

Affordable Care Act (ACA) Provider Enrollment Frequently Asked Questions (FAQ)

Texas Medicaid is complying with provisions of the Affordable Care Act of 2010 (ACA), which affect Texas Medicaid providers.

The purpose of this FAQ is to answer the questions that Texas Medicaid providers might have about changes to the Texas Medicaid program, provider enrollment, and program participation.



Revised 12/20/2016

CONTENTS:

Section 1: Provider Re-enrollment.....	2
Section 2: Risk Categories	9
Section 3: Provider Screening	11
Section 4: Application Fee.....	12
Section 5: Ordering- and Referring-Only Providers	14
Section 6: Compliance Programs.....	16
Section 7: PCP Rate Increase.....	17



TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Section 1: Provider Re-enrollment

The Centers for Medicare and Medicaid Services (CMS) recently announced that the previous March 24, 2016 deadline for Medicaid provider re-enrollment is extended to Sept. 25, 2016. Though this extension gives states additional time to ensure providers comply with Patient Protection and Affordable Care Act (PPACA) requirements, Texas Medicaid encourages all providers who have not yet submitted a re-enrollment application to begin this process immediately to avoid potential payment disruptions.

See Also:

For more information about provider re-enrollment, see the [ACA page](#) on the TMHP website.

Note: *This deadline extension also applies for CSHCN Services Program Hospice and Medical Foods providers.*

1.1 What does re-enrollment entail?

Re-enrollment includes the submission of a new Texas Medicaid provider enrollment application, all additional documentation, and application fee (see Section 4) to continue participation in Texas Medicaid. Receipt of a completed application will initiate the provider screening process (see Section 3).

Providers were first notified of the re-enrollment requirements in November 2012. Additional articles regarding re-enrollment continue to be published on the ACA webpage on the TMHP website at www.tmhp.com.

1.2 Do providers have to initiate the re-enrollment process or will it be initiated by TMHP?

Providers must initiate the re-enrollment process by the submission of a Texas Medicaid Provider Enrollment Application accompanied by an application fee, if applicable.

1.3 I enrolled before January 1, 2013. When can I begin the re-enrollment process?

You may begin this process as early as today. All providers who enrolled prior to January 1, 2013, must complete the re-enrollment process by Sept. 25, 2016.

1.4 I only provide Medicaid services through managed care organizations. Do I need to re-enroll?

Yes. All Texas Medicaid providers enrolled before January 1, 2013, must re-enroll by Sept. 25, 2016. This requirement applies to those providing services through Medicaid managed care organizations (MCO) or through traditional fee-for-service Medicaid.

Just as providers must be enrolled in Texas Medicaid before they can be contracted and credentialed by an MCO or dental plan, providers must be re-enrolled to maintain credentialing with their plan. In order to maintain credentialing with your Medicaid MCOs, please be sure you are fully re-enrolled prior to the Sept. 25, 2016 deadline. To be considered fully re-enrolled, providers must submit a completed re-enrollment application and receive a notification from the Texas Medicaid & Healthcare Partnership (TMHP) that their application has been approved. To allow sufficient time for re-enrollment application processing, providers are encouraged to begin this process immediately.

1.5 Can I view my re-enrollment status online?

Yes. Effective December 11, 2015, Provider Administrator accounts on the TMHP website will display re-enrollment status.

1.6 How do I view my re-enrollment status?

To view your status:

1. Go to the TMHP website at www.tmhp.com.
2. Log into My Account as a provider administrator.
3. Select Provider Information Management System (PIMS), which is located under “Manage Provider Accounts.”
4. The PIMS Administrator Screen will display two new columns: “Federal Re-enrollment Complete” and “Federal Re-enrollment Date.”

NPI	Federal Re-Enrollment Complete	Federal Re-Enrollment Date
1234567	“ Yes ” indicates that your re-enrollment is complete, and you are compliant with the ACA.	The date displayed in this column is your next re-enrollment date. If you do not re-enroll before this date, your enrollment will be terminated. Your TPI will be automatically deactivated without advance notice. Providers that have not completed re-enrollment will see a date of 9/25/2016 displayed. This is the federally-mandated date for all providers to complete re-enrollment.
1234568	“ No ” indicates that you have <i>not</i> re-enrolled and are <i>not</i> compliant with the ACA.	

5. You can also click on any of the listed NPIs to go to the PIMS information Change Screen. The PIMS Information Change Screen will display two new fields: “Federal Re-Enrollment Complete” and “Federal Re-Enrollment Date.” The Federal Re-Enrollment Complete field is located under the Plan Affiliation, and the Federal Re-Enrollment Date is located under the Group Affiliation.

Note: Associated performing providers will only be displayed if they are linked to the Provider Administrator account.

1.7 Will providers who enrolled prior to January 1, 2013, be issued a new TPI number?

No, your TPI will remain the same.

1.8 I have several TPIs. Do I need to re-enroll each TPI separately, or can I re-enroll them together?

Effective November 23, 2015, TMHP will automatically re-enroll some TPIs if the NPI and license number match an ACA-compliant TPI that has already been re-enrolled. Only individual limited-risk providers that have multiple TPIs are eligible for this automatic match re-enrollment (groups and facilities are excluded). The following provider types are eligible for automatic match enrollment:

- Audiologist
- Case Management/Home and Community Based Services (HCBS) Provider
- CCP Provider

- Certified Nurse Midwife/Registered Nurse/Licensed Midwife
- Certified Registered Nurse Anesthetist (CRNA)/Anesthetist Assistant (AA)
- Chiropractor
- Comprehensive Care Program (CCP) Social Worker
- Dentist (D.D.S, D.M.D)
- Family Planning Clinic Individual Provider
- Genetics
- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Counselor (LPC)
- Occupational Therapist
- Optometrist
- Oral Maxillofacial Surgeon
- Orthodontist
- Pharmacist
- Physician (D.O. or M.D.)
- Physician Assistant/Nurse Practitioner/Clinical Nurse Specialist (PA/NP/CNS)
- Podiatrist
- Psychologist
- Radiologist
- Respiratory Therapists
- Texas Health Steps (THSteps)—Dental
- THSteps—Medical

1.9 What will the next re-enrollment date be for TPIs that are automatically re-enrolled?

All automatically matched TPIs will have the same enrollment termination date as the latest re-enrolled TPI. For example, if a provider has ten limited-risk TPIs and has re-enrolled three of them, the termination dates for all ten associated identifiers will match the most recently re-enrolled TPI.

At the end of this term, the TPI assigned will automatically terminate without advance notice.

TMHP will automatically re-enroll additional TPIs on a regular basis. Beginning December 12, 2015, providers should check their re-enrollment information and termination dates through their Provider Administrator account.

1.10 What do I do if I need to update my demographic information?

If you are an existing provider, review and update your demographic information in the Provider Information Management System (PIMS) through My Account.

1.11 I am a provider with several TPIs, but I do not qualify for automatic re-enrollment. How do I re-enroll?

You can re-enroll through the Provider Enrollment on the Portal (PEP) application. You can re-enroll in multiple programs at once. Separate applications are required for each provider type and specialty.

1.12 We are a group with over 50 providers. Does each individual doctor have to re-enroll under our group?

Yes. All providers, including groups and performing providers within those groups must re-enroll by Sept. 25, 2016.

1.13 I enrolled after January 1, 2013. Do I also have to re-enroll? If so, by when?

Yes. In accordance with Title 42, Code of Federal Regulations (CFR) §455.414, all providers who enroll *on or after* January 1, 2013, must re-enroll *at least* every five years. The Texas Health and Human Services Commission (HHSC) may require certain providers to re-enroll more frequently. All providers that enroll or re-enroll in Texas Medicaid *on or after* January 1, 2013, will receive a letter upon enrollment in Texas Medicaid. The new enrollment letter will reference a “limited term enrollment” and inform each provider of their re-enrollment date.

1.14 How often will I need to re-enroll?

A provider’s re-enrollment period will vary based on a number of factors, including the risk category to which their provider type has been assigned. For more information, please see Section 2.

1.15 I am a Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies (DMEPOS) provider. Why do I have to re-enroll more frequently than any other provider?

Section 6401 of the Affordable Care Act of 2010 (ACA) requires DMEPOS providers to re-enroll every three years. (See Section 2 for additional information.)

1.16 Is there a schedule similar to Medicare’s notifying providers when their provider type may begin the re-enrollment process?

There is no set schedule for re-enrollment for specific provider types. Providers may begin this process as early as today. Providers are encouraged to contact a TMHP provider enrollment representative for guidance on initiating the re-enrollment process. You reach a TMHP provider enrollment representative by calling the TMHP Contact Center at **1-800-925-9126** or the TMHP–CSHCN Services Program Contact Center at **1-800-568-2413**.

1.17 CMS doesn’t want providers to submit their Medicare revalidation applications until the providers have been notified that it is their turn to re-enroll. To avoid paying an application fee twice, can I wait to re-enroll in Texas Medicaid until after my Medicare revalidation is complete?

It is recommended that all providers who must re-enroll do so as early as possible do avoid missing the deadline. All providers who enrolled in Texas Medicaid *before* January 1, 2013, must be fully re-enrolled by Sept. 25, 2016.

1.18 Is any of the enrollment information provided through the Provider Enrollment, Chain, and Ownership System (PECOS) for Medicare shared or linked to the Medicaid application, similar to the Electronic Health Record (EHR) portals?

Currently, that functionality is not available. The current Medicare PECOS system does not allow state programs to have a systematic extract that provides the full detail information found in PECOS.

1.19 What happens if I encounter problems during online re-enrollment and must begin the process again? Is there a limit to the number of times I may initiate re-enrollment?

TMHP does not limit the number of times that a provider initiates, but does not complete, an enrollment application. However, if a provider submits an enrollment application and the application is denied, a provider may only appeal once. In accordance with [1 TAC §352.11\(d\)](#), a provider can appeal by requesting an informal desk review. After which, a final decision will be made.

If you encounter problems during online re-enrollment, contact a TMHP enrollment representative to assist with the process (*see question 1.9, above*).

1.20 Is there any way to expedite the application review process?

No. Applications are worked in the order that they are received. Texas Medicaid is committed to avoiding any unnecessarily lengthy periods of time for completing the provider screening and application process.

1.21 If there is a delay in processing the re-enrollment applications, will providers continue to be paid until the applications are finalized?

The Patient Protection and Affordable Care Act (PPACA) requires providers to have revalidated their enrollment in state Medicaid programs by September 24, 2016. In accordance with PPACA and based on direction from the Texas Health and Human Services Commission (HHSC), TMHP has accepted and is processing completed revalidation applications received by September 24, 2016. There will be no dis-enrollment action taken on providers that met this submission date and continue to respond to application deficiencies by specified deadlines.

TMHP has begun dis-enrollment actions on providers that failed to submit a completed revalidation application by September 24, 2016. These actions will be completed and a final dis-enrollment effective date of January 31, 2017, will be applied to any provider that failed to meet the application submission deadline. Providers may refer to the [notification published on August 31, 2016](#), for details on dis-enrollment actions.

1.22 When completing the re-enrollment application, the information provided will replace the old application, correct? Is there a way to review what the current information is that's on the application if it's not on or in PEP?

The re-enrollment information will replace the old application. Limited information is carried over to the re-enrollment application for providers that submit their re-enrollment application using Provider Enrollment on the Portal (PEP). Providers are encouraged to retain all application documentation.

1.23 Are there any other new requirements that we should be aware of?

Yes. In addition to re-enrolling all providers, Texas Medicaid is now required to capture both the Employer Identification Number (EIN) and Social Security Number (SSN) of each of the following:

- Each provider or supplier
- Each person with ownership or control interest in the provider or supplier
- Any subcontractor in which the provider or supplier directly or indirectly has a 5 percent or more ownership interest
- Any managing employees including directors and officers of corporations and non-profit organizations and charities

This information is captured through the Disclosure of Ownership and Control Interest Statement found within the Texas Medicaid Provider Enrollment Application or available for download in the Forms section of the TMHP website at www.tmhp.com.

Also, providers must now attest to having a compliance program in place (Section VIII of the HHSC Medicaid Provider Agreement) and must satisfy an internal review requirement (Section IX of the HHSC Provider Agreement). See *Section 6: Compliance Programs* on page 16 for more information.

1.24 I submitted an application the first week of December 2013, before these new ACA requirements took effect. Will I need to provide a new application?

Yes. Providers who submitted a non-ACA-compliant application and received a TPI, must re-enroll with an ACA-compliant application prior to Sept. 25, 2016.

1.25 What are the advantages of using PEP?

PEP guides applicants through the enrollment process and can help you complete the application more accurately by doing the following:

- PEP automatically populates duplicate data fields, which reduces errors and shortens the time needed to complete the application.
- Prior to submission, the system checks the information to ensure all of the questions are answered and the information is consistent throughout the application.
- The new E-signature option allows providers to sign and submit re-enrollment documents online.
- Online tracking of application status.

If there is missing or incomplete information, a deficiency notice will be sent to the provider. If a provider signs up to have deficiency notifications sent by e-mail, the system sends an update to the e-mail address on file. Corrections can then be made and submitted online. Providers have 30 days to address the deficiency in the application.

1.26 How can providers get started on PEP?

Visit the TMHP website at www.tmhp.com, and click on the “Not yet a provider?” web ad on the right side of the page. On the next page, click on the “I would like to...” link at the top right of the page. On the following page, click the “Activate my account (Provider Enrollment on the Portal [PEP]) link.”

1.27 If I need help completing the re-enrollment application, is there a department at TMHP that can assist me?

TMHP has provider enrollment representatives that can assist with your re-enrollment needs. You can access a TMHP provider enrollment representative by calling the TMHP Contact Center at **1-800-925-9126** or the TMHP–CSHCN Services Program Contact Center at **1-800-568-2413**.

1.28 Once my application is submitted, how long will it be until I receive my TPI?

When an application is submitted, HHSC conducts a background check. This can take up to 60 calendar days (though most are completed within 30 calendar days). TMHP is contractually required to complete the enrollment process within 5 days of the receipt of the application from HHSC.

Section 2: Risk Categories

2.1 How are providers categorized by risk?

CMS has defined three levels of risk: limited, moderate, and high. Provider types are assigned to each category based on an assessment of the risk of fraud, waste, and abuse. For Medicaid provider types not recognized under Medicare, HHSC has assessed the risk using criteria similar to those used by CMS.

2.2 Which types of providers are included in each category?

The following table shows the provider types for each risk category:

Provider Type Risk Categories			
Limited Risk			
<ul style="list-style-type: none"> Physicians Non-physician practitioners Medical groups and clinics Ambulatory surgical centers (ASCs) Audiologists 	<ul style="list-style-type: none"> Federally qualified health centers (FQHC) Hospitals, including critical access hospitals Indian and Tribal Health Services facilities 	<ul style="list-style-type: none"> End stage renal disease facilities Mass immunization roster billers Occupational therapists enrolling as individuals or as group practices 	<ul style="list-style-type: none"> Pharmacies Radiation therapy centers Rural health clinics (RHC) Skilled nursing facilities Speech language pathologists
Moderate Risk			
<ul style="list-style-type: none"> Ambulance service suppliers Community mental health centers Outpatient rehabilitation facilities 	<ul style="list-style-type: none"> Independent clinical laboratories Independent diagnostic testing facilities Hospice organizations (CSHCN Services Program only) 	<ul style="list-style-type: none"> Physical therapists enrolling as individuals or as group practices Portable X-ray suppliers Currently enrolled (re-enrolling) home health agencies 	<ul style="list-style-type: none"> Currently enrolled (re-enrolling) DMEPOS providers Comprehensive outpatient rehabilitation facilities
High Risk			
<ul style="list-style-type: none"> Prospective (newly enrolling) home health agencies 	<ul style="list-style-type: none"> Prospective (newly enrolling) DMEPOS providers 		

2.3 Can an individual provider be moved to a different risk category?

Yes. CMS and HHSC have the discretion to move a provider and/or provider type to a higher risk category, and HHSC may require more stringent screening than that of CMS. However, HHSC may not assign any provider type to a lower risk category than what CMS has deemed appropriate for a provider type that is recognized by Medicare.

2.4 Can TMHP change the risk category I am assigned to?

No. TMHP cannot change the risk category assigned to a provider. Risk categories are assigned by CMS and HHSC.

2.5 How does my risk category affect my re-enrollment?

Providers in the moderate and high risk categories may be required to re-enroll more frequently than others. For example, DMEPOS providers (in the high risk category) are required to re-enroll every three years, while physicians (in the low risk category) are required to re-enroll every five years.

In addition, each risk category has required screening elements.

The following table shows the screening activities associated with each risk category:

Risk	Screening Activities
Limited	Verification of provider-specific requirements, including but not limited to the following: <ul style="list-style-type: none"> • License verification • National Provider Identifier (NPI) verification • Federal and state database checks • Ownership/controlling interest information verification
Moderate	<ul style="list-style-type: none"> • All screening activities for limited risk providers • Unannounced site visits before and after enrollment or re-enrollment
High	<ul style="list-style-type: none"> • All screening activities for limited and moderate risk providers • Verification that all providers and their owners who meet the 5 percent direct or indirect ownership requirement submitted proof of fingerprinting

Section 3: Provider Screening

3.1 Is provider screening a new requirement?

No, provider screening is not a new requirement. TMHP and HHSC have always performed screening activities that include license verification and criminal history checks. Beginning January 1, 2013, all Texas Medicaid providers will be screened according to their risk category in order to fulfill additional requirements for enrollment as mandated by Section 6401 of ACA. Please refer to the table in Section 2 of this document for the screening activities associated with each risk category.

See Also:

For more information about provider screening, refer to [1 TAC, Part 15, Chapters 352 and 371](#).

3.2 What are the guidelines or requirements for submitting the fingerprint submissions for owners?

For information related to the submission of fingerprints for all high-risk providers, refer to the Texas Medicaid Provider Fingerprinting Requirement Frequently Asked Questions that is located on the [Federal Re-enrollment page](#) of TMHP.com.

3.3 If I have already been surveyed by a Licensure Survey for the year, will this suffice for the site visit?

No, the pre-enrollment and post-enrollment site visits as detailed in 42 CFR §455.432 are required of providers who are designated as “moderate” or “high” risk under ACA guidelines. This requirement is separate from Licensure Surveys Requirements.

3.4 How long are the site visits?

The length of the site visits will differ from provider to provider.

3.5 What will happen at the unannounced site visit?

During the unscheduled and unannounced pre-enrollment site visits, an audit will be performed to ensure that prospective providers meet enrollment requirements. During post-enrollment site visits, an audit will be performed to ensure that current providers remain operational and continue to meet required provider standards.

3.6 If a physician provides durable medical equipment (DME), in what risk category will the practice be classified?

A physician and a DME provider are two unique provider types and are screened independently of one another in accordance to requirements of their respective risk categories. Refer to the table in Section 2 for more information on risk categories.

Section 4: Application Fee

Texas Medicaid must comply with 42 CFR §455.460, which requires an application fee for institutional providers. CMS defines an institutional provider as any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (but not physician and non-physician practitioner organizations), or CMS-855S or associated internet-based PECOS enrollment application.

4.1 How much is the application fee?

The amount of the application fee is subject to change every calendar year. Each year, CMS will publish the application fee in the Federal Register 60 days prior to the new calendar year. The fee for calendar year 2016 was \$554.00. The fee for calendar year 2017 is \$560.00.

See Also:

For more information about the application fee, refer to [1 TAC §352.7](#).

4.2 Who needs to pay the application fee?

The application fee is required for any newly enrolling or re-enrolling “institutional provider,” including providers that are applying for a new practice location as defined in 42 CFR §455.460. Please refer to [1 TAC §352.7](#) for more information about the application fee.

Note: *Physicians and non-physician providers are not required to pay the application fee. This includes physicians and non-physician practitioners in medical groups and clinics.*

To determine if your provider type is required to pay the application fee, refer to the [Application Fee Matrix](#) available at on the TMHP website.

4.3 How is “institutional provider” defined by CMS?

CMS defines an institutional provider as any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (but not physician and non-physician practitioner organizations), or CMS-855S or associated internet-based PECOS enrollment application. CMS allows Texas Medicaid to impose the application fee on any institutional entity that bills the state Medicaid program or Children’s Health Insurance Program (CHIP) on a fee-for-service basis. Please refer to the [Application Fee Matrix](#) available at on the TMHP website for details on application fee requirements for Texas Medicaid providers.

4.4 All of my providers are under one Texas Provider Identifier (TPI). Is the fee for each individual provider or by TPI?

The application fee is required for each *application* submitted to Texas Medicaid.

4.5 Do I need to pay another fee to Texas Medicaid if I already paid an enrollment or re-enrollment fee to Medicare?

No. If you have paid an application fee and are approved for enrollment in Medicare or another state’s Medicaid program or Children’s Health Insurance Plan (CHIP), you do not have to pay another application fee to Texas Medicaid. However, you must provide proof to Texas Medicaid that the application fee was paid (*see question 4.7 below*). Your proof of payment will only be valid during the current enrollment period and will only apply to the same Medicare type and specialty that is recognized by

Texas Medicaid. Your Texas Medicaid enrollment application will not be processed until proof of payment is provided to Texas Medicaid.

4.6 How do I show proof of payment made to Medicare or another State's Health-Care Program?

Proof of payment must be in the form of a payment confirmation receipt complete with the amount, date, and time that the payment was made. The receipt must also confirm the entity to which payment was made. Providers are encouraged to contact a TMHP provider enrollment representative for guidance on acceptable payment confirmations.

Note: Proof of payment is only valid for the most current enrollment period.

4.7 I paid a fee when I re-credentialed my license with DADS. Do I have to pay another re-enrollment fee?

Yes. The fee that was paid for Department of Aging and Disability Services (DADS) re-credentialing is separate from the ACA required application fee. The application fee applies to any newly enrolling or re-enrolling institutional provider, including providers that are applying for a new practice location as defined in 42 CFR §455.460. Providers can refer to [1 TAC §352.7](#) for more information about the application fee.

4.8 I have submitted an application to Texas Medicaid, but I cannot afford the new application fee at this time. What do I do?

Consistent with 42 CFR §424.514 and Medicare guidance, Texas Medicaid will allow providers to submit a request for a hardship exception waiving the application fee. The provider must submit a letter that explains the request for the hardship exception and includes supporting documentation (i.e., historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.). HHSC will confer with CMS on the final decision to approve or deny the hardship exception request.

Providers that are enrolled in Medicare or another state's Medicaid or CHIP program and that were granted a hardship exception must still request a hardship exception from Texas Medicaid. The hardship exception will only be valid during the current enrollment period.

4.9 If a physician is also enrolled as a DME provider, is an application fee required?

The application fee is only required for the durable medical equipment (DME) enrollment. Physician and non-physician practitioner providers are excluded from the application fee requirement.

4.10 If I use PEP for re-enrollment, do I need to mail the payment before or after the online submission is complete?

TMHP recommends mailing the payment after the online TMHP Provider Enrollment on the Portal (PEP) submission is complete, so that the payment is applied appropriately.

Section 5: Ordering- and Referring-Only Providers

Ordering- and referring-only providers are those providers whose only relationship with Texas Medicaid is ordering or referring services for Medicaid clients. These providers are now required to enroll with Texas Medicaid as participating providers.

See Also:

For more information about ordering- and referring- only providers, see [Effective January 2013: Ordering- and Referring-Only Providers Must Enroll in Texas Medicaid; Impact on Provider Claims Filing](#).

5.1 Do ordering- and referring-only providers complete the same enrollment application as billing and performing providers?

No. Ordering- and referring-only providers complete the “[Texas Medicaid Provider Enrollment Application Ordering- and Referring Only](#)”. This condensed application is available through Provider Enrollment on the Portal (PEP) for electronic enrollment and as a downloadable portable document format (PDF) file from the TMHP website for paper submission.

Note: Ordering- and referring-only providers are not required to pay an application fee.

5.2 How often are ordering- and referring-only providers required to re-enroll?

A provider’s re-enrollment period will vary based on a number of factors, including the risk category to which their provider type has been assigned. For more information, please see Section 2.

5.3 How long does the enrollment process take for ordering- or referring-only providers?

Applications are usually processed within 30–45 calendar days of the date of the applications’ submission. It may take longer if the application is incomplete or if additional information is needed.

5.4 If I enroll using the ordering- and referring-only application, can I submit claims to Medicaid for reimbursement?

No. If you want to submit claims to Texas Medicaid for payment, you must submit the full Texas Medicaid Provider Enrollment Application.

5.5 I am a billing provider with Texas Medicaid and I would like to become an ordering- and referring-only provider. What must I do?

To change your enrollment status from a Medicaid billing provider to an ordering- and referring-only provider you must submit the [Texas Medicaid Provider Enrollment Application Ordering- and Referring-Providers Only](#)

After you change your enrollment status, you will be unable to submit claims for reimbursement to Texas Medicaid.

5.6 Does a billing provider have to indicate the ordering- or referring-only provider on claims?

Yes. The ordering/referring information should be reported in Block 17, “Name of Referring Provider or Other Source,” along with the ordering/referring provider’s NPI in Block 17b of the CMS-1500 claim form.

5.7 How can a billing provider confirm that the ordering- and referring-only provider has begun the process of enrollment or is enrolled as a participating provider?

HHSC is reviewing tools that will enable providers to verify an ordering- or referring-only provider's participation in Texas Medicaid. In the interim, the billing provider may choose to contact ordering/referring providers to ensure the enrollment process has begun.

5.8 Will claims be rejected or denied if the ordering- and referring-only provider is not enrolled in Medicaid?

Claims will not be denied at this time. However, after a suitable period of time to allow for ordering-or referring-only providers to complete the enrollment process, claims will be subject to denial if the ordering- and referring-only provider is not enrolled in Texas Medicaid. Providers will receive a minimum 45-day advanced notice before claim denials will begin.

5.9 We are an FQHC and bill under our facility. We have enrolled our providers as ordering/referring, but in the future do we need to add them as billing providers?

Not necessarily. Billing must always be done under the facility TPI if the providers employed by the FQHC do not have associated NPIs. Providers who only order or refer services for Medicaid clients must comply with 42 CFR §455.410, which requires all ordering and referring physicians and other professionals who provide services under the state plan or under a waiver of the state plan to be enrolled in Texas Medicaid as participating providers.

Section 6: Compliance Programs

6.1 What is a Compliance Program?

According to CMS, and as defined by the United States Sentencing Commission (USSC), a compliance program is a program designed to prevent and detect criminal conduct. Further, compliance efforts are fundamentally designed to establish a culture within an organization that promotes the prevention, detection, and resolution of conduct that does not conform to federal and state law or to federal health-care program requirements.

6.2 Do I have a Compliance Program as specified in TAC §352.5(b)(11)?

Although CMS has not finalized specific compliance program requirements, each organization should assess its individual internal processes and procedures to ensure it has a compliance program applicable to its organizational structure and business needs.

6.3 What are the core elements of an effective Compliance Program as referenced in TAC §352.5(b)(11)?

According to CMS by way of the ACA, the elements described by the USSC are used as the basis for the core elements of the required compliance programs for Medicare, Medicaid, and CHIP enrollment. Although compliance programs may differ between organizations based upon the type or specialty of the services provided, according to CMS, an effective compliance program includes the following:

- The development and distribution of written policies, procedures, and standards of conduct to prevent and detect inappropriate behavior;
- The designation of a chief compliance officer and other appropriate bodies (for example a corporate compliance committee) that are charged with the responsibility of operating and monitoring the compliance program and who report directly to high-level personnel and the governing body;
- The use of reasonable efforts not to include any individual in the substantial authority personnel whom the organization knew, or should have known, has engaged in illegal activities or other conduct inconsistent with an effective compliance and ethics program;
- The development and implementation of regular, effective education and training programs for the governing body, all employees, including high-level personnel, and, as appropriate, the organization's agents;
- The maintenance of a process, such as a hotline, to receive complaints and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation;
- The development of a system to respond to allegations of improper conduct and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations, or federal health-care program requirements;
- The use of audits or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas;
- The investigation and remediation of identified systemic problems, including making any necessary modifications to the organization's compliance and ethics.

Section 7: PCP Rate Increase

Individual physicians who submitted a valid attestation form on or before March 31, 2014, may qualify for rate increase payments for eligible services that were rendered for dates of service from January 1, 2013 through December 31, 2014. Individual physicians who submitted a valid attestation form on or after April 1, 2014, may receive the rate increase payments for services that were rendered beginning the date TMHP received the valid form.

Note: *The deadline to submit attestation forms for supplemental rate increase payments has passed.*

See Also:

For more information about the PCP rate increase for primary care services, see the [ACA webpage](#) on the TMHP website.

7.1 When and how are supplemental payments issued?

TMHP issues the necessary payments to fee-for-service and carve-out service providers through supplemental payments for eligible claims that were submitted in a given calendar quarter. Medicaid Managed Care Organizations (MCOs) issue the necessary payments for MCO service providers.

Beginning in May 2014, TMHP began processing eligible fee-for-service and carve-out service claims that were submitted between January 1, 2013, and April 30, 2014, with dates of service on or after January 1, 2013, in batches on a weekly basis until all supplemental payments were made. TMHP continues to make payments on a quarterly basis.

Each MCO received funds from HHSC to provide the calendar year 2013 and first quarter 2014 supplemental payments to its MCO providers. HHSC began sending payments and files with the list of providers to MCOs in January 2014. MCOs are required to make payments for subsequent quarters on a quarterly basis.

For fee-for-service and carve-out service providers, the supplemental payment will appear on the provider's weekly Remittance & Status (ER&S) Report as a line item on the payout report with explanation of benefits (EOB) 01230 which states, "The ACA Primary Care Rate Increase has been applied to this primary care service."

7.2 Who qualifies for the rate increase and supplemental payments?

The rate increase is intended for physicians providing primary care services as defined in 42 CFR §440.50, which states the following:

"Physicians' services," whether furnished in the office, the beneficiary's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician—

- (1) Within the scope of practice of medicine or osteopathy as defined by State law; and
- (2) By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

Note: *Physicians who provide services in support of eligible physicians (e.g., neurologists, obstetricians/gynecologists [OB/GYNs], pathologists, anesthesiologists, and surgeons who provide services to the patients of eligible physicians), are not eligible for the rate increase.*

In addition, 42 CFR §447.400 states the following:

“...a physician who self-attests to a specialty designation of family medicine, general internal medicine or pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA). Such physician then attests that he/she:

(1) Is Board certified with such a specialty or subspecialty and/or

(2) Has furnished evaluation and management services and vaccine administration services under codes described in paragraph (b) of this section that equal at least 60 percent of the Medicaid codes he or she has billed during the most recently completed CY or, for newly eligible physicians, the prior month.”

Providers can refer to the following websites for details on the types of subspecialties recognized:

- [American Board of Medical Specialties \(ABMS\)](#)
- [American Board of Physician Specialties \(ABPS\)](#)
- [American Osteopathic Association \(AOA\)](#)

Physicians who are certified in internal medicine, family practice, or pediatrics by a board other than the ABMS, the AOA, or the ABPS can self-attest to the appropriate specialty and meet the 60 percent claims history requirement to qualify.

Note: *The physician’s self-attested board certification must be current or supported by a 60 percent claims history.*

7.3 What is the ACA PCP rate increase amount?

Providers can refer to the article titled “[Follow-up to ‘HHSC and Texas Medicaid Have Begun Issuing Supplemental Payments to Eligible Providers for the Affordable Care Act of 2010 \(ACA\) Rate Increase for Primary Care Services’](#),” which was published on the TMHP website on March 28, 2014, for information about the ACA primary care services rate increase amounts.

7.4 How is the supplemental payment calculated for Crossovers (i.e., claims for dual eligible clients)?

For eligible professional Medicare crossover claims where client liability (Medicare coinsurance + deductible) is greater than \$0, the supplemental payment amount will be calculated on the claim detail level as follows:

(Medicare Coinsurance + Medicare Deductible) – Medicaid Paid Amount = Supplemental payment