MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 12-55

Distribution: All Providers

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Subject: Medicaid Provider Screening/Enrollment and Program Integrity

Effective: As Indicated

Programs Affected: Medicaid, Medicaid Health Plans, Adult Benefits Waiver, Plan First!, Maternity Outpatient Medical Services, Children's Special Health Care Services

As required by Sections 6401 and 6501 of the Affordable Care Act (ACA), the Michigan Department of Community Health (MDCH) is implementing new Medicaid provider screening and enrollment requirements and new measures related to Medicaid fraud and abuse for the Medicaid Fee-for-Service (FFS) program. This bulletin provides an overview of the major changes. The changes are effective immediately, unless otherwise noted. Medicaid Health Plans (MHPs) and other managed care plans and organizations are not required to implement the screening and enrollment changes, but must comply with ownership and controlling interest disclosures as outlined in Item 12.

1. **Categorization of Providers Based on Level of Risk – High, Moderate or Limited:** Provider types must be categorized based on the potential risk of fraud, waste, and abuse to the Medicaid Program. For provider types recognized under the Medicare Program, MDCH has adopted the risk categorization established by the Centers for Medicare and Medicaid Services (CMS). For non-Medicare provider types, MDCH establishes the risk level. A provider's categorical risk level may be adjusted to "high" due to payment suspension, overpayment status or Office of Inspector General (OIG)/Medicaid Program exclusion status, and after lifting of a temporary moratorium.

2. **Screening Activities Based on Risk Category and Provider Type:** Additional provider screening activities are required and will be conducted based on the provider's categorical risk level. The following table summarizes the general screening activities by risk category and type of provider.

Category	Type of Provider	Screening Activities
High	• Prospective (newly enrolling) home health agencies • Prospective (newly enrolling) Durable Medical Equipment, Prosthetics/Orthotics, & Supplies (DMEPOS) suppliers	• Fingerprint based criminal background checks • Unannounced pre- and post-enrollment site visits • Verifications including licensure, Social Security number, taxpayer identification number, National Provider Identifier, OIG exclusion status, and information regarding disclosed individuals

Category	Type of Provider	Screening Activities
Moderate	• Ambulance services • Community mental health centers • Comprehensive outpatient rehabilitation facilities • Hospice organizations • Independent clinical laboratories • Physical therapists enrolling as individuals or as group practices • Revalidating home health agencies • Revalidating DMEPOS suppliers	• Unannounced pre- and post-enrollment site visits • Verifications including licensure, Social Security number, taxpayer identification number, National Provider Identifier, OIG exclusion status, and information regarding disclosed individuals
Limited	• All other provider types	• Verifications including licensure, Social Security number, taxpayer identification number, National Provider Identifier, OIG exclusion status, and information regarding disclosed individuals

3. **Site Visits:** All enrolled providers must permit unannounced on-site inspections as a condition of participation. MDCH has begun conducting pre-enrollment and post-enrollment site visits of providers designated as "moderate" and "high" categorical risk.

4. **Criminal Background Checks:** All enrolled providers, or any person with a five percent or more direct or indirect ownership interest in the provider, must consent to criminal background checks, including fingerprinting, as a condition of participation. MDCH will begin conducting criminal background checks and will require submission of fingerprints from providers designated as "high" categorical risk when directed by CMS. Implementation of this requirement was delayed by CMS pending further guidance, however, MDCH will implement once guidance is provided.

5. **Enrollment Application Fees:** All providers, except individual physicians and non-physician practitioners, are subject to an application fee. The fee is required for each enrolled provider type at the time of initial enrollment and reenrollment. The fee is not required for revalidation or interim updates to provider enrollment information. **Providers who are enrolled in or have paid the application fee to Medicare or another State's Medicaid or Children's Health Insurance Program (CHIP) are not required to pay an application fee to the Michigan Medicaid Program.** The application fee amount is established by CMS and updated annually. For 2012, the application fee is $523. MDCH will begin collecting application fees as soon as online CHAMPS provider enrollment changes are completed. Providers subject to the application fee may request a hardship exception by submitting a written request to MDCH.

6. **Enrollment of Ordering/Referring Providers:** Federal regulations require all ordering or referring physicians or other professionals, except those that are members of risk-based managed care organizations, providing services to Michigan Medicaid beneficiaries be enrolled in the Michigan Medicaid program. Claims for services rendered as a result of an order or referral must contain the name and individual National Provider Identifier (NPI) of the physician or other professional who ordered or referred the items or services. For all institutional claims the attending physician must be Medicaid enrolled. If the ordering/referring/attending provider information is not reported on the claim or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid. MDCH will initially implement information-only edits to notify providers if the ordering/referring/attending provider NPI is missing from a claim or if the provider is not enrolled. Notification edits will be replaced with claim denial edits. Future policy bulletins will provide additional information about these requirements and the implementation of claim edits. Rendering providers should ensure their referral sources are aware of this requirement. Ordering/referring/attending providers may initiate the enrollment process at any time.

This requirement does not apply to claims for carved-out services paid by FFS Medicaid for beneficiaries enrolled in a Medicaid Health Plan, as long as the ordering/referring/attending provider is a contracted provider in the health plan's network. In order to determine if providers are in a health plan network, all health plan network providers who are not Medicaid-enrolled providers will be requested to register with the Community Health Automated Medicaid Processing System (CHAMPS). Instructions and timeframes for registering in CHAMPS will be provided in a future bulletin.

7. **Enrollment Information and Disclosures:** Additional provider enrollment information, including home address, date of birth, and Social Security number, will be required from providers and other disclosed individuals (e.g. owners, managing employees, agents, etc.). MDCH will begin collecting the information as soon as online CHAMPS provider enrollment changes are completed.

8. **Revalidation of Enrollment:** All providers will be required to revalidate their Medicaid enrollment information a minimum of once every five years, or more often if requested by MDCH. MDCH will notify providers when revalidation is required. **Providers are reminded that they must notify MDCH within 35 days of any change to their enrollment information.**

9. **Temporary Moratoria on Enrollment of New Providers:** A temporary moratoria, numerical caps, or other limits may be placed on the enrollment of new providers or provider types identified as having a significant potential or increased risk for fraud, waste, or abuse, as long as it would not adversely impact beneficiaries' access to medical assistance. There are no moratoria in place at this time.

10. **Termination and Denial of Enrollment**: MDCH may terminate or deny enrollment in the Michigan Medicaid program. Termination of enrollment means a provider's billing privileges have been revoked and all appeal rights have been exhausted or the timeline for appeal has expired. Denial of enrollment means the provider's application will not be approved for participation in the Medicaid program. The basis for termination or denial of enrollment includes, but is not limited to:

    - Failure to submit timely and accurate information;
    - Failure to cooperate with MDCH screening methods;
    - Conviction of a criminal offense related to Medicare, Medicaid, or the Title XXI program in the last 10 years;
    - Termination on or after January 1, 2011, under Medicare or the Medicaid program or Children's Health Insurance Program (CHIP) of any other State;
    - Failure to submit sets of fingerprints as required within 30 days of a CMS or MDCH request;
    - Failure to permit access to provider locations for site visits;
    - Falsification of information provided on the enrollment application; or
    - Inability to verify a provider applicant's identity.

    Providers may appeal the decision to terminate or deny enrollment. Denial of enrollment due to a temporary enrollment moratorium is appealable, but the scope of review is limited to whether the temporary moratorium applies to the provider appealing the denial. The basis for imposing a temporary moratorium is not subject to review. After termination from the Medicaid Program, the provider must contact MDCH to request re-enrollment as a Medicaid provider and reinstatement of billing privileges. Providers whose enrollment has been denied are not prohibited from submitting a subsequent re-enrollment application.

11. **Payment Suspension:** MDCH may temporarily suspend payments to a provider after determining there is a credible allegation of fraud for which an investigation is pending under the Medicaid program. An allegation of fraud may be from any source including fraud hotline complaints, claims data mining and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indications of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. Providers will be notified within 90 days of initiation of a payment suspension. The notification will include the general allegations as to the nature of the suspension action, the period of suspension, and the circumstances under which the suspension will be terminated. Providers may submit written evidence for consideration through the

administrative appeal process. All payment suspensions will include referral to the Medicaid fraud control unit.

12. **Disclosures from Fiscal Agents and Managed Care Entities**: The following ownership and controlling interest disclosures are required from fiscal agents and managed care entities:

    - The name and address of any person (individual or corporation) with an ownership or control interest. 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 (in the case of an individual);
    - Other tax identification number (in the case of a corporation) with an ownership or control interest or in any subcontractor in which the disclosing entity has a 5 percent or more interest;
    - Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a 5 percent or more interest is related to another person with ownership or control interest as a spouse, parent, child, or sibling;
    - The name of any other fiscal agent or managed care entity in which an owner has an ownership or control interest; and
    - The name, address, date of birth, and Social Security Number of any managing employees.

    These disclosures are due upon any of the following: submission of a proposal in accordance with the State's procurement process, execution of a contract with the State, renewal or extension of a contract, and within 35 days after any change in ownership.

    Managed care entities include managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), and health insuring organizations (HIO). In Michigan, this includes the following entities: Medicaid Health Plans, County Health Plans, Healthy Kids Dental Plans, MIChild Health and Dental Plans, Program of All Inclusive Care for the Elderly (PACE) Organizations, Mental Health and Substance Abuse PIHPs, Pharmacy Benefits Manager and Non-Emergency Medical Transportation Broker.

MDCH will continue to provide updates as these requirements are implemented. Providers may learn more about the ACA provider screening and enrollment requirements in the Federal Register, Volume 76, No. 22, Page 5862, published February 2, 2011.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Director
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