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 and future state of provider enrollment
- Understand the federal regulations governing provider enrollment

Why PEP 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

Agenda

- PRMP and MMIS
- Current 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
- PEP Statistics (October 20, 2022)
- Future State of Provider Enrollment

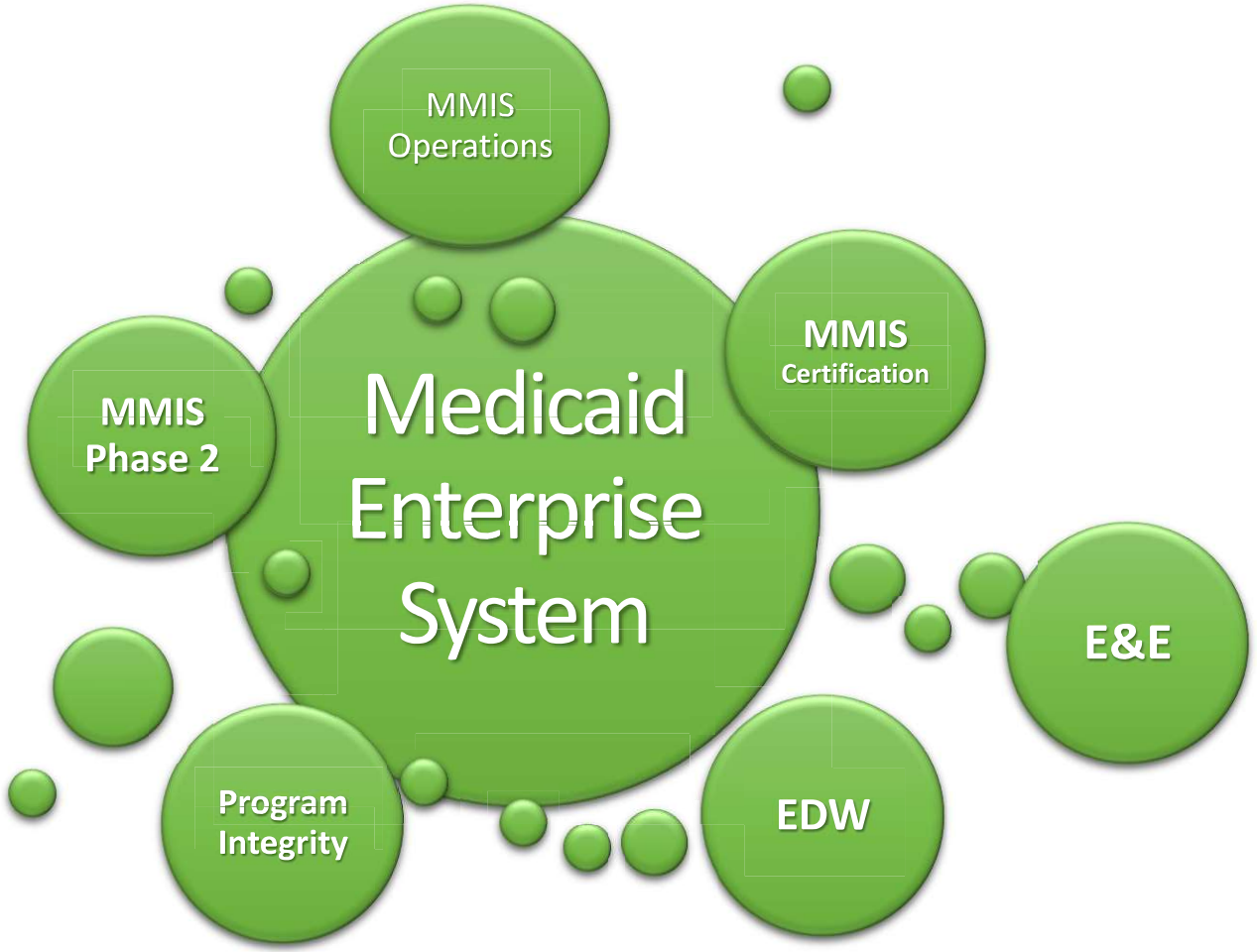
PRMP Vision

- Transform PRMP program into an information-driven agency
- Improve program oversight
- Leverage technology advancements to improve healthcare outcomes for its citizens
- Improve the quality of healthcare services
- Increase credibility of the Medicaid program office within the Government of Puerto Rico CMS

PRMP Projects

- MMIS
  - MMIS Phase 1
    - MMIS Operations / Program Integrity /MCFU
    - MMIS Certification
  - MMIS Phase 2
    - Provider Enrollment
- Eligibility and Enrollment

PRMP Projects



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Current

State of Provider Enrollment

Current Provider Enrollment

- PRMP is currently enrolling providers
  - PRMP began enrolling providers since April 26, 2020
- Enrollment was prior conducted by the managed care organizations (MCOs)/pharmacy benefit managers (PBMs) that enroll providers into their networks
  - MCO/MAO/PBM's still needs to complete full credentialing of providers

Current Provider Enrollment

- Administración de Seguros de Salud de Puerto Rico (ASES) is still responsible for monitoring the MCOs to ensure appropriate licensure and credentialing is conducted
- A provider may still be enrolled in more than one organization but, it is now enrolled with PRMP

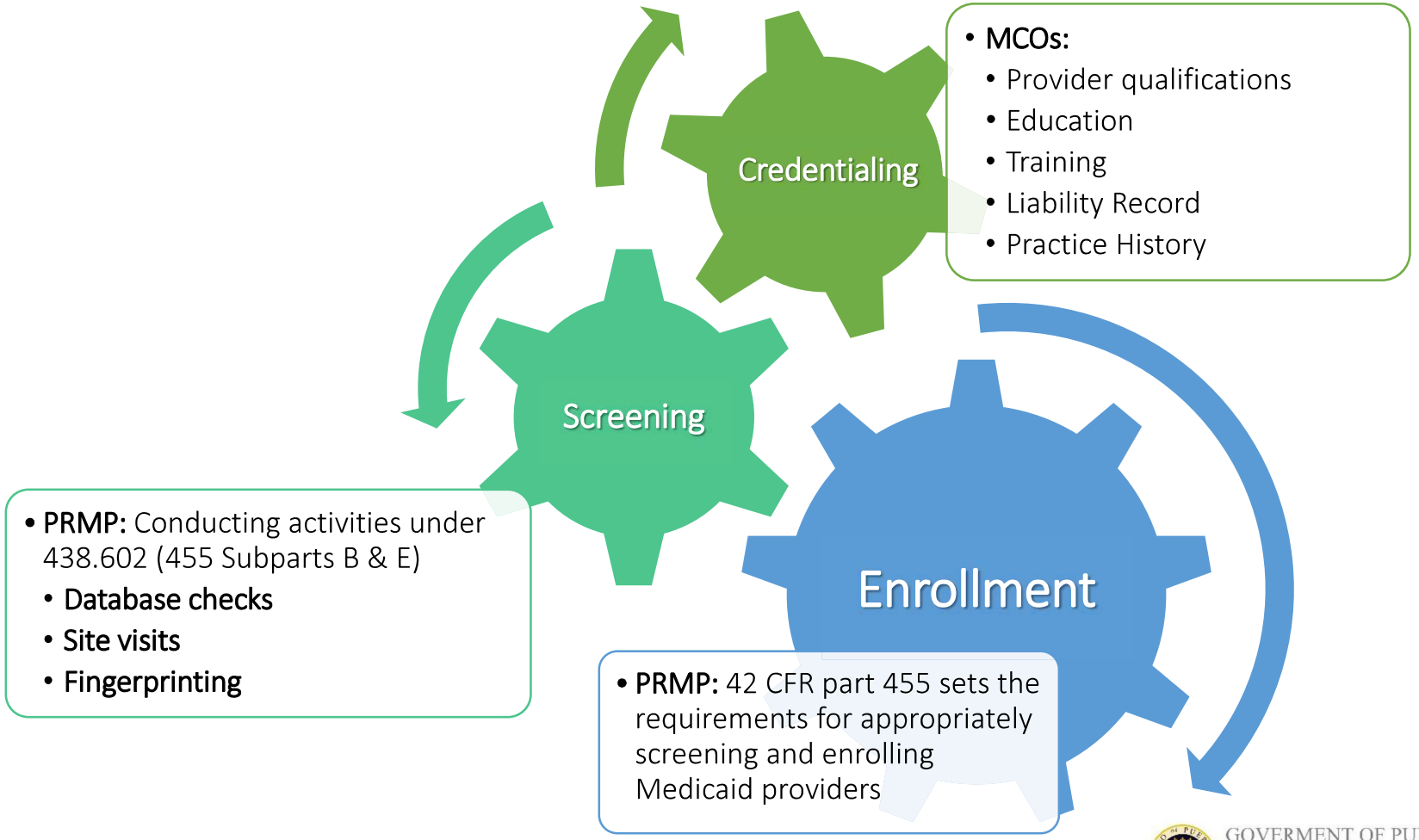
Federal Requirements

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

Code of Federal Regulations (CFR)



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Federal Requirements

Enrollment and Screening

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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.

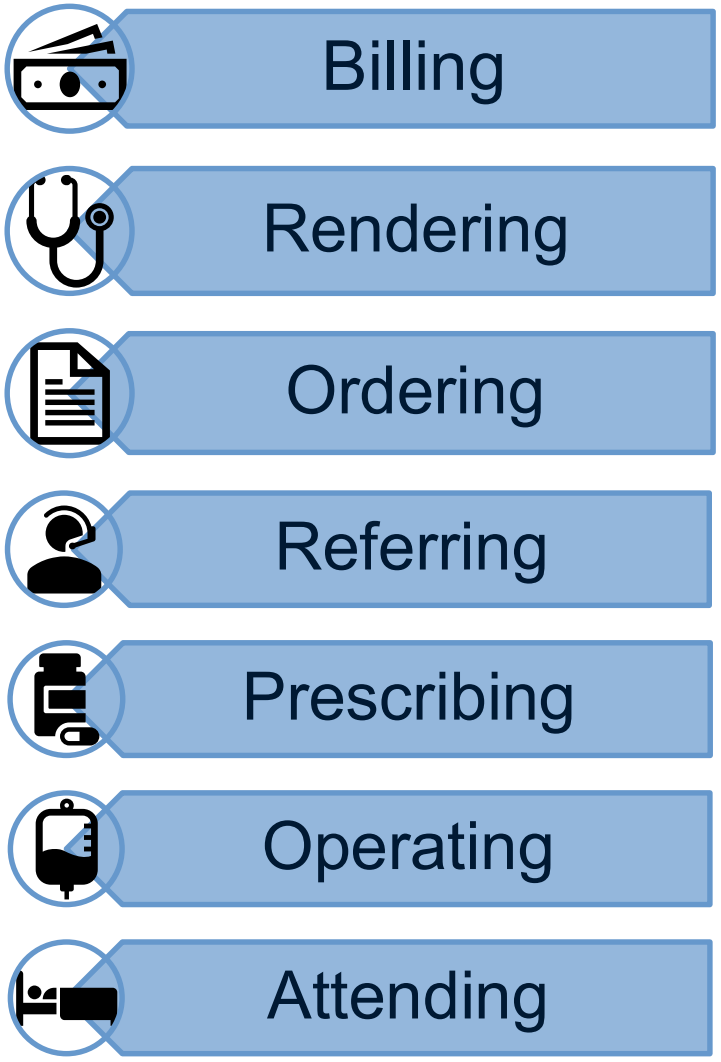
(c) The State Medicaid agency may rely on the results of the provider screening performed by any of the following:

(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.



Federal Requirements

Screening Levels

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Subpart E
§455.450 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…*

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)

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

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

Federal Requirements

Verification of Provider Licenses

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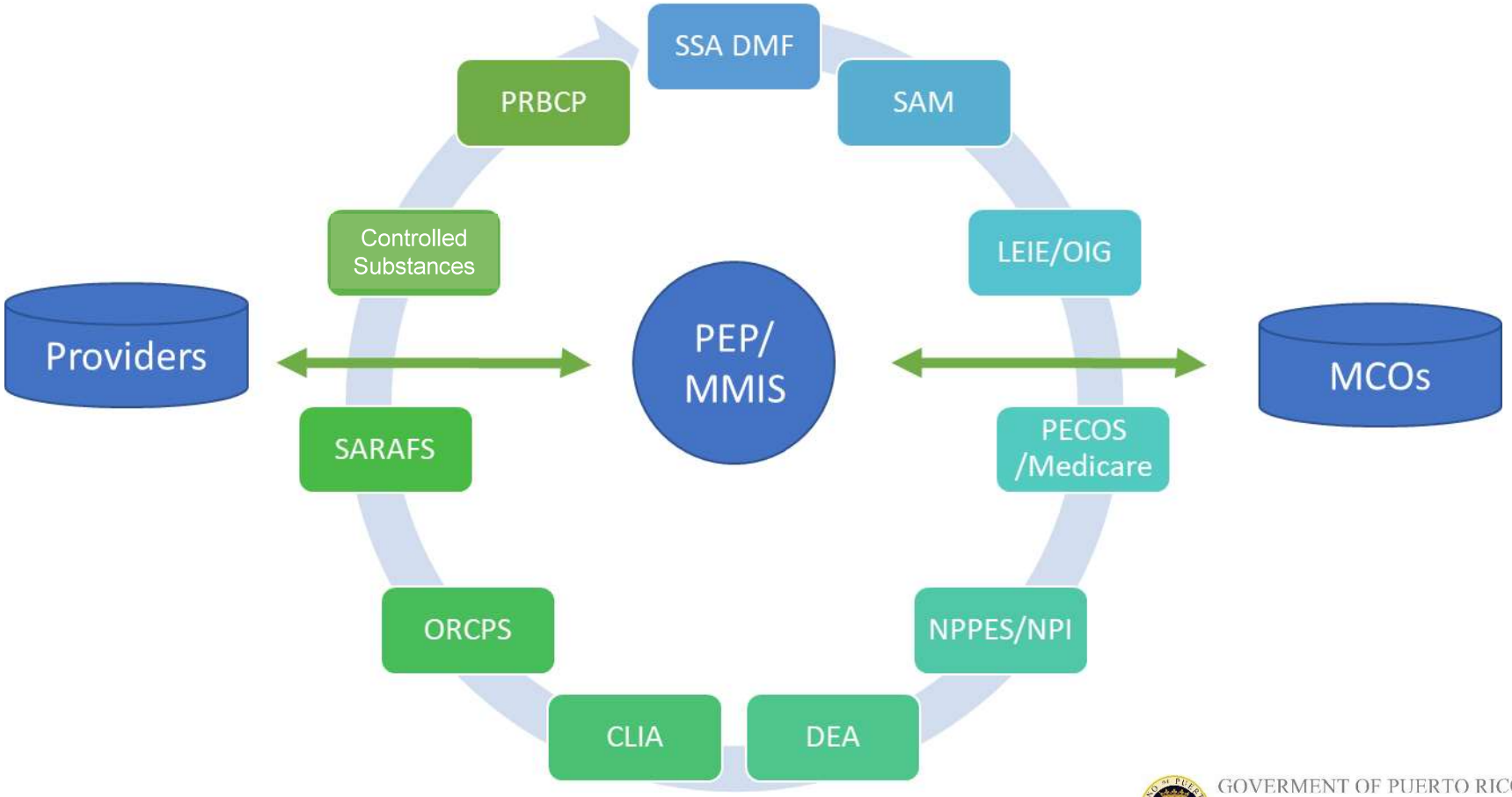
Subpart E
§455.412 Verification of Licenses

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.

Provider Enrollment Portal (PEP)



Federal Requirements

Federal Database Checks

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Medicaid Program

Subpart E
§455.436 Federal Database Checks

The State Medicaid agency must do all 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.

Federal Requirements

Site Visits

Subpart E
§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 all provider locations.*

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

Federal Requirements

Criminal Background Checks

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Medicaid Program

Subpart E
§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.

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).

Federal Requirements

Application Fee

Subpart E
§455.460 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.

PEP Enrollment Process Flow

Process Flow

Provider Enrollment Portal

Statistics: October 20, 2022

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PEP Statistics as of October 20, 2022

- Approved PEP applications – 23,438
- Active Provider Counts in MMIS – 26,528
  - Provider counts by service location is greater than approved PEP applications
  - In one application (i.e., Individual or Sole Proprietor) a provider may enroll more than one service location
- There are 18,301unduplicated NPIs approved

PEP Statistics as of October 20, 2022

Row Labels	Count of ATN
Ambulance	242
Ambulatory Surgical Center	31
Audiologist	85
Audiologist Group	12
Center for Diagnosis and Treatment	112
Certified Addiction Counselor	23
Chiropractor	237
Chiropractor Group	112
Comprehensive Outpatient Rehabilitation Facility	13
Dentist	1,227
Dentist Group	263
Developmental Disability Center	2
Dialysis Center	47
Durable Medical Equipment	63
External Clinic - Hospital Based	15
Family Planning Center	2
Federally Qualified Health Center	122
Hearing Aid Supplier	3
Home Health Agency	45
Hospice	51
Hospital	71
Imaging Center	249
Imaging Center - Mobile	3
Implant Supplier	31
Infusion Center / Agency	8
Inpatient Rehabilitation Facility	9
Laboratory	881
Licensed Marriage Counselor	3
Mental Health Center	123
Methadone Center	6
Midwife Group	1

Row Labels	Count of ATN
Multi-disciplinary Group	185
Non-Emergency Medical Transportation	35
Nurse Practitioner	2
Nutritionist/Dietician	266
Nutritionist/Dietician Group	20
Occupational Therapist	131
Occupational Therapist Group	12
Optometrist	567
Optometrist Group	137
Pediatric Center	13
Pharmacy	1,204
Physical Therapist	294
Physical Therapy Group	119
Physician	11,661
Physician Assistant	26
Physician Group	1,955
Podiatrist	62
Podiatrist Group	14
Primary Care Center	81
Prosthesis and Orthotics Supplier	6
Psychologist	1,256
Psychologist Group	92
Skilled Nursing Facility - Free Standing	4
Skilled Nursing Facility - Hospital Based	3
Social Worker	350
Speech Language Pathologist	259
Speech Language Pathologist Group	58
Urgent Care Center	33
Vaccination Center	246
Vision Center / Optics	247
Wound Care Center / Hyperbaric Medicine	8
Grand Total	**23,438**

PEP Statistics as of October 20, 2022 (cont.)

- PHE Waivers
  - Due to the CMS Public Health Emergency (PHE) there is still the following COVID waived providers:
    - Providers that needs to pay Application Fees – 2,691
    - Providers that requires Background Checks – 117
      - Both Application Fees and Background Checks were approved but pending the PHE lift for re-evaluation
    - Site Visits were previously waived, PRMP request CMS clearance for conducting those Site Visits:
      - Site Visits passed -1,806
      - Site Visits failed - 136
      - Site Visits in 1st attempt 3
      - Total Site Visits – 1,945

PEP Future State

What still needs to happen?

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PEP Future State

- Providers still needs to enroll all places of services
  - PRMP estimates 5,000 more enrollment applications
    - Unique NPI providers to enroll – 1,000
    - Groups needs to enroll all places of service of their associated providers
- PRMP needs to update the current policy on Out of State providers
  - To include or exclude providers from MAO's such as pharmacies
  - Including those providers, will represent more than 6,000 additional enrollments

PEP Future State

- PRMP/ASES needs to update carrier agreements to include PEP as a condition to participate in their networks
- MCO/MAO/PBM's will need to activate edits to deny all providers (and/or services locations) not enrolled PEP