Fact Sheet

Medicaid Provider Enrollment Requirements

The Affordable Care Act mandates regulations and procedures that govern providers who wish to enroll in their State Medicaid program or Children's Health Insurance Program (CHIP).[1] References to Medicaid in this document include CHIP.

One purpose of the Affordable Care Act is to reduce the amount of improper payments in Medicaid by minimizing the risk of allowing unscrupulous providers to bill the Medicaid program. As noted by the U.S. Government Accountability Office, the enrollment and other requirements of the Affordable Care Act are "aimed at reducing waste, fraud, and abuse."[2] This fact sheet provides a brief overview of the rules that apply to fee-for-service (FFS) providers enrolling in Medicaid and CHIP.

What Information Must Providers Disclose?

Individual providers enrolling in Medicaid or CHIP must disclose information, including, but not limited to:

- Date of birth (DOB) and Social Security Number (SSN);
- Licensure;[3]
- National Provider Identifier; and
- Convictions of any criminal offense related to the person's involvement in any program under Medicare, Medicaid, or CHIP since those programs began.[4]

Corporations, partnerships, managed care plans, and fiscal agents must also disclose information upon enrollment in Medicaid or CHIP. A disclosing entity is defined as "a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent."[5] Disclosing entities must disclose:

- Names and addresses of any persons with an ownership or control interest in the entity;
- Names, addresses, DOBs, and SSNs of any managing employee of the disclosing entity;

- Whether a person with an ownership interest is related to another person with an ownership or control interest;
- Names of other disclosing entities in which the owner has an ownership or control interest;[6] and
- Convictions of persons who have ownership or control interests in the provider, or who are agents or managing employees of the provider entity.[7]

Both individuals and entities must disclose family relationships between persons with ownership or control interests in the disclosing entity.[8] Within 35 days of a request from the State Medicaid agency (SMA), enrolling providers must disclose:

- Ownership interests in subcontractors with whom the provider has had business transactions totaling more than $25,000 during the previous 12 months; and
- Any significant business transactions between the provider and any wholly owned supplier or any subcontractor during the previous 5 years.[9]

Federal regulations define a "person with an ownership interest" as an individual or entity that has direct or indirect ownership interests in the disclosing entity totaling 5 percent or more.[10] Direct ownership interest means possession of equity in the capital, the stock, or the profits of the disclosing entity.[11] Indirect ownership interests are interests in entities other than the disclosing entity that in turn have an ownership interest in the disclosing entity.[12] A provider is required to disclose ownership interests not only when submitting an application for enrollment, but also when signing the provider agreement, when the SMA requests such information on revalidation, and within 35 days after any change in ownership of the disclosing entity.[13] The ownership disclosure requirements that have been in place for FFS providers since 2011 will be phased in for managed care network providers by July 1, 2018.[14]

Guidance on the Disclosure Requirements

The U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) found that SMAs had difficulty implementing the disclosure requirements. HHS-OIG recommended CMS ensure SMAs are requesting providers disclose all required ownership information.[15] CMS took significant steps, before the report, to ensure SMAs do this. CMS' Center for Program Integrity published a "Toolkit to Address Frequent Findings" of CMS' program integrity reviews regarding disclosures of ownership and control. This resource explains the background of the rule on ownership disclosure, breaks it down into subparts, and provides examples.[16] CMS also published the "Medicaid Provider Enrollment Compendium" (MPEC), which consolidates guidance to SMAs on implementing the ownership disclosure requirements. The MPEC urges SMAs to educate providers on disclosure requirements, and suggests ways of doing this "may include enrollment websites, provider information bulletins, and inclusion in provider agreements." CMS will update and expand the MPEC, so SMAs and providers should check the website.[17]

Other guidance from CMS is available for SMAs. In a 2010 compilation of best practices, CMS suggested SMAs should provide dedicated space in the provider contract and in the enrollment application form for the applicant to supply ownership disclosure information, including space for multiple corporate addresses, and ownership percentages.[18] In a toolkit published in September 2014, CMS suggested SMAs should request providers to submit not only DOBs but also SSNs for persons with an ownership or control interest in the disclosing entity. Application forms and contracts should contain spaces for both. The toolkit further suggests the SMA or contract procurement entity should consult the program integrity staff on contract language. This would help ensure the incorporation of all disclosure requirements. The toolkit suggests it would be helpful if State program integrity and enrollment staff trained procurement staff on disclosure requirements.[19, 20] Finally, a 2008 Medicaid Director's Letter contains guidance still relevant, including a recommendation States refuse to process applications with apparently incomplete disclosure information.[21]

How Are Providers Categorized for Screening?

Under 42 Code of Federal Regulations Section 455.450, the SMA assigns a risk level to providers enrolling, revalidating enrollment, or re-enrolling in Medicaid or CHIP, according to the category or type of provider.[22] The three risk categories, and some examples, are:

- Limited risk
  - Physician or non-physician practitioners, hospitals, skilled nursing facilities, rural health clinics, and end-stage renal disease facilities.
- Moderate risk
  - Ambulance suppliers, community mental health centers, comprehensive outpatient rehabilitation facilities, hospice organizations, currently enrolled home health agencies (HHA), and currently enrolled durable medical equipment (DME) suppliers.
- High risk
  - Newly enrolling HHA and DME suppliers,
  - Any provider that has a payment suspension based on a credible allegation of fraud within the last 10 years,[23]
  - Any provider excluded within the past 10 years by HHS-OIG or an SMA,[24, 25]
  - Any provider that has a qualifying Medicaid overpayment,[26]
  - The provider is enrolling within 6 months of the date of the lifting of a temporary moratorium that at the time would have barred the provider's enrollment.[27]

SMAs should consult the MPEC for additional information on these factors, such as what constitutes a qualifying Medicaid overpayment.

States may impose additional screening methods "in addition to or more stringent than" those in the regulations.[28] This could result in a change in the risk category assigned for certain types of providers. Providers should check with their SMA to determine their risk category.

What Types of Screening Activities Do SMAs Perform for Enrollment?

For all providers applying to enroll in Medicaid, the SMA must perform the activities in Table 1 according to the provider's risk category.[29]

Table 1. SMA Activities by Risk Level

SMA Activities	Limited Risk	Moderate Risk	High Risk
• Disclosures and Database Checks • Obtain disclosures regarding ownership and criminal convictions • Check exclusion data bases • Check other databases to confirm identity and licensure	X	X	X
On-site Visit • Conduct an on-site visit to confirm accuracy of information submitted in the provider's application[30]	Not Applicable	X	X
Fingerprints • Conduct a fingerprint-based criminal background check (FCBC) of the provider or, in the case of an institutional provider, every person with a 5 percent or more ownership interest[31]	Not Applicable	Not Applicable	X

The databases that SMAs must check include:

- The Social Security Administration's Death Master File;[32]
- The National Plan and Provider Enumeration System's National Provider Identifier Registry;[33]
- The List of Excluded Individuals/Entities;[34] and
- The System for Award Management's Advanced Search Exclusion Database Exclusions Extract (which replaced the Excluded Parties List System.)[35]

Since June 1, 2016, SMAs have been required to verify convictions of owners, agents, and managing employees of newly enrolling DME suppliers through a fingerprint-based criminal background check.[36, 37, 38] SMAs that had not implemented fingerprint-based background checks by June 1, 2016, were required by then to have in place a CMS-approved plan to implement such checks.[39] In addition to the required database checks, SMAs may also wish to use sources like States' Secretary of State business registration sites to validate current status and ownership or leadership of a reported entity, the United States Postal Service website at https://www.usps.com to verify an address, or an assessor's website to validate address and ownership information.

What Are the Provider Enrollment Application Fees, and Who Is Required to Pay a Fee?

States must collect an application fee to offset the costs associated with screening potential providers or revalidating providers. Individual physicians or non-physician practitioners,[40] or providers already enrolled in Medicare are not required to pay this fee. Institutional providers, such as hospitals, skilled nursing facilities, ambulance services, and pharmacies, are required to pay a fee.[41, 42] Each provider subject to a fee is required to pay only one fee per enrollment or validation cycle.[43, 44]

To allow SMAs to verify Medicare enrollment, CMS established a process by which dedicated users from each State have read-only access to Medicare's enrollment database, the Provider Enrollment, Chain and Ownership System (PECOS).[45] When CMS started the process, SMA users could only obtain the information by manually looking up each provider. Now SMA users have access to a monthly PECOS data-extract file.[46]

If a provider is simultaneously enrolling in another State's Medicaid or CHIP program, and is not excused from payment of the application fee (for example, by a hardship

exception or an access waiver), the SMA should contact that other State to confirm the information and coordinate collection of a single application fee.[47] CMS adjusts the application fee for each calendar year based on the consumer price index. The application fee for 2016 is $554.[48]

When Does CMS Prohibit Providers From Enrolling?

- The Affordable Care Act gives CMS the authority to temporarily prohibit enrolling new providers of services and suppliers in Medicare or Medicaid as necessary to prevent or combat fraud, waste, and abuse through imposition of moratoria.[49] The Affordable Care Act also gives States the authority to impose such moratoria, so long as CMS agrees.[50]
- Moratoria may be imposed for 6 months and extended in 6-month increments.[51]
- CMS publishes announcements of its moratoria in the Federal Register.[52] SMAs can post information about State moratoria on SMA websites.

Denials and Terminations of Enrollment—What Can a Provider Do?

A provider may be denied enrollment in Medicaid or CHIP if the various screening criteria are not satisfied. Similarly, an enrolled provider may be terminated for failure to meet specific criteria.[53]

Federal regulations ensure the SMA must give providers any appeal rights available under procedures established by State law or regulations.[54] Therefore, if a provider's enrollment is denied or terminated, the provider may contest that action if that State has appeal rights. Providers should check with their SMA to find out whether appeal rights are available in their State.

Materials Available on the Internet

To see the electronic version of this fact sheet, and the other products included in the "Medicaid Provider Enrollment" Toolkit posted to the Medicaid Program Integrity Education page, visit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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