continues the process only if it agrees the provider has demonstrated a hardship.
- A SMA may deny a provider's hardship exception request or may recommend approval by CMS. Only CMS may approve a request.
- If the state recommends approval of a request, it forwards the following to CMS, by email or fax:
  - Provider's request package
  - The provider's NPI and address

## ii. CMS Review Process

- CMS will review complete hardship exception packages. If a package is not complete, CMS will request the state to develop for completeness.
- If the provider has already paid an application fee to Medicare, the analyst will notify the state that the provider is not subject to a fee, and CMS will not review the package for a decision. Otherwise, CMS will review the package submitted for a decision.
- If CMS determines additional documentation is required from the provider to demonstrate hardship, CMS will send a letter to the SMA to notify the state that more information is required. The state has 30 days to respond with the additional supporting documentation. If CMS does not receive documentation in the required time frame, CMS will take no further action.
- Within 60 days of the state's submission of the hardship exception recommendation, CMS will reply by email to the individual who submitted the recommendation or to the general mailbox that the state uses to submit the recommendations. In the email, CMS will supply a decision letter.
- The state communicates with the provider and the area that is responsible for collection of the fee. CMS does NOT communicate directly with the provider. CMS only communicates with the state.
- In the case of denial, the state may ask for reconsideration. In this situation, the state should, but is not required to, supply additional documentation to support their position that the exception should be granted.

## 5. Access Waiver

In addition to the case-by-case hardship exceptions discussed above, § 1866(j)(2)(C)(ii) also permits CMS to waive the application fee for certain Medicaid providers (such as those within a certain provider type and/or geographic area) when the state demonstrates that the imposition of the fee on those providers would impede beneficiary access to care. To request a waiver on this basis, the State Medicaid Plan must submit a letter requesting CMS' approval for such a waiver. The letter from the State Medicaid Plan must establish the supporting basis for a waiver based on access to care considerations. CMS will approve or deny the State Medicaid Plan's request and reply by letter to the State Medicaid Plan.

## 1.9 – Denials

This section covers the SMA's denial of new enrollment applications.

### A. Mandatory Denials

Under § 455.416, the SMA must deny the provider's enrollment application in the following circumstances:

- 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 Medicare and Medicaid in the last 10 years, unless the SMA determines that denial is not in the Medicaid Program's best interests and documents that determination in writing. (§ 455.416(b))
- The provider is terminated under Medicare or under the Medicaid Plan of any other state. (§ 455.416(c)) This provision is limited to "terminations" as defined in § 455.101. In contrast to the other circumstances in which denial is required, the SMA does not have the authority to determine that in this circumstance denial is not in the Medicaid Program's best interests.
- The provider, or a person with an ownership or control interest or who is an agent or managing employee of the provider, fails to submit timely or accurate information, unless the SMA determines that denial is not in the Medicaid Program's best interests and documents that determination in writing. (§ 455.416(d))
- The provider, or any person with a 5 percent or greater direct or indirect ownership interest in the provider, fails to submit a set of fingerprints as prescribed by the SMA within 30 days of a CMS or SMA request, unless the SMA determines that denial is

not in the Medicaid Program's best interests and documents that determination in writing. (§ 455.416(e))

- The provider fails to permit access to provider locations for any site visits under § 455.432, unless the SMA determines that denial is not in the Medicaid Program's best interests and documents that determination in writing. (§ 455.416(f))

## **B. Discretionary Denials**

Under § 455.416(g), the SMA may deny the provider's enrollment application if it:

- Determines that the provider has falsified any information provided on the application; or
- Cannot verify the identity of any provider applicant.

The SMA may also deny an application if the application does not meet applicable state requirements (e.g., requirements in state regulations).

Under § 431.51(c)(2), the State Medicaid Plan has the authority to set reasonable standards relating to the qualifications of providers.

## **1.10 – Terminations**

This section covers the SMA's termination of existing provider agreements.

### **A. Mandatory Terminations**

Under § 455.416, the SMA:

- Must terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under this Subpart. (§ 455.416(a))
- Must terminate the enrollment of any provider where 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 in the last 10 years, unless the SMA determines that termination is not in the Medicaid Program's best interests and documents that determination in writing. (§ 455.416(b))

- Must terminate the enrollment of any provider that is terminated under Medicare, or under the Medicaid Plan of any other state. (§ 455.416(c)) This provision is limited to “terminations” as defined in § 455.101. In contrast to the other circumstances in which termination is required, the SMA does **not** have the authority to determine that in this circumstance termination is not in the Medicaid Program’s best interests. A provider subject to this termination requirement may not remain enrolled under any circumstances.
- Must terminate the provider's enrollment if the provider, or a person with an ownership or control interest or who is an agent or managing employee of the provider, fails to submit timely or accurate information, unless the SMA determines that termination is not in the Medicaid Program’s best interests and documents that determination in writing. (§ 455.416(d))
- Must terminate enrollment if the provider, or any person with a 5 percent or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner prescribed by the SMA within 30 days of a CMS or SMA, unless the SMA determines that termination of enrollment is not in the Medicaid Program’s best interests and documents that determination in writing. (§ 455.416(e))
- Must terminate enrollment if the provider fails to permit access to provider locations for any site visits under § 455.432, unless the SMA determines that termination of enrollment is not in the Medicaid Program’s best interests and documents that determination in writing. (§ 455.416(f))

Each of the termination/denial reasons listed under § 455.416 is “for cause.”

## **B. Discretionary Terminations**

Under § 455.416, the SMA:

- May terminate the provider's enrollment if CMS or the SMA:
  - (1) Determines that the provider has falsified any information provided on the application; or
  - (2) Cannot verify the identity of any provider applicant. (§ 455.416(g))

Under § 431.51(c)(2), the State Medicaid Plan has the authority to set reasonable standards relating to the qualifications of providers.

## C. “For Cause”

### 1. Definition of “For Cause”

Pursuant to the definition of “termination” in § 455.101, the requirement for denial or termination based on termination by another program applies where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked by another program “for cause.” “For cause” includes, but is not limited to reasons of (1) fraud, (2) integrity, or (3) quality.

The scope of the requirement for a State Medicaid Plan to terminate a provider based upon the requirements under § 455.416(c) is limited to “for cause” terminations which include terminations based upon reasons of fraud, integrity, or quality, for which the provider has exhausted appeal rights or the timeline for appeal has expired. Also see Section 1.10.E “Implementation of Terminations Based on Another State Medicaid Program’s Termination.”

Situations that would qualify as a “for cause” termination triggering the requirement for other states to deny or terminate a provider’s enrollment include, but are not limited to:

- Adverse licensure actions (e.g., provider reported into the National Practitioner Data Bank (NPDB) because of license revocation)
- Fraudulent conduct
- Abuse of billing privileges (e.g., billing for services not rendered or for medically unnecessary services)
- Misuse of billing number
- Continued billing after a license suspension
- A state or federal exclusion
- Falsification of medical records concerning Medicaid beneficiaries

Situations that do not qualify as “for cause” terminations include, but are not limited to:

- License expiration due to, for instance, relocation to another state
- Failure to submit claims over a period of time
- Voluntarily termination of enrollment.

- A Medicare-imposed payment suspension carried out by CMS under the federal regulations at 42 CFR 405 Subpart C.

## 2. Exclusion vs. Termination

The terms “termination” and “exclusion” have different meanings. For purposes of § 455.416(c), a “termination” is as defined in § 455.101. “Exclusion” from participation in a federal health care program (e.g., Medicare and Medicaid) is a penalty imposed on a provider by the OIG under the federal regulations at 42 C.F.R. §1001 Subpart C. Individuals and entities may be excluded by the OIG for misconduct ranging from fraud convictions, to patient abuse, to defaulting on health education loans. States may also exclude providers from their Medicaid Programs under state law or pursuant to 42 C.F.R. § 1002.2.

Each of the termination/denial reasons listed under § 455.416 is “for cause.”

### **D. Implementation of Terminations Based on Medicare Administrative Action**

#### 1. State Terminations Based on Medicare Payment Suspensions

In regards to Medicare payment suspensions carried out by CMS under the federal regulations at 42 CFR 405 Subpart C, a provider’s Medicare payment suspension status does not provide a basis for a State Medicaid Plan to administer a “for cause” termination.

Under 405.370, suspension of payment is defined as the withholding of payment by a Medicare contractor from a provider or supplier of an approved Medicare payment amount before a determination of the amount of the overpayment exists, or until the resolution of an investigation of a credible allegation of fraud.

CMS does not revoke a Medicare provider based upon a Medicare payment suspension.

#### 2. State Terminations Based on Medicare Revocations

##### a. Identifying Medicare “For Cause” Revocations

##### i. Data Source for Medicare “For Cause” Revocations

Medicare revokes providers both on a “for cause” or a “not for cause” basis. For this reason, PECOS and the PECOS extract files are not the best source for a state to identify the “for cause” revocations triggering the state’s obligation to terminate pursuant to § 455.416(c). Instead, CMS has established a secure access for states to a data source for all Medicare “for cause” revocations. Medicare revocations are not included in the Medicare “for cause” revocations

file until all associated appeal rights are exhausted. A SMA must base its own terminations on this data source.

#### b. Medicare Appeals Exhaustion

Consistent with the definition of “termination” in § 455.101 (see section 1.1.2 “Selected Definitions”), the SMA shall not terminate the provider under § 455.416(c) unless the latter has exhausted all appeal rights concerning the Medicare revocation or the timeframe for such appeal has expired. CMS does not share “for cause” revocations with State Medicaid Plans until appeal rights are exhausted. Consider the following example:

Provider X, dually enrolled in Medicare and in state A’s Medicaid Program, is revoked by Medicare. X appeals the revocation. State A’s obligation to terminate X’s Medicaid enrollment is not triggered until X has exhausted all appeal rights or the timeframe for such appeal has expired.

#### c. Timely Action

A SMA is expected to take timely action based on Medicare “for cause” revocation. Timely action is defined here as within 60 business days from the date upon which CMS notifies the SMA of the revocation. CMS does not notify a SMA of a Medicare revocation until all provider appeal rights concerning the Medicare revocation are exhausted, or the timeframe for such appeal has expired.

When a SMA takes an untimely termination action based on a Medicare for cause revocation, i.e., beyond the 60 business days as described, this could potentially result in loss of Federal Financial Participation (FFP for failure to comply with the federal regulation at § 455.416.

### **E. Implementation of Terminations Based on Another State Medicaid Program’s Administrative Action**

#### 1. Termination of an Individual Provider with Active State Licensure

When a SMA takes a for cause termination action on an individual provider, under § 455.416, to the extent that provider is enrolled in any other State’s Medicaid Plan, that other State’s Medicaid Plan must likewise terminate the individual provider. This applies irrespective of the subject provider’s licensure status in any state.

## 2. State Termination Based on Another State Medicaid Program's Termination

### a. Identifying Medicaid "For Cause" Terminations

#### i. Data Source for State Terminations

CMS has established a secure web-based portal, the MFT Tibco server, to facilitate the sharing of information by states regarding terminated Medicaid providers.

The current process to report terminations to CMS is: States email the Provider Termination mailbox (ProviderTerminations@cms.hhs.gov) with their completed CMS Medicaid termination notification (a template) plus the termination letter and then CMS inputs that information into a spreadsheet which is uploaded to the Tibco MFT server every other Thursday for states to access. The only way a state can access the termination information reported to CMS is via the Tibco MFT server.

b. Each of the termination/denial reasons under § 455.416 are considered "for cause." See Section 1. 10.C. "For Cause."

#### b. State Medicaid Plan Appeals Exhaustion

Consistent with the definition of "termination" in § 455.101 (see section 1.1.2 "Selected Definitions"), the SMA shall not terminate the provider under § 455.416 unless the latter has exhausted all appeal rights concerning the initial termination or the timeframe for such appeal has expired. Consider the following example:

The state A SMA terminates Provider Y's enrollment under § 455.416(f) for failure to permit access to location. This is a "for cause" termination. Y also enrolled in state B's Medicaid Program. The termination by state A does not trigger state B's obligation to terminate pursuant to § 455.416(c) until Y has exhausted all appeal rights concerning the termination by state A.

#### c. Timely Action

A SMA is expected to take timely action based on Medicaid "for cause" terminations. Timely action is defined as within 60 days from the date upon which CMS or the other state's Medicaid agency notifies the SMA of the Medicaid termination. CMS does not notify a SMA of a Medicaid termination until all provider appeal rights concerning the terminations are exhausted, or the timeframe for such appeal has expired.

### 3. Reporting

#### a. General

At least monthly, the SMA should report information on providers it has terminated for cause from its Medicaid Program, regardless of any action taken against such providers by another entity (including the OIG). The SMA must report providers terminated on or after January 1, 2011. With respect to this reporting, “terminations” includes only those terminations actions taken on a for cause basis and for which the appeal process is exhausted. The current process to report terminations to CMS is: States email the Provider Termination mailbox (ProviderTerminations@cms.hhs.gov) with their completed CMS Medicaid termination notification (a template) plus the termination letter and then CMS inputs that information into a spreadsheet which is uploaded to the Tibco MFT server every other Thursday for states to access. The only way a state can access the termination information reported to CMS is via the Tibco MFT server.

Under § 1002.3(b)(3), the SMA also must promptly notify the OIG of any action it takes to limit the ability of an individual or entity to participate in its program, regardless of the basis for that action.

## **1.11 – Appeals**

### **A. General Requirement**

Under § 455.422, the SMA must give providers that are denied or terminated under § 455.416 any appeal rights available under procedures established by state law or regulations.

### **B. Scope of Termination Appeals**

The scope of appeals for the original terminating program (i.e., Medicare or Medicaid) should include a full appeal on the merits regarding the basis of the termination. The original terminating program’s appeals process shall provide for review of the underlying basis for the termination, but no other state’s appeals process shall provide for such review. When other states subsequently terminate the provider based upon that initial termination, the scope of any appeal of the subsequent termination shall be restricted to whether the provider was, in fact, terminated by the initiating program, and shall not provide for a review of the basis for the original action.

## 1.12 – Moratoria

### A. CMS-Imposed Moratoria

Under § 455.470(a):

- Prior to imposing moratoria under § 424.570, the Secretary (CMS) consults with any affected SMA regarding the imposition of temporary moratoria on enrolling new providers or provider types. (§ 455.470(a)(1))
- The SMA will impose temporary moratoria on enrollment of new providers or provider types identified by the Secretary as posing an increased risk to the Medicaid Program. (§ 455.470(a)(2))
- The SMA is not required to impose such a moratorium if the SMA determines that imposing the moratorium would adversely affect beneficiaries' access to medical assistance. (§ 455.470(a)(3)(i)) If the SMA makes such a determination, the SMA must notify the Secretary in writing. (§ 455.470(a)(3)(ii)) (NOTE: CMS recommends that the SMA explain the bases of its concerns regarding beneficiary access.)

### B. State-Imposed Moratoria

Under § 455.470(b):

- The SMA may impose temporary moratoria on enrolling new providers or provider types that the SMA identifies as having a significant potential for fraud, waste, or abuse and that the Secretary has identified as being at high risk for fraud, waste, or abuse. (§ 455.470(b)(1))
- Before implementing moratoria, caps, or other limits, the SMA must determine that its action would not adversely impact beneficiaries' access to medical assistance. (§ 455.470(b)(2))
- The SMA must notify the Secretary in writing if it seeks to impose such moratoria, including all details of the moratoria, and obtain the Secretary's concurrence with imposition of the moratoria. (§ 455.470(b)(3))

Under § 455.470(c):

- The SMA must impose the moratorium for an initial period of 6 months. (§ 455.470(c)(1))

- If the SMA determines that it is necessary, the SMA may extend the moratorium in 6-month increments. (§ 455.470(c)(2)). Each time, the SMA must document in writing the necessity for extending the moratorium. (§ 455.470(c)(3)) This documentation must be made available to CMS for concurrence prior to the extension.

CMS must concur with any state-based moratorium. The SMA shall send any required notifications or requests for approval under § 455.470 to [ProviderEnrollmentMoratoria@cms.hhs.gov](mailto:ProviderEnrollmentMoratoria@cms.hhs.gov)

The SMA has considerable discretion regarding other aspects and parameters of administering such moratoria.