Medicaid IN Schools

FREQUENTLY ASKED QUESTIONS ABOUT:
Indiana School Corporation Medicaid Provider Enrollment

INDIANA'S SCHOOL CORPORATION MEDICAID PROVIDER ENROLLMENT REQUIREMENT

Where can I find the statute requiring that school corporations enroll as Medicaid providers?

The entire Indiana Code is available online at http://www.in.gov/legislative/ic/code/. The specific state statute requiring Indiana public school corporations to enroll as Indiana Medicaid medical service providers is IC 12-15-1-16.

Does the school corporation have to enroll in Medicaid even if it does not intend to claim Medicaid reimbursement for covered IEP-required medical services provided to Medicaid-enrolled students?

Yes, although IC 12-15-1-16 does not require public school corporations to participate in Medicaid claiming, it requires every Indiana public school corporation to complete the Indiana Medicaid provider enrollment. A public school corporation is not charged a fee to enroll as a Medicaid provider.

MANDATORY SOCIAL SECURITY NUMBER DISCLOSURE

My superintendent has concerns about including her social security number (SSN) on the school corporation's Medicaid provider enrollment form; can we avoid that?

*A federal mandate aimed at reducing Medicaid and Medicare fraud and abuse requires that the managing individual of every Medicaid-enrolled provider entity disclose his or her Social Security Number. As noted on the following pages containing excerpts from **Federal Register** / Vol. 76, No. 22 / Wednesday, February 2, 2011, the Social Security Number is used to verify that the managing individual is not barred from participating in federally funded programs due to prior fraudulent activity.*

The following safeguards are in place to protect Indiana Medicaid provider enrollment data:

- *Every Medicaid employee and contractor must pass a thorough background check and participate in Health Insurance Portability and Accountability Act ("HIPAA") privacy training before accessing Medicaid data and computer systems*
- *All Medicaid data is stored behind firewalls on secure servers in facilities with badge readers limiting access to every entrance*
- *Before viewing electronically stored Medicaid data employees and contractors must first:*
  - *Log in to a secure local area network, and*
  - *Log in to the data display application*

PERIODIC MANDATORY MEDICAID PROVIDER ENROLLMENT REVALIDATION

My district enrolled years ago but doesn't bill. Must we revalidate our Medicaid provider enrollment?

Failure to complete the Medicaid provider enrollment revalidation every five years results in termination of the district's existing Medicaid Provider enrollment. To remain in compliance with the Medicaid provider enrollment requirement in IC 12-15-1-16, Indiana public school corporations must complete the required revalidation process by the state Medicaid agency's designated deadline.

as a way to minimize the administrative burden of enrolling additional providers, State Medicaid agencies may implement a streamlined enrollment process for those providers who only order or refer, that is who do not bill for services, similar to the CMS–855–O process in the Medicare program. *Comment:* A commenter questioned whether a provider that has enrolled as a participating provider to comply with § 455.410(b) must submit fee-for-service claims to the Medicaid agency, or is the provider's status as an enrolled provider sufficient for compliance. *Response:* Under § 455.410(b), a physician or other professional need not submit fee-for-service claims to the State Medicaid agency to remain enrolled as a Medicaid provider. *Comment:* With respect to § 455.440, one State asked whether the provider's NPI must be on each and every claim or whether it is sufficient for the provider's NPI to be on file with the State Medicaid agency, and whether the prescribing provider's NPI would be required on pharmacy claims. *Response:* Under § 455.440, "all claims for payment for items and services that were ordered or referred" must contain the NPI. This is based upon the statutory requirement in section 1902(kk)(7)(B) of the Act that States require the NPI "of any ordering and referring physician or other professional to be specified on any claim for payment that is based upon an order or referral of the physician or other professional." Therefore, the provider's NPI must be on every claim, including pharmacy claims; it is not sufficient for the provider's NPI to be on file. g. Other State Screening—Medicaid and CHIP Section 1902(kk)(8) of the Act establishes that States are not limited in their abilities to engage in provider screening beyond those required by the Secretary. Accordingly, in § 455.452, we proposed that States may utilize additional screening methods, in accordance with their approved State plan. As stated previously, pursuant to section 2107(e)(1) of the Act and specified in our regulations in Part 457, all provisions that apply to Medicaid under sections 1902(a)(77) and 1902(kk) of the Act apply to CHIP. Because we proposed a new regulation under which all provider screening requirements that apply to Medicaid providers will apply to providers that participate in CHIP, this requirement for other State screening under § 455.452 applies in CHIP.

h. Final Screening Provisions— Medicaid and CHIP We are adopting the Medicaid and CHIP provider screening requirements as proposed with the following modifications: • We clarified § 455.104(b)(1) regarding the elements of corporate addresses. • We clarified § 455.104(b)(2) with regard to whom the spouse, parent, child, or sibling is related. • We clarified § 455.104(b)(4) to require managing employees to provide SSNs and DOBs. • We clarified § 455.104(c)(1), and § 455.104(c)(1)(i) and (ii) to include submission of disclosures from disclosing entities as well as providers. • We clarified § 455.104(c)(1)(iii) to require submission of disclosures upon the request of the Medicaid agency during the revalidation of enrollment process.• We are adopting § 455.450 with modifications, having clarified that the State agency must screen applications both in re-enrollment and re-validation of enrollment in the introductory paragraph; deleted the reference to publicly traded companies in § 455.450(a); deleted reference to persons with controlling interests, agents and managing employees who are required to provide fingerprints in § 455.450(d); and clarified the basis for adjusting a screening level related to moratoria § 455.450(e)(2). • At § 455.414 we clarified that States must revalidate the enrollment information of all providers at least every 5 years. • We are adopting § 455.416 with modifications clarifying terminations of persons with 5 percent of more direct or indirect ownership interests in the provider; and deleting reference to persons with controlling interests, agents and managing employees under bases for termination for failure to provide fingerprints.• We clarified § 455.434 to require criminal background checks from providers or persons with a five percent or more direct or indirect ownership interest in the provider who meet the State Medicaid agency's criteria as a high risk to the Medicaid program; and to require fingerprints from providers and person with a five percent or more direct or indirect ownership interest in the provider, upon the State Medicaid agency's or CMS' request. • We are not finalizing the proposed provision that States deactivate the enrollment of any provider that has not billed for 12 months. • And finally, we are not finalizing the proposed requirement at § 438.6(c)(5)(vi) that required all ordering and referring Medicaid Managed Care network providers to be enrolled as participating providers based on commenters' concerns regarding access to services for beneficiaries. 5. Solicitation of Additional Comments Regarding the Implementation of the Fingerprinting Requirements While this final rule with comment period is effective on the date indicated herein, we strongly believe that certain issues warrant further discussion. Accordingly, we will continue to seek comment limited to our implementation of the fingerprinting provisions contained in § 424.518 and § 455.434 of this rule. Specifically, we seek comment on methods that we can use to ensure the privacy and confidentiality of the records that will be generated pursuant to adopting the criminal history records check provisions specified herein. As described, we will adopt all protocols issued by the FBI. However, we are interested in any other privacy concerns that interested parties may have in addition to thoughts on how best to address these concerns. In addition, we seek comment on the means by which we can measure the effectiveness of our adoption of criminal history records checks. That is, we are seeking comments on tangible, measureable methods we should use to demonstrate the effectiveness of these provisions. In addition, we seek comment on whether we should adopt additional technology to identify providers and suppliers that are enrolling in the program. In the proposed rule, we solicited specific comments on this topic. However, we are interested in receiving additional input from providers, suppliers, and other interested parties in light of the provisions set forth in this final rule with comment period. As noted, we are only seeking comment on the limited areas previously described. We will accept public comment for 60 days following publication of this final rule with comment period. To reiterate, we are finalizing the requirement that providers and suppliers will be subject to criminal history records checks in the event they are considered within the "high" level of risk as described in this rule. Providers and suppliers, and all other commenters, are encouraged to submit comments within the 60-day window to assist us in best implementing the requirements that we are finalizing surrounding this

agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing. (f) Must terminate or deny enrollment if the provider fails to permit access to provider locations for any site visits under § 455.432, unless the State Medicaid agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing. (g) May terminate or deny the provider's enrollment if CMS or the State Medicaid agency— (1) Determines that the provider has falsified any information provided on the application; or (2) Cannot verify the identity of any provider applicant.

§ 455.420 Reactivation of provider enrollment. After deactivation of a provider enrollment number for any reason, before the provider's enrollment may be reactivated, the State Medicaid agency must re-screen the provider and require payment of associated provider application fees under § 455.460.

§ 455.422 Appeal rights. The State Medicaid agency must give providers terminated or denied under § 455.416 any appeal rights available under procedures established by State law or regulations.

§ 455.432 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.

§ 455.434 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.

§ 455.436 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.

§ 455.440 National Provider Identifier. The State Medicaid agency 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.

§ 455.450 Screening levels for Medicaid providers. 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. (a) *Screening for providers designated as limited categorical risk.* When the State Medicaid agency designates a provider as a limited categorical risk, the State Medicaid agency must do all of the following: (1) Verify that a provider meets any applicable Federal regulations, or State requirements for the provider type prior to making an enrollment determination. (2) Conduct license verifications, including State licensure verifications in States other than where the provider is enrolling, in accordance with § 455.412. (3) Conduct database checks on a pre-and post-enrollment basis to ensure that providers continue to meet the enrollment criteria for their provider type, in accordance with § 455.436. (b) *Screening for providers designated as moderate categorical risk.* When the State Medicaid agency designates a provider as a "moderate" categorical risk, a State Medicaid agency must do both of the following: (1) Perform the "limited" screening requirements described in paragraph (a) of this section. (2) Conduct on-site visits in accordance with § 455.432. (c) *Screening for providers designated as high categorical risk.* When the State Medicaid agency designates a provider as a "high" categorical risk, a State Medicaid agency must do both of the following: (1) Perform the "limited" and "moderate" screening requirements described in paragraphs (a) and (b) of this section. (2)(i) Conduct a criminal background check; and (ii) Require the submission of a set of fingerprints in accordance with § 455.434. (d) *Denial or termination of enrollment.* A provider, or any person with 5 percent or greater direct or indirect ownership in the provider, who is required by the State Medicaid agency or CMS to submit a set of fingerprints and fails to do so may have its— (1) Application denied under § 455.434; or (2) Enrollment terminated under § 455.416. (e) *Adjustment of risk level.* The State agency must adjust the categorical risk level from "limited" or "moderate" to "high" when any of the following occurs: (1) The State Medicaid agency imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse, the provider has