GOVERMENT OF PUERTO RICO

Department of Health
Medicaid Program

Provider Enrollment Portal (PEP)
by the State Medicaid Agency
Puerto Rico Medicaid Program (PRMP)

Disclaimer

The information provided is intended to be a general summary. This presentation does not represent official guidance. The information herein is correct as of the date presented.

Goals and Objectives

- Be aware of the current state and future plans for provider enrollment

- Understand the federal regulations governing provider enrollment

- Learn about additional resources

Why Is This Important?

Ensures that providers are qualified

Ensures that Puerto Rico Medicaid Program (PRMP) is in compliance with federal regulations

Reduces the risk of fraud

Ensures that members receive quality care

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Agenda

- Current and Future State of Provider Enrollment
- Federal Requirements
  - Enrollment and screening
  - Screening levels
  - Verification of provider licenses
  - Federal database checks
  - Site visits
  - Criminal background checks
  - Application fee
  - Ownership disclosure
- Communication Plan
- Resources

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Current and Future
State of Provider Enrollment

Current Provider Enrollment

- PRMP does not currently enroll providers
  - As of the implementation of Phase 1 of the Puerto Rico Medicaid Management Information System (PRMMIS),
- Enrollment is conducted by the managed care organizations (MCOs)/pharmacy benefit managers (PBMs) that enroll providers into their networks

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Current Provider Enrollment

- Administración de Seguros de Salud de Puerto Rico (ASES) is responsible for monitoring the MCOs to ensure appropriate licensure and credentialing is conducted

- A provider may be enrolled in more than one organization

Future Provider Enrollment 2019

- Phase 2 of the PRMMIS will implement the capability to enroll providers.
- Functionality will include everything needed to meet federal regulations including:
  - Screening of providers
  - Verification of licenses
  - Criminal background checks
  - Federal database checks
  - Revalidation
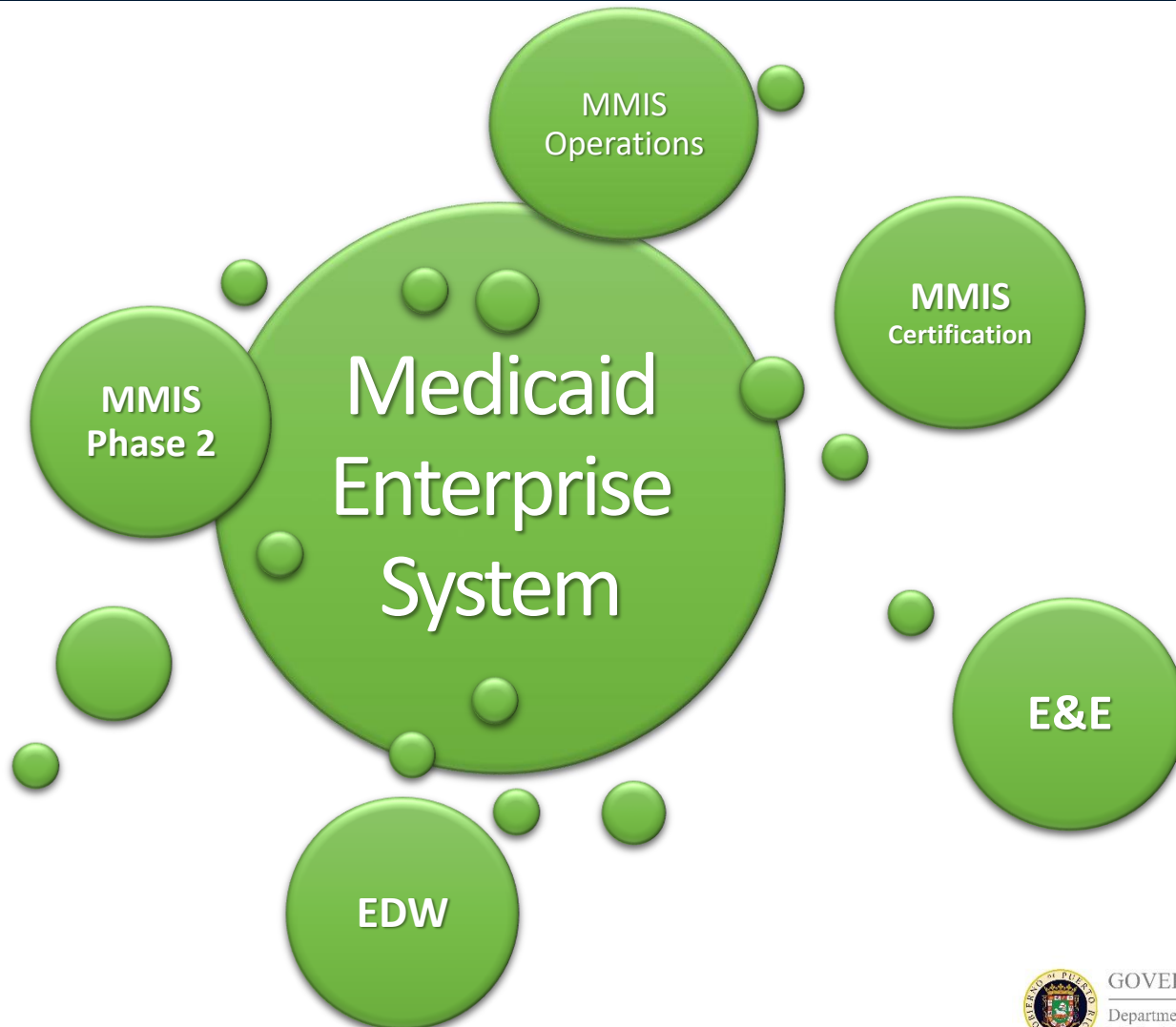
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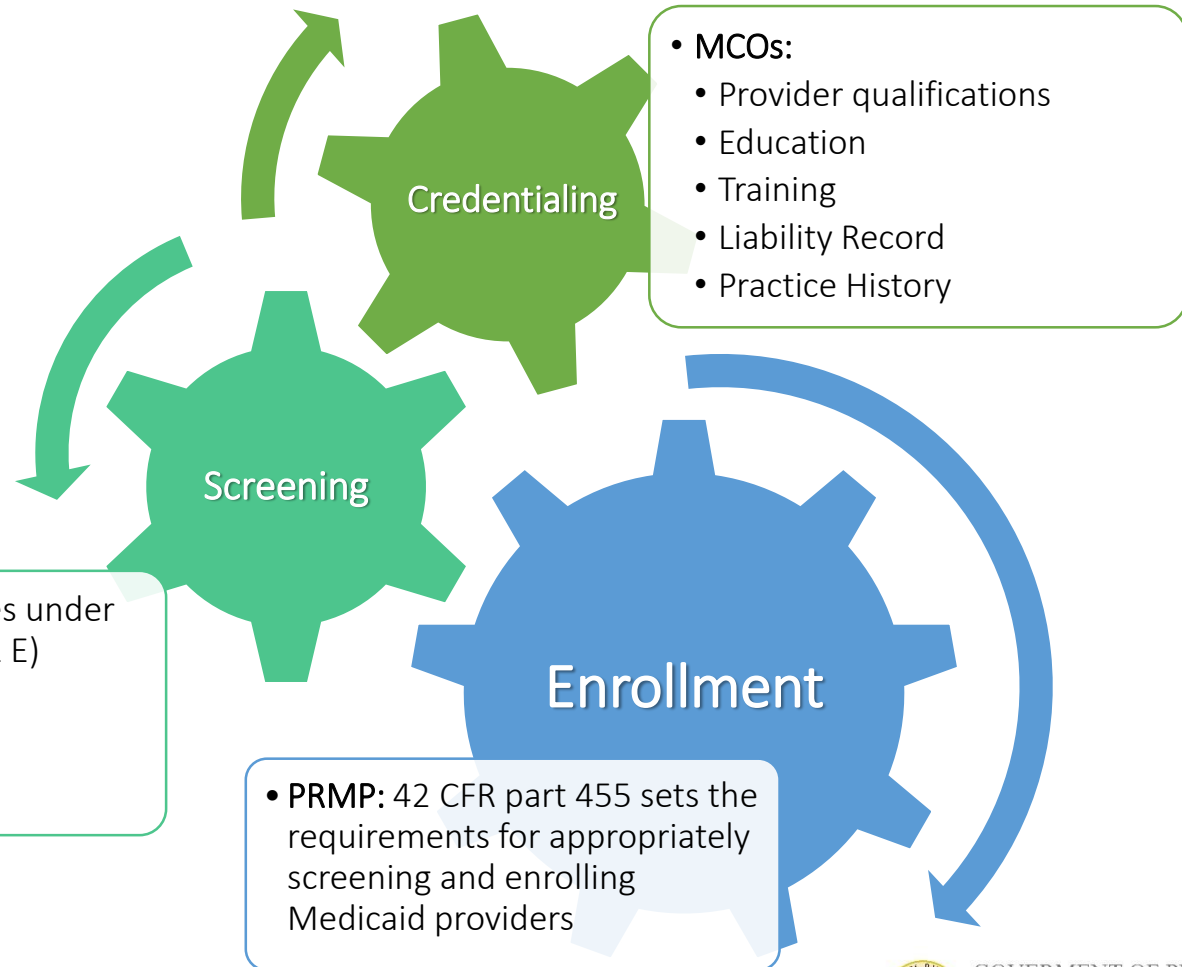Medicaid Program

Federal Requirements

Increased Regulations

The Affordable Care Act of 2010 (ACA) imposed new requirements on State Medicaid Agencies (SMAs) including:

- Enrollment and screening of all providers involved in covered services
- Collection of ownership/control information
- Verification and monitoring of licensure
- Collection of fees for provider enrollment
- Revalidation of providers every 3 years

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Code of Federal Regulations (CFR)

- MCOs:
  - Provider qualifications
  - Education
  - Training
  - Liability Record
  - Practice History

Credentialing

Screening

Enrollment

- **PRMP:** Conducting activities under 438.602 (455 Subparts B & E)
  - Database checks
  - Site visits
  - Fingerprinting

- **PRMP:** 42 CFR part 455 sets the requirements for appropriately screening and enrolling Medicaid providers

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Federal Requirements
Enrollment and Screening

Subpart E
§455.410 Enrollment and Screening

(a) The State Medicaid agency must require all enrolled providers to be screened under to this subpart.

(b) The State Medicaid agency 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.

(c) The State Medicaid agency 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.*

Enrollment

All providers connected to the covered service must enroll.

💵	Billing
🩺	Rendering
📄	Ordering
👤	Referring
💊	Prescribing
🩸	Operating
🛏	Attending

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Federal Requirements

Screening Levels

- *A State Medicaid agency must screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of "limited," "moderate," or "high."*

  - *If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable…*

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Breaking Down the Regulation: Screening Levels and Requirements

Requirement	Limited	Moderate	High
Verify that the provider meets any applicable federal regulations or state requirements for the provider type. §455.450(a)(1)	✓	✓	✓
Conduct state license verifications, including licensure verifications in states other than where the provider is enrolling. §455.412	✓	✓	✓
Conduct federal 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. §455.436	✓	✓	✓
Conduct on-site visits. §455.432.		✓	✓
Conduct a criminal background check. §455.434			✓
Require the submission of a set of fingerprints. §455.434			✓

Breaking Down the Regulation:
Risk Level – Limited

Includes (for all inclusive list see 424.518(a)(1)):

- Physician and non-physician practitioners (nurse practitioners, OT, PT, speech/language pathologists, audiologists, medical groups and clinics)

- Ambulatory surgical centers

- End-stage renal disease facilities

- Federally qualified health centers (FQHC)

- Histocompatibility labs

- Hospitals

- Mammography screening centers

- Organ procurement organizations

- Pharmacies

- Radiation therapy centers

- Skilled nursing facilities (SNFs)

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Breaking Down the Regulation: Risk Level – Moderate

- Ambulance services
- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Hospice organizations
- Independent clinical labs
- Independent diagnostic testing facilities
- Physical therapists enrolling as individuals or as group practices
- Portable x-ray suppliers
- Revalidating home health agencies
- Revalidating durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) providers

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Breaking Down the Regulation: Risk Level – High

- Newly enrolling home health agencies
- Newly enrolling DMEPOS suppliers
- Must elevate provider to High regardless of type when:
  - Payment suspension is imposed based on a credible allegation of fraud, waste or abuse; remains high for 10 years
  - Provider is found to have existing Medicaid overpayments of $1500 or more (when applying or revalidating)
  - Provider has been excluded by Office of Inspector General (OIG) or another State's Medicaid program within the previous 10 years
  - SMA or CMS in previous 6 months lifted a temporary moratorium for the particular provider type

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Federal Requirements
Verification of Provider Licenses

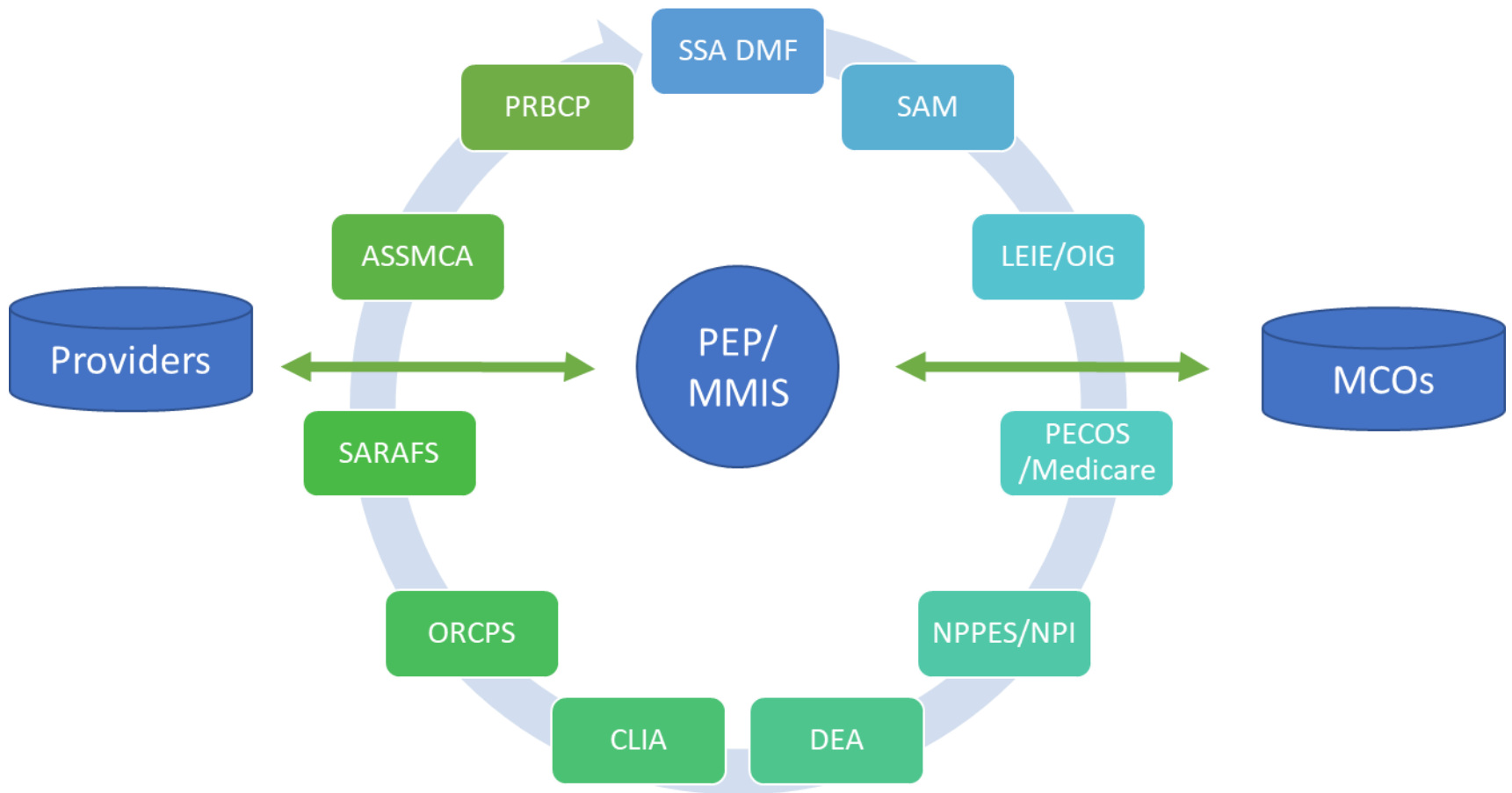*The State Medicaid agency must—*

>*(a) Have a method for verifying that any provider purporting to be licensed in accordance with the laws of any State is licensed by such State.*

>*(b) Confirm that the provider's license has not expired and that there are no current limitations on the provider's license.*

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Provider Enrollment Portal (PEP)

Federal Requirements
Federal Database Checks

The State Medicaid agency must do all of the following:

> *(a) 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.*

> *(b) 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), and any such other databases as the Secretary may prescribe.*

> *(c)(1) Consult appropriate databases to confirm identity upon enrollment and reenrollment; and*

> *(2) Check the LEIE and EPLS no less frequently than monthly.*

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Federal Requirements

Site Visits

The State Medicaid agency—

> *(a) Must conduct pre-enrollment and post-enrollment site visits of providers who are designated as "moderate" or "high" categorical risks to the Medicaid program. The purpose of the site visit will be to verify that the information submitted to the State Medicaid agency is accurate and to determine compliance with Federal and State enrollment requirements.*

> *(b) Must require any enrolled provider to permit CMS, its agents, its designated contractors, or the State Medicaid agency to conduct unannounced on-site inspections of any and all provider locations.*

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Site Visits

Visits can be contracted to an outside vendor and may consist of:

- Taking photos
- Observe that the business is in operation at that location
- Verify that the facility is open and operational with both business personnel and customers present
- Verify hours of operation
- Proof of business records such as rental agreements
- Inventory
- Staff interviews may be conducted as well

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Federal Requirements
Criminal Background Checks

The State Medicaid agency—

(a) 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 level of screening based on risk of fraud, waste or abuse as determined for that category of provider.

(b) Must establish categorical risk levels for providers and provider categories who pose an increased financial risk of fraud, waste or abuse to the Medicaid program.

(1) Upon the State Medicaid agency determining that a provider, or a person with a 5 percent or more direct or indirect ownership interest in the provider, meets the State Medicaid agency's criteria hereunder for criminal background checks as a "high" risk to the Medicaid program, the State Medicaid agency will require that each such provider or person submit fingerprints.

(2) The State Medicaid agency 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 State Medicaid agency, within 30 days upon request from CMS or the State Medicaid agency.

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Department of Health
Medicaid Program

Federal Requirements
Disclosure of Ownership

Subpart B
§455.104 Disclosure of Ownership

(a) Who must provide disclosures. The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.

(b) What disclosures must be provided. The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:

> *(1)(i) 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.*
>
> *(ii) Date of birth and Social Security Number (in the case of an individual).*
>
> *(iii) Other tax identification number (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.*

Subpart B
§455.104 Disclosure of Ownership

(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; or 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.

(3) 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.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

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Federal Requirements

Application Fee

(a) Beginning on or after March 25, 2011, States must collect the applicable application fee prior to executing a provider agreement from a prospective or re-enrolling provider other than either of the following:

> *(1) Individual physicians or non-physician practitioners.*

> *(2)(i) Providers who are enrolled in either of the following:*

>> *(A) Title XVIII of the Act.*

>> *(B) Another State's title XIX or XXI plan.*

> *(ii) Providers that have paid the applicable application fee to—*

>> *(A) A Medicare contractor; or*

>> *(B) Another State.*

(b) If the fees collected by a State agency in accordance with paragraph (a) of this section exceed the cost of the screening program, the State agency must return that portion of the fees to the Federal government.

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Process Flow

Collect provider enrollment information and supporting documentation via Provider Enrollment Portal (PEP)

Validate provider enrollment information and screen providers

Approve providers for participation including billing, rendering, ordering, referring, attending, operating and prescribing
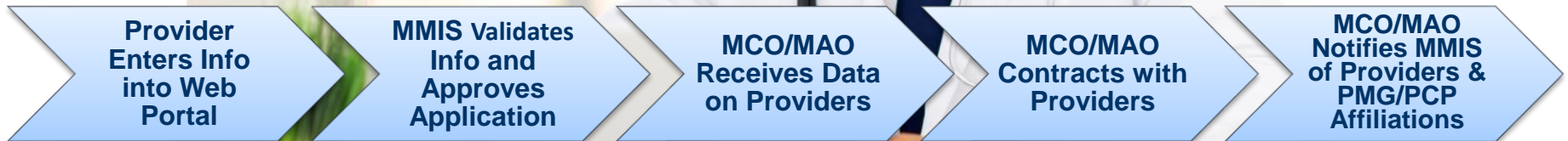
Communicate and share information with MCO & MAO regarding which providers are enrolled

Receive info from MCO & MAO regarding which providers are contracted along with Primary Medical Group (PMG) and Primary Care Provider (PCP) affiliations

Process Flow

Provider Enters Info into Web Portal → MMIS Validates Info and Approves Application → MCO/MAO Receives Data on Providers → MCO/MAO Contracts with Providers → MCO/MAO Notifies MMIS of Providers & PMG/PCP Affiliations

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Outreach Communication Plan

Component 3: PRMP / Health Professions Organizations/ MCOs

February 2020 through Go-live

o Individual Providers

- *Share timelines, scope, policies and instructions.*
- *Complete trainings for PEP.*

Component 2: PRMP

August through January 2020

o MCOs

- *Achieved that the MCOs are aboard to collaborate and carry the message about what is to come for providers.*

o Hospitals , Primary Care Facilities, FQHCs, Medical Groups, Laboratories, Imaging Centers, Pharmacies

- *Share timelines, scope, requirements and policies.*

Component 1: PRMP

May through July 2019

o MCOs &Health Professions Organizations

- *PRMP awareness campaign.*
- *Share strategic dates.*
- *MES Technology Project awareness.*

Next Steps

Roll out plan to be developed
- Scheduled start dates by provider type

Communications to be shared
- Information and training via website, health professional organization meetings, conventions, WebEx

Providers will enroll via PEP

Provider enrollment information will be shared with MCO/MAO to confirm contracts

Key Messages

- Health Professional Organizations support is needed to get the word to providers

- Collaboration between PRMP and Providers is key

Resources

- Code of Federal Regulations – Title 42, Chapter IV, Subchapter C, Part 455 https://www.ecfr.gov/cgi-bin/text-idx?SID=6aa2021b042321fcac25facf1426491b&mc=true&tpl=/ecfrbrowse/Title42/42cfr455_main_02.tpl

- Medicaid Provider Enrollment Compendium (MPEC) https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-6232017.pdf

- Medicaid Program Integrity Resources https://www.medicaid.gov/medicaid/program-integrity/affordable-care-act-program-integrity-provisions/index.html

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Questions?

Send us your questions :
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Thank you!