MAXIMUS

District of Columbia
Department of Health Care Finance

Provider Data Management System and Service (PDMS) Project

Summary of Affordable Care Act Changes to Provider Screening and Enrollment

42 CFR 455 Subpart E – Provider Screening and Enrollment

What does CFR stand for?

CFR or Code of Federal Regulations is an annual codification of the general and permanent rules published in the Federal Registry by the executive departments and agencies of the Federal Government. The purpose of the CFR is to present the official and complete text of agency regulations in one organized publication and to provide a comprehensive and convenient reference for all those who may need to know the text of general and permanent Federal regulations.

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455.400 Purpose

This subpart implements section 1866(j), 1902(a)(39), 1902(a)(77), and 1902(a)(78) of the Act. It sets forth District plan requirements regarding the following:

(a) Provider screening and enrollment requirements.

(b) Fees associated with provider screening.

(c) Temporary moratoria on enrollment of providers.

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455.405 District plan requirements

The District of Columbia plan must provide that the requirements of 455.410 through 455.450 and 455.470 are met.

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455.410 Enrollment and screening of providers

a) The District Medicaid agency must require all enrolled providers to be screened under to subpart.

b) The District Medicaid agency must require all ordering or referring physicians or other professionals providing services under the District plan or under a waiver of the plan to be enrolled as participating providers.

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

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- Medicare contractors
- Medicaid agencies or
- Children's Health Insurance Programs of other States

455.412 Verification of provider licenses

The District Medicaid agency must –

a) Have a method for verifying that any provider purporting to be licensed in accordance with laws of any State/District of Columbia is licensed by such District.

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455.412 Verification of provider licenses (cont.)

b) Confirm that the provider's license has not expired and that there are no current limitations on the provider's license.

455.414 Revalidation of enrollment

The District Medicaid agency must revalidate the enrollment of all providers regardless of provider type at least every 5 years. However, the District requires DME providers to re-enroll every 3 years.

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455.416 Termination or denial of enrollment

The District Medicaid agency:

a) Must terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under this subpart.

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455.416 Termination or denial of enrollment (cont.)

b) Must deny enrollment or terminate the enrollment of any provider where any person with a 5 percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years, unless the District Medicaid agency determines that denial or termination of enrollment is not in the best interest s of the Medicaid program and the District Medicaid agency documents that determination in writing.

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455.416 Termination or denial of enrollment (cont.)

(c) Must deny enrollment or terminate the enrollment of any provider that is terminated on or after January 1, 2011, under the title XVIII of the Act or under the Medicaid program or CHIP of any other State.

(d) Must terminate the provider’s enrollment or deny enrollment of the provider if the provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information, unless the District Medicaid agency determines that

termination or denial of enrollment is not in the best Interests of the Medicaid program and the District Medicaid agency documents that determination in writing.

(e) Must terminate or deny enrollment if the provider, or any person with a 5 percent or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the Medicaid agency within 30 days of a CMS or a District Medicaid agency request, unless the District Medicaid agency determines that termination or denial of

enrollment is not in the best interests of the Medicaid agency documents that determination in writing.

(f) Must terminate or deny enrollment if the provider fails to permit access to provider locations for any site visits under 455.432, unless the District Medicaid agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the District Medicaid agency documents that determination in writing.

(g) May terminate or deny the provider's enrollment if CMS or the District Medicaid agency –

(1) Determines that the provider has falsified any information provided on the application; or

(2) Cannot verify the identity of any provider applicant.

455.420 Reactivation of provider enrollment

After deactivation of a provider enrollment number for any reason, before the provider's enrollment may be reactivated, the District Medicaid agency must re-screen the provider and require payment of associated provider application fees under 455.460.

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455.422 Appeal Rights

The District Medicaid agency must give providers terminated or denied under 455.416, any appeal rights available under procedures established by District law or regulations.

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455.432 Site visits

The District 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 District Medicaid agency is accurate and to determine compliance with Federal and District enrollment requirements.

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(b) Must require any enrolled provider to permit CMS, its agents, its designated contractors, or the District Medicaid agency to conduct unannounced on-site inspections of any and all provider locations.

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455.434 Criminal background checks

The District 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 District 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.

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455.434 Criminal background checks (cont.)

(1) Upon the District Medicaid agency determining that a provider, or a person with a 5 percent or more direct ownership interest in the provider, meets the District Medicaid agency's criteria hereunder for criminal background checks as a "high" risk to the Medicaid program, the District Medicaid agency will require that each such provider or person submit fingerprints.

(2) The District 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 District Medicaid

agency, within 30 days upon request from CMS or the District Medicaid agency.

455.436 Federal database checks

The District Medicaid agency must do all of 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

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List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe.

(1) Consult appropriate databases to confirm identity upon enrollment and reenrollment; and

(2) Check the LEIE and EPLS no less frequently than monthly.

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455.440 National Provider Identifier

The District Medicaid agency must require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services.

455.450 Screening levels for Medicaid providers

A District 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”,

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"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.

a) *Screening for providers designated as limited categorical risk*. When the District Medicaid agency designates a provider as a limited categorical risk, the District Medicaid agency must do all of the following:
   1. Verify that a provider meets any applicable Federal regulations, or District requirements for the provider type prior to making an enrollment determination.

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455.450 Screening levels for Medicaid providers (cont.)

2. Conduct license verifications, including State licensure verifications in States other than where the provider is enrolling, in accordance with 455.412.
3. Conduct database checks on a pre- and post-enrollment basis to ensure that providers continue to meet the enrollment criteria for their provider type, in accordance with 455.436.

(b) *Screening for providers designated as moderate categorical risk.* When the District Medicaid agency designates a provider as a

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"moderate" categorical risk, the District Medicaid agency must do both of the following:

1. Perform the "limited" screening requirements described in paragraph (a) of this section.
2. Conduct on-site visits in accordance with 455.432.

(c) *Screening for providers designated as high categorical risk*. When the District Medicaid agency designates a provider as a "high" categorical risk, the District Medicaid agency must do both of the following:

1. Perform the "limited" and "moderate" screening requirements described in paragraph (a) and (b) of this section.

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2. (i) Conduct a criminal background check; and (ii) Require submission of a set of fingerprints in accordance with 455.434.

(d) *Denial or termination of enrollment*. A provider, or any person with 5 percent or greater direct or indirect ownership in the provider, who is required by the District Medicaid agency or CMS to submit a set of fingerprints and fails to do so may have its –

1. Application denied under 455.434; or
2. Enrollment terminated under 455.416.

(e) *Adjustment of risk level*. The District agency must adjust the categorical risk level from “limited” or “moderate” to “high” when any of the following occurs:

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1. The District Medicaid agency imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse, the provider has an existing Medicaid overpayment, or the provider has been excluded by the OIG or another State's Medicaid program within the previous 10 years.

2. The District Medicaid agency or CMS in the previous 6 months lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within 6 months from the date the moratorium was lifted.

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455.452 Other District screening methods

Nothing in this subpart must restrict the District Medicaid agency from establishing provider screening methods in addition to or more stringent than those required by this subpart.

455.460 Application fee

(a) Beginning on or after March 25, 2011, the District 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:

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1. Individual physicians or non-physician practitioners.
2. Providers who are enrolled in either of the following:
   i. Title XVIII of the Act.
   ii. Another State's title XIX or XXI plan.
3. Providers that have paid the applicable application fee to
   i. A Medicare contractor; or ii.
   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 District agency must return that portion of the fees to the Federal government.

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455.470 Temporary moratoria

(a) (1) The Secretary consults with any affected District Medicaid agency regarding imposition of temporary moratoria on enrollment of new providers or provider types prior to imposition of the moratoria, in accordance with 424.570 of this chapter.

(3) The District Medicaid agency will impose temporary moratoria on enrollment of new providers or provider types identified by the Secretary as posing an increased risk to the Medicaid program.

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(3)(i) The District Medicaid agency is not required to impose such a moratorium if the District Medicaid agency determines that imposing a temporary moratorium would adversely affect beneficiaries' access to medical assistance. (ii) If the District Medicaid agency makes such determination, the District Medicaid agency must notify the Secretary in writing.

(b) (1) The District Medicaid agency may impose temporary moratoria on enrollment of new providers, or impose numerical caps or other limits that the District Medicaid agency identifies as having a significant potential for fraud, waste, or abuse and that the

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Secretary has identified as being at high risk for fraud, waste, or abuse.

(2) Before implementing the moratoria, caps, or other limits, the District Medicaid agency must determine that its action would not adversely impact beneficiaries’ access to medical assistance.

(3) The District Medicaid agency must notify the Secretary in writing in the event the District Medicaid agency seeks to impose such moratoria, including all details of the Moratoria; and obtain the Secretary’s concurrence with imposition of the moratoria.

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(c) (1) The District Medicaid agency must impose the moratorium for an initial period of 6 months.

(2) If the District Medicaid agency determines that it is necessary, the District Medicaid agency may extend the moratorium in 6-month increments.

(3) Each time, the District Medicaid agency must document in writing the necessity for extending the moratorium.