MEDICAID POLICY INFORMATION SHEET

Policy Analyst: Vicki Goethals

Phone Number:

Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

The purpose of this policy is to provide clarity to ordering and referring providers regarding existing Medicaid enrollment requirements as defined by the 21st Century Cures Act and establish a framework for exceptions as identified in the Medicaid Provider Enrollment Compendium.

Reason for policy (problem being addressed):

To ensure compliance with federal provider enrollment requirements while clarifying the allowable exceptions to ensure Medicaid beneficiary care quality.

Budget implication:

☒ budget neutral
☐ will cost MDHHS $, and (select one) budgeted in current appropriation
☐ will save MDHHS $

Is this policy change mandated per federal requirements?

No.

Does policy have operational implications on other parts of MDHHS?

The enrollment requirement applies to all ordering and referring providers participating in Medicaid.

Does policy have operational implications on other departments?

No

Summary of input:

☐ controversial (Explain)
☒ acceptable to most/all groups
☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☐ Yes ☒ No If Yes, please provide status: ☐ Approved ☐ Pending Approval ☐ Denied Date: Date:	Public Notice Required: ☐ Yes ☒ No If yes, Submission Date:

DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services		
	Project Number: 2451-Pharmacy	**Date:** November 18, 2024

Comments Due: December 23, 2024
Proposed Effective Date: February 1, 2025
Direct Comments To: Vicki Goethals
Address:
E-Mail Address: goethalsv@michigan.gov
Phone: **Fax:** 517-346-9809

Policy Subject: Clarification of Enrollment Requirement for Prescribers

Affected Programs: Medicaid, Plan First, Children's Special Health Care Services (CSHCS), Maternity Outpatient Medical Services (MOMS)

Distribution: All Providers

Summary: The purpose of this policy is to provide clarity to ordering and referring providers regarding existing Medicaid enrollment requirements as defined by the 21st Century Cures Act and establish a framework for exceptions as identified in the Medicaid Provider Enrollment Compendium.

Purpose: To ensure compliance with federal provider enrollment requirements while clarifying the allowable exceptions to ensure Medicaid beneficiary care quality.

Cost Implications: Budget neutral

Potential Hearings & Appeal Issues: None

State Plan Amendment Required: Yes ☐ **No** ☒ **If yes, date submitted:**	**Public Notice Required: Yes** ☐ **No** ☒ **Submitted date:**
Tribal Notification: Yes ☐ **No** ☒ **- Date:**	

THIS SECTION COMPLETED BY RECEIVER

☐ **Approved**	☐ **No Comments**
	☐ **See Comments Below**
☐ **Disapproved**	☐ **See Comments in Text**

Signature:	**Phone Number**
Signature Printed:	
Bureau/Administration *(please print)*	**Date**

Proposed Policy Draft

Michigan Department of Health and Human Services
Behavioral & Physical Health and Aging Services Administration

Distribution: All Providers

Issued: December 30, 2024 (proposed)

Subject: Clarification of Enrollment Requirement for Prescribers

Effective: February 1, 2025 (proposed)

Programs Affected: Medicaid, Plan First, Children's Special Health Care Services (CSHCS), Maternity Outpatient Medical Services (MOMS)

Section 6401 of the Patient Protection and Affordable Care Act and Section 5005(b)(2) of the 21st Century Cures Act established a requirement that all states must enroll providers in their state Medicaid program who prescribe drug products to Medicaid beneficiaries. On August 2, 2019, the Michigan Department of Health and Human Services (MDHHS) issued bulletin MSA 19-20 (effective October 1, 2019) to establish the provider enrollment requirements of prescribing providers in accordance with these acts.

The MDHHS Medicaid provider enrollment process still adheres to the criteria set forth by the 21st Century Cures Act and by MSA 19-03 (provider enrollment fitness criteria). The purpose of this bulletin is to provide clarifications to the framework that establishes exceptions to these requirements based on the Medicaid Provider Enrollment Compendium (MPEC), published by the Centers for Medicare & Medicaid Services (CMS).

Since October 1, 2019, pharmacy benefit claims submitted by a prescriber who is not enrolled in the Community Health Automated Medicaid Processing System (CHAMPS) have been denied per NCPDP Code 889: PRESCRIBER NOT ENROLLED IN STATE MEDICAID PROGRAM. However, in order for MSA 19-20 to be complaint with 42 CFR § 435.930(c), which allows emergency coverage, pharmacies have been allowed to utilize Submission Clarification Codes (SCC) in NCPDP field 420-DK in accordance with MSA 19-20. These include:

- 13 – Payer-Recognized Emergency/Disaster Assistance Request
- 55 – Prescriber Enrollment in State Medicaid Program has been validated

Utilization of SCC 55 will continue to be allowed as originally established in MSA 19-20. However, beginning February 1, 2025, the submission of SCC 13 may only be utilized during an emergency circumstance in accordance with the MPEC, which only allows exceptions for each of the scenarios below where all respective criteria has been met:

1. Ordering Referring Providers are Ineligible to Enroll in the State Medicaid Program

    - Providers that are allowed to function under a scope of practice that authorizes them to order or refer, but they are not eligible to enroll in the state Medicaid program.

2. Medicaid Beneficiary Secures Order or Referral Prior to Participation

    - If the order or referral was made before the beneficiary was Medicaid eligible, then the beneficiary may have the order filled or the referral fulfilled and the claim for the order or referral will be paid. (76 FR 5905)

3. Services Ordered or Referred by an Out-of-State Professional

    - An item or service is furnished by:
        - An institutional provider at an out-of-state practice location (i.e., located outside the geographical boundaries of the reimbursing state's Medicaid plan);
        - An individual practitioner in an institutional setting at an out-of-state practice location (i.e., located outside the geographical boundaries of the reimbursing state's Medicaid plan); or
        - A pharmacy, pursuant to an order (i.e., prescription) written by an individual practitioner in an institutional setting at an out-of-state practice location (i.e., located outside the geographical boundaries of the reimbursing state's Medicaid plan).
    - The NPI of the ordering referring provider is represented on the claim;
    - The prescribing provider is enrolled and in an "approved" status in Medicare or in another state's Medicaid plan;
    - The claim represents services provided;
    - The claim represents services covered under the state plan; and
    - The claim represents either:
        - A single instance of care or order over a 180-day period; or
        - Multiple instances of care provided to a single beneficiary, over a 180-day period.

Monitoring and Post Payment Audit Recovery

Factors taken into consideration when approving a retrospective billing date may include, but are not limited to:

- Emergency access
- Prior authorization
- Whether a provider is enrolled in Medicare or another states' Medicaid program

Providers utilizing the override exceptions may be subject to ongoing monitoring to ensure compliance with any conditions associated with the exception and to assess the continued need for the exception. Exceptions may be reviewed randomly and periodically to determine if they remain justified and necessary. Post payment audit recovery will take place if a provider

fails to comply with the conditions of the exceptions or if circumstances justifying the exception change.