VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS

Standard Operating Procedure

Title: Provider Screening & Enrollment

DVHA Unit: Member and Provider Services (MPS)

Issuance Date: February 1, 2024

(Must be reviewed annually)

Applicable Regulations, Guidelines, and AHS Policy:

Federal statute or rule:

42 CFR Part 455, Subpart E - Provider Screening and Enrollment

State Plan:

4.30, 4.31

Purpose:

State Medicaid Plans pay providers for furnishing covered services to eligible members, including either on a fee-for-service basis or through risk-based managed care arrangements. If state Medicaid agencies pay fraudulent providers, either directly or through managed care plans, for services that the providers did not furnish or for services they did furnish to members they knew had no need for the services:

- Medicaid funds are diverted from their intended purpose,
- Members who need services may not receive them,
- Members who do not need services may be harmed by unnecessary care,
- Members seeking care may not see qualified providers who are compliant with federal and state requirements.

Identifying overpayments due to fraud and recovering those overpayments from providers that engaged in the fraud is resource-intensive and can take years. In contrast, keeping ineligible entities and individuals from enrolling in State Medicaid Plans as providers in the first place allows the program to avoid paying claims to such parties and then attempting to identify and recover those overpayments. Provider screening enables states to identify such parties before they enroll and start billing.

Procedure:

DVHA's Fiscal agent processes all enrollment, reenrollment, and revalidation requests and screens in accordance with 42 CFR § 455.

Fiscal agent assigns risk levels in accordance with 42 CFR § 455.

Fiscal agent sends all provider enrollment applications to MPS for review and final approval via the Provider Management Module (PMM), regardless of risk level.

MPS reviews the application to ensure risk level screening requirements are met. Under federal regulation § 455.410, SMAs must require all enrolled providers to be screened based on the level of risk of fraud, waste, or abuse of the State Medicaid Plan. In conducting risk-based screening of providers enrolled in both Medicare and Medicaid, State Medicaid Agencies (SMAs) may, but are not required to, rely on the results of screening performed by Medicare or its contractors. Any initial screening by Fiscal agent that results in a possible issue regarding standard of care, licensing, malpractice, and/or legal obligation issues are sent to the State Review step within PMM.

In addition to the Limited risk screening requirements conducted by fiscal agent, Moderate risk level providers are sent to MPS for the Site Visit requirement via the PMM system. If confirmation is made that either PECOS or another SMA performed a site visit, MPS notes the visit date and who performed the visit in the PMM system.

If no site visits are performed by CMS or another SMA, a member of the MPS team will perform either a physical or virtual site visit. Either a physical or virtual site visit will be attempted within 30 days of receiving an application from the fiscal agent.

If the provider is located within Vermont, a physical site visit will be conducted by the MPS team. The visit is performed unannounced in most cases; however, this is determined on a case-by-case basis. The MPS team member will tour the provider's practice and review the site visit checklist with the appropriately identified staff member(s). A picture of the provider's signage and hours of operation, if applicable, is taken upon completion of the visit for MPS' records.

If the provider is located outside Vermont, a virtual site visit will be arranged by the MPS team via Microsoft Teams. The provider will be required to virtually tour the MPS staff around the practice using a mobile device. The checklist will be reviewed with the provider and a screenshot of their signage and hours of operation, if applicable, is taken for MPS' records.

Upon completion, the attached site visit checklist is uploaded to the enrollment record in the PMM system.

Based on the information from the site visit, the provider may or may not be approved for participation in Vermont Medicaid program. In either case, the fiscal agent generates a letter to the provider notifying them of the decision.

High risk providers are required to have a site visit, criminal background checks, and fingerprints on file.

The site visit process outlined for Moderate risk providers is also followed for High-Risk providers.

Additionally, checks for fingerprints in PECOS and with other SMAs are conducted. If no fingerprints are on file, MPS will advise the provider via a letter to submit fingerprints. The provider must send the results to DVHA, which will include the actual fingerprints as well as the criminal background information. The cost of the fingerprints is incurred by the provider. The provider or owner has 30 days from the date of application to provide fingerprints or the application is returned. If the fingerprints or criminal background check come back with convictions related to health care fraud, crimes against a child or vulnerable adult, or crimes involving illegal use, possession, or distribution of a controlled substance, the application will be denied.

All applications are reviewed by MPS in the Final Review step of the PMM module to ensure all screening activities are completed. Providers are notified in writing of approval or denial to participate with Vermont Medicaid.

DVHA will allow providers to act within the scope of their licenses and/or certifications and bill for covered services that meet the needs of enrollees so long as the provider has the requisite expertise, as evidenced by licensure or certification, to provide said services, and the services are covered under the enrollee's applicable benefit plan.

Revision History:

Date	Summary of Revisions
4/5/2022	OMU review. No substantial changes.
9/21/23	OMU review. Changes tracked were accepted. New director noted. Date changed from 4/5/22 to 9/21/23.
10/30/23	Updates to include virtual site visit information.
2/6/24	Changed SOP to outline the DVHA process for screening and enrollment activities of all provider risk levels (Limited, Moderate and High Risk). Title change from Moderate and High Risk Screening SOP to Provider Enrollment and Screening SOP.
2/26/24	OMU review for Act 156.

Table 1 Revision History