



Section 6401 of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010ⁱ (collectively known as the Affordable Care Act or ACA), requires State Medicaid agencies to make significant changes to provider enrollment as part of the ongoing effort to reduce fraud, waste, and abuse. This issue brief focuses on the procedures States must establish for conducting provider screening, and also the application fee which States must collect prior to executing a provider agreement.

Overview

Federal Centers for Medicare and Medicaid Services (“CMS”) regulations published February 2, 2011 (“Final Rule”), require all participating Medicaid providers to be screened according to their risk level, upon initial enrollment, and upon re-enrollment or re-validation of enrollment.ⁱⁱ In addition, the State Medicaid agency must re-validate the provider enrollment at least once every five (5) years.ⁱⁱⁱ

The type of screening required for each provider depends upon the risk of fraud, waste and abuse. States are required to categorize each provider type as either “limited,” “moderate” or “high” risk. States have significant discretion in categorizing the provider types, but CMS encourages States to use the same screening levels as apply under Medicare for Medicaid provider types that are also recognized provider types under Medicare. (See Chart 1.)

Chart 1. Medicare Provider/Supplier Risk Level Assignment

Risk Level	MEDICARE provider/supplier category
“Limited”	Physician or non-physician practitioners and medical groups or clinics, with the exception of physical therapists and physical therapist groups; ambulatory surgical centers; competitive acquisition program/Part B program vendors; ESRD facilities; FQHCs; histocompatibility laboratories; hospitals, including CAHs; Indian Health Service facilities; mammography screening centers; mass immunization roster billers; organ procurement organizations; pharmacies; radiation therapy centers; religious non-medical health care institutions; RHCs; and SNFs.
“Moderate”	Ambulance suppliers; community mental health centers; comprehensive outpatient rehabilitation facilities; hospice organizations; independent diagnostic testing facilities; independent clinical laboratories; physical therapy, including physical therapy groups and portable x-ray suppliers; currently enrolled (revalidating) home health agencies.
“High”	Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of DMEPOS.

For those provider types *not* recognized under Medicare (e.g., ICFs, waiver providers), States must assess the risk of fraud, waste, and abuse posed by a particular provider type, using similar criteria to those used by CMS in assigning the risk level Medicare providers and suppliers^{iv} For example, “moderate” risk level provider types lack individual professional licensure, and are characterized by ease of entering the business without clinical or business experience; “high” risk level provider types are especially vulnerable to improper payments due to a high number of

entities already enrolled. Importantly, however, CMS did not propose to limit the ability of States to assign a particular provider type to a higher screening level than the level assigned by Medicare.

Provider screening methods range from provider state license verification and (all risk levels), to criminal history record checks (high risk level only). Chart 2 provides the screening associated with each risk level:

Chart 2: Provider Screening Requirements

Type of screening required	Risk Level		
	Limited	Moderate	High
Verification of any provider-specific requirements established by Medicaid	X	X	X
Conduct license verifications	X	X	X
Database Checks (to verify SSN and NPI, the NPDB, licensure, a HHS OIG exclusion, tax-payer identification, tax delinquency, death of individual practitioner, and persons with an ownership or control interest, authorized official, delegated official, or supervising physician)	X	X	X
Unscheduled or Unannounced Site Visits		X	X
Fingerprint-Based Criminal History Record Check of law enforcement repositories			X

State Medicaid agencies are permitted to establish additional screening methods in addition to, or more stringent than, those required by CMS.^v

Federal Database Checks

For *all* provider types, the State Medicaid agency must 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.^{vi}

“Person with an ownership or control interest” is defined as a person or corporation that

- a. Has an ownership interest totaling five (5) percent or more in the provider;
- b. Has an indirect ownership interest equal to five (5) percent or more in the provider (indirect ownership interest means an ownership interest in an entity that has an ownership interest in the provider);
- c. Has a combination of direct and indirect ownership interests equal to five (5) percent or more in the provider;
- d. Owns an interest of five (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 five (5) percent of the value of the property or assets of the provider;
- e. Is an officer or director of the provider (if it is organized as a corporation); or
- f. Is a partner in the provider (if it is organized as a partnership).^{vii}

CMS requires States to check the following databases: (1) Social Security Administration’s Death Master File; (2) the National Plan and Provider Enumeration System (“NPPES”); (3) the

List of Excluded Individuals/Entities (“LEIE”); (4) the Excluded Parties List System (“EPLS”); and (5) any such other databases as CMS may prescribe.^{viii} These checks must be completed at enrollment and re-enrollment, and the LEIE and EPLS must be checked *at least once monthly*.^{ix}

Criminal Background Checks and Fingerprint Collection

State Medicaid agencies must require *high* risk provider types, and any person with a five (5) percent or more ownership interest in the provider, to consent to criminal background checks, which includes fingerprinting.^x There is no similar requirement applicable to persons with only a control interest in the provider, or the agents or managing employees of high risk providers who do not have a five (5) percent or more ownership interest. States have wide latitude as to how to conduct the background checks, but CMS recommends a FBI criminal history record check.^{xi}

In its Final Rule, CMS advised that States are not required to implement criminal background checks and fingerprinting until CMS issues additional guidance.^{xii} However, States are permitted to go forward if they so choose.^{xiii} When States do implement the background check and fingerprint requirement, they have the discretion to impose requirements more stringent than those imposed by CMS.^{xiv}

Although it is clear that background checks are required, the Final Rule does not specify how States must handle background checks which uncover criminal activity. Denial of enrollment is mandatory when any five (5) percent owner has been convicted of a criminal offense related to that person’s involvement with Medicare, Medicaid, or title XXI in the last ten (10) years (unless State determines this is not in the State’s best interest).^{xv} What remains unanswered, importantly, is whether States may add additional disqualifying offenses, and whether these offenses must somehow be reasonably related to the Medicaid program. The preamble to the Final Rule suggests that States have significant leeway to refuse to enroll, or may terminate the enrollment agreement of, providers for a number of reasons related to the provider’s status or history, including an exclusion from Medicare, Medicaid, or any other Federal health care program, conviction of a criminal offense related to Medicare or Medicaid, or submission of false or misleading information on the Medicaid enrollment application.^{xvi} Lacking additional guidance, it appears that States may be able to craft unique approaches as to how each will treat the results of a criminal background check.

Application Fee

Beginning March 25, 2011, unless exempt, each prospective or re-enrolling provider must pay an application fee for each provider agreement.^{xvii} If the State requires a provider agreement for each practice location, then the provider must pay the application fee for each practice location.^{xviii} The fee is \$523.00 for calendar year 2012 and increases each year by the CPI for all urban consumers. It is non-refundable, except in limited circumstances. The following provider-types are exempt from paying the fee: (1) individual physicians or non-physician practitioners; (2) providers enrolled in Medicare, another State Medicaid program, or CHIP; and (3) States may request hardship waivers for specific providers, as well as a particular group or category of providers, if the State demonstrates the imposition of the fee would impede beneficiary access to care.

Applicability to ANCOR Members

As mentioned above, states appear to have wide latitude to implement the new federal requirements regarding provider screening and enrollment. There are likely to be many variations depending on how each state chooses to implement the requirements. ANCOR will be keeping tabs on this issue and is interested in hearing from the membership as to concerns or questions that develop.

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- i Public Law No. 111-148, effective March 23, 2010, as amended by Public Law No. 111-152, effective March 30, 2010.
- ii 42 C.F.R. Part 455, subpart E
- iii 42 C.F.R. § 455.414.
- iv 76 Fed. Reg. 5862, 5895 (Feb. 2, 2011)
- v 42 C.F.R. § 455.452.
- vi Id. § 455.436(a).
- vii Id. § 455.101.
- viii Id. § 455.436(b).
- ix Id. § 455.436(c).
- x Id. § 455.434(b).
- xi 76 Fed. Reg. at 5903.
- xii Id. at 5902.
- xiii Id.
- xiv Id.
- xv 42 C.F.R. § 454.416.
- xvi 76 Fed. Reg. at 5899.
- xvii 42 C.F.R. § 455.460.
- xviii See 76 Fed. Reg. at 5913 (stating that Medicare providers and suppliers will be charged the fee for each form CMS-855 they submit for enrollment of revalidation).