Guam Medicaid/Medically Indigent Program Provider Manual Chapter 200 Presentation

Background

- This presentation is a supporting document to assist providers with enrollment in Guam Medicaid/MIP.
- The chapter provides an overview of provider enrollment requirements and timelines, which include federal and territory regulations.

Who Must Enroll

Individual Practitioners

- A provider who owns their own business and does not employ other individuals. They do not share a tax ID or NPI with other individuals or groups.

Group Practices

- A provider who sees beneficiaries directly but works for a group, clinic, hospital, or other organization.

Facilities

- A provider entity (such as a hospital, clinic, or nursing facility) that bills for covered services under its facility/organizational NPI and tax ID, rather than as an individual practitioner.

Ordering, Referring, and Prescribing (ORP) Providers

- A provider who does not bill for services and is not listed as a rendering provider on a professional claim.

Enrollment Types

Medicaid provider enrollment generally falls into four categories:

- **Initial enrollment** for new providers
- **Reenrollment** when a provider enrolls again after leaving the program
- **Reactivation** to restore an inactive enrollment
- **Revalidation** to confirm ongoing eligibility and update information

Enrollment Types (continued)

Initial Enrollment

An initial enrollment is when a provider, not previously enrolled in the Guam Medicaid/MIP Program, completes the enrollment process.

Requirements include:

- Completed Application
- Required Documentation
- Completed Disclosure
- Completed Provider Agreement
- Exclusion Checks
- Verification of Licensure/Credentials
- Risk-Based Screening

Example: Dr. Joe Brown wishes to enroll in the Guam Medicaid program for the first time. He has never been enrolled previously.

Enrollment Types (continued)

Reenrollment

Reenrollment is the process by which a previously enrolled provider re-enrolls in the Guam Medicaid/MIP program after being disenrolled (i.e., terminated, deactivated, or otherwise removed).

Requirements include:

- Same requirements as initial enrollment
- Prior payment suspensions or overpayment issues must be resolved before approval

Example: Dr. Joe Brown voluntarily disenrolled from the Guam Medicaid program in 2024. Dr. Brown now wishes to reenroll in the program and serve Medicaid beneficiaries once again. Dr. Brown will need to complete all initial enrollment requirements before the application can be approved.

Enrollment Types (continued)

Reactivation

Reactivation is the process used to **restore a provider to active billing status when the provider is already enrolled but has been placed in an inactive status** (i.e., due to failure to respond to requests, lapse in license, or voluntary inactivation).

Requirements include:

- Verification that the reason for inactivity has been corrected
- Updates of licenses, disclosures, and demographics
- Could include limited screening rather than full risk-based screening

Example: Dr. Joe Brown was placed in an inactive status due to a license lapse. He requested reactivation of his account upon submission of updated licensing documentation.

Enrollment Types (continued)

Revalidation

Revalidation is the process by which a **provider is required to update/validate their enrollment information** at least every five years.

Requirements include:

- Updated application, disclosures, and credentials
- Risk-based screening (including site visits or fingerprinting if applicable)

Example: Dr. Joe Brown has been a Guam Medicaid provider for five years. Based on federal guidelines, he is required to revalidate his enrollment within the next 30 days based on the five-year revalidation requirement.

Enrollment Determinations

Medicaid enrollment determinations are made through a structured review process in which the Medicaid agency evaluates whether an applicant meets all federal and state participation requirements.

Approval – Guam Medicaid program staff approve an enrollment application based on the provider meeting all requirements for enrollment

Denial – Based on federal and territory guidelines (i.e., conviction of a criminal offense, incomplete application)

Termination – Based on federal and territory guidelines (i.e., provider failure to comply with screening requirements for site visit, provider identity cannot be verified)

Retroactive Enrollment Start Date

- Providers can request an enrollment start date that is before the date upon which Guam Medicaid/MIP approved the enrollment.
- Retroactive provider enrollment is limited to three (3) months before the date the completed application is approved.

Ordering, Referring, and Prescribing Providers

An ORP is an enrolled practitioner who orders services (such as lab tests), prescribes medications, or refers a Medicaid beneficiary for care.

Medicaid agencies must require **all ordering, prescribing, or referring (ORP) physicians or other professionals providing services** under the Guam State Plan or under a waiver of the plan **to be enrolled as participating providers**.

Provider Types Eligible to Enroll Include: (some examples)

- Physician
- Dentist
- Podiatrist
- Optometrist

Provider Eligibility Requirements

To participate in Medicaid, providers must be properly licensed and enrolled with the territory Medicaid agency, meet federal and territory screening and disclosure requirements, execute a Medicaid provider agreement, and comply with all applicable federal and territory laws, regulations, and guidance.

Requirements include:

- Licensure/Certification compliance
- Active National Provider Identifier (NPI)
- Pass federal exclusion checks
- Meet federal screening level requirements
- Provide specialty with proof of training
- Active Medicare certification (if applicable)
- Employer Identification Number (EIN)/Taxpayer Identification Number (TIN)/Social Security Number (SSN)
- Disclosure of Ownership
- Provider Agreement signature

Application Requirements

- Complete, sign, and submit all required forms.
- The applicant must also submit copies of current licensure, certification, or accreditation.
- The provider must also disclose whether his/her license or other accreditation/certification has been revoked or suspended in any state or territory.

Provider Screening and Risk Levels

Why are Screening and Exclusion Checks Important?

Provider screening is a critical safeguard that protects patients, providers, and the long-term sustainability of Medicaid.

Provider Screening

In accordance with federal screening requirements, Medicaid agencies are required to conduct risk-based screening for the following enrollment transactions:

- **Initial enrollment** applications
- **Revalidation** applications
- **Change of ownership** application
- Application to **add a new practice location**
- Applications **reporting a new owner**, regardless of ownership percentage, submitted as a change of information or other enrollment transactions under Title XIX

Provider Screening (continued)

Screening is conducted based on the Centers for Medicare and Medicaid Services (CMS) risk assessment and the assignment of a provider type to one of the following risk levels:

Limited risk

- Examples include: physician, audiologist, ambulatory surgical center (ASC)

Moderate risk

- Examples include: ambulance provider, physical therapist (PT), independent laboratory

High risk

- Examples include: Newly enrolling skilled nursing facilities (SNF), home health agencies, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers

Screening and Risk Levels

Risk Levels

Medicaid Activities	Limited Risk	Moderate Risk	High Risk
Disclosures and Database Checks			
· Obtain disclosures regarding ownership and possible criminal activities	✓	✓	✓
· Check exclusion databases	✓	✓	✓
· Check additional databases to confirm	✓	✓	✓
Site Visit			
· Conduct on-site visits to confirm the accuracy of information submitted by the provider in the enrollment application		✓	✓
Fingerprints			
· Conduct fingerprint-based criminal background checks (FCBCs) of the provider or, in the case of an institutional provider, each person with a 5% or more ownership interest			✓

Site Visits

The State Medicaid Agency must **conduct pre-enrollment and post-enrollment site visits of providers who are designated as "moderate" or "high" categorical risks** to the Guam Medicaid program.

The purpose of the site visit will be to verify that the information submitted to the Guam Medicaid program is accurate and to determine compliance with federal and state or territory enrollment requirements.

- **Moderate Risk Provider** Examples – Ambulance, Physical Therapists, Clinical Laboratories
- **High Risk Provider** Examples – Skilled Nursing Facility, Hospice, Home Health Agency (initial enrollments)

Provider Agreement

Each provider must complete and sign a provider agreement that affirms the provider's compliance with all laws and rules governing the delivery and reimbursement of services or goods to Medicaid and MIP beneficiaries. **The agreement is a legal contract between the provider and the Bureau of Health Care Financing Administration (BHCFA).**

The provider agreement shall include, but is not limited to, requirements that the provider agrees to the following requirements:

- **Maintain Records**: Maintain records necessary to fully disclose the extent of services furnished and retain such records for the required retention period, which is seven years for the Guam Medicaid program, unless a longer retention period is otherwise required

Provider Agreement (continued)

- **Furnish Information Upon Request**: Make records and information available, upon request, to the state or territorial Medicaid agency, CMS, the Medicaid Fraud Control Unit, or any other law enforcement or investigative entity, in accordance with applicable federal and territorial requirements
- **Comply with Ownership and Control Disclosure Requirements**: Comply with all ownership and controlling interest disclosure requirements as specified in 42 CFR Part 455.
- **Advance Directives Compliance**: Hospitals, nursing facilities, home health agencies, and hospices must comply with advanced directive requirements
- **Use NPI**: Furnish and include NPI on all Medicaid claims

Provider Changes and Maintenance Requirements

Change	Requirement
Physical, Mailing, and Email Address	New address, previous address, effective date
Name	New name, previous name, provider ID, effective date
Telephone/Fax	New and previous telephone number, new and previous fax number, effective date
Medicare Status	Provide a written notification of any change
Group Membership	Individual's name, effective date, professional license, curriculum vitae, specialty documentation or certification
Specialty	New specialty, effective date, supporting certification/documentation
Ownership	Notify Guam Medicaid/MIP 60 days before the effective date of the change, new provider agreement
Federal TIN	New TIN, effective date, new name (if applicable)
Billing Agent	Medicaid provider number, name of old and new billing agents, effective date, new Billing Agent Agreement

Provider Changes and Maintenance Requirements (continued)

- 42 CFR § 455.104(c) requires that providers disclose changes to their enrollment information to the Medicaid agency. This includes updates to ownership or control interests, managing employees, practice locations, and other critical data elements.

- ***Providers must disclose changes within 35 calendar days of the change occurring.***

Provider Changes and Maintenance Requirements (continued)

- Failure to provide timely and accurate updates can result in denial or termination of enrollment, as well as denial of claims for services rendered during periods of noncompliance.

- The Medicaid agency is responsible for ensuring all disclosures are up to date and taking appropriate action if providers do not comply with these requirements.

Enrollment Fee

Institutional providers and suppliers, such as DMEPOS suppliers and opioid treatment programs, pay an application fee when enrolling, reenrolling, revalidating, or adding a new practice location.

Physicians, nonphysician practitioners, physician organizations, nonphysician organizations, and Medicare Diabetes Prevention program suppliers are exempt from the application fee.

Hardship Exception – The Guam Medicaid/MIP program can waive the application fee.

- A written request for a hardship exception, including any supporting documentation that describes the hardship and justifies an exception to paying the application fee, should be submitted along with the provider application for enrollment.

Appeals

- The provider will need to resubmit the application packet, making any necessary corrections before resubmitting it to the Guam Medicaid program.
- DPHSS reserves the right to establish a formal appeals process.

Moratoria

A provider enrollment moratoria is a **temporary suspension** by CMS or the territory on enrolling new providers or suppliers in a specific geographic area and/or for specific provider or supplier types.

During a moratoria:

- New enrollments are not allowed
- Adding new practice locations can be restricted
- Currently enrolled providers or revalidations are not affected
- There are no moratoria currently in place on the federal or territory level

How to Apply

Steps:

1. Complete and sign the application
2. Include any required documentation (certification, license, etc.) along with the application
3. Submit application and documentation through the Guam Medicaid/MIP provider portal here
4. Respond immediately to any requests for additional information or corrections

Common Application Errors

Below are the **most common application errors** received:

- Missing signatures
- Expired license
- Incomplete ownership disclosure
- Incorrect NPI or Tax ID
- Missing required documentation

Incorrect entries on the enrollment application **can cause**:

- Increase in turnaround time
- Create mismatches that complicate the verification process
- Expired licensure can create eligibility gaps
- Provider payment recoupment risk

What To Do After Application Approved

After the provider receives notice that the enrollment application has been approved, they should:

- Watch for communications from Guam Medicaid/MIP
- Complete the claims submission setup process
- Respond to revalidation notices
- Notify the Guam Medicaid/MIP Provider Enrollment Unit of any changes in information immediately