Janet T. Mills
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Testimony of the Office of MaineCare Services
Department of Health and Human Services

In Support of LD 121
An Act To Require a Background Check for High-risk Health Care Providers Under the MaineCare Program

Hearing Date: March 2, 2021

Senator Claxton, Representative Meyer, and Members of the Joint Standing Committee on Health and Human Services, my name is Bill Logan. I am the Director of Compliance at the Office of MaineCare Services. I am here today to introduce and speak in support of LD 121, *An Act To Require a Background Check for High-risk Health Care Providers Under the MaineCare Program.* The Department thanks Senator Claxton for sponsoring this bill on our behalf.

The Affordable Care Act (ACA) requires states to implement a Fingerprint-Based Criminal Background Check (FCBC) for Medicaid providers considered "high-risk" as defined in Federal law. States were required to be in compliance with FCBC requirements by July 1, 2018. Maine's Medicaid program remains non-complaint with the Federal regulations and needs to implement FCBC requirements. The fingerprints will be run through both Maine's and the FBI's criminal background databases.

Providers who fall into the category of "high risk" will have to undergo a fingerprint-based criminal background check when enrolling as a MaineCare provider. The Department is presently drafting rules to define "high risk" in line with the federal regulation definitions (see attachments). Consistent with the provider types designated as high risk under federal regulations, the Department intends to categorize the following newly enrolling provider types as "high risk": Home Health Agencies, Durable Medical Equipment providers, Medicare Diabetes Prevention Programs, and opioid treatment programs that have not been fully and continuously certified by SAMHSA since October 23, 2018.

In addition to the categorically "high risk" provider types, the risk level of an individual provider will be adjusted to "high risk" based upon the occurrence of certain events, such as a previous exclusion from Medicaid within the past 10 years, conviction for certain state or federal felony offenses within the past 10 years, exclusion or debarment from participation in a Federal or State health care program within the past 10 years, having been terminated or otherwise precluded from billing Medicare, and other similar events.

Providers will have to cover the costs of their own background checks, currently the cost is $54 per individual check.

I will be happy to answer any questions you have and will plan to attend the work session.

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42 CFR 424.502

As used in this subpart, unless the context indicates otherwise —

Affiliation means, for purposes of applying § 424.519, any of the following:

(1) A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization.

(2) A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization.

(3) An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including, for purposes of this paragraph (3), sole proprietorships), either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W-2 employee of the organization.

(4) An interest in which an individual is acting as an officer or director of a corporation.

(5) Any reassignment relationship under § 424.80.

Approve/Approval means the enrolling provider or supplier has been determined to be eligible under Medicare rules and regulations to receive a Medicare billing number and be granted Medicare billing privileges.

Authorized official means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

Change in Majority Ownership occurs when an individual or organization acquires more than a 50 percent direct ownership interest in an HHA during the 36 months following the HHA's initial enrollment into the Medicare program or the 36 months following the HHA's most recent change in majority ownership (including asset sale, stock transfer, merger, and consolidation). This includes an individual or organization that acquires majority ownership in an HHA through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's most recent change in majority ownership.

Deactivate means that the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information.

Delegated official means an individual who is delegated by the "Authorized Official," the authority to report changes and updates to the enrollment record. The delegated official must be an individual with ownership or control interest in, or be a W-2 managing employee of the provider or supplier.

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Deny/Denial means the enrolling provider or supplier has been determined to be ineligible to receive Medicare billing privileges for Medicare covered items or services provided to Medicare beneficiaries.

Disclosable event means, for purposes of § 424.519, any of the following:

(1) Currently has an uncollected debt to Medicare, Medicaid, or CHIP, regardless of—

(i) The amount of the debt;

(ii) Whether the debt is currently being repaid (for example, as part of a repayment plan); or

(iii) Whether the debt is currently being appealed;

(2) Has been or is subject to a payment suspension under a federal health care program (as that latter term is defined in section 1128B(f) of the Act), regardless of when the payment suspension occurred or was imposed;

(3) Has been or is excluded by the OIG from participation in Medicare, Medicaid, or CHIP, regardless of whether the exclusion is currently being appealed or when the exclusion occurred or was imposed; or

(4) Has had its Medicare, Medicaid, or CHIP enrollment denied, revoked, or terminated, regardless of—

(i) The reason for the denial, revocation, or termination;

(ii) Whether the denial, revocation, or termination is currently being appealed; or

(iii) When the denial, revocation, or termination occurred or was imposed.

Enroll/Enrollment means the process that Medicare uses to establish eligibility to submit claims for Medicare-covered items and services, and the process that Medicare uses to establish eligibility to order or certify Medicare-covered items and services. The process includes—

(1) Identification of a provider or supplier;

(2) Except for those suppliers that complete the CMS-855O form, CMS-identified equivalent, successor form or process for the sole purpose of obtaining eligibility to order or certify Medicare covered items and services, validating the provider or supplier's eligibility to provide items or services to Medicare beneficiaries;

(3) Identification and confirmation of the provider or supplier's practice location(s) and owner(s); and

(4) Except for those suppliers that complete the CMS-855O form, CMS-identified equivalent, successor form or process for the sole purpose of obtaining eligibility to order or certify Medicare covered items and services, granting the Medicare provider or supplier Medicare billing privileges.

Enrollment application means a CMS-approved paper enrollment application or an electronic Medicare enrollment process approved by OMB.

Final adverse action means one or more of the following actions:

(1) A Medicare-imposed revocation of any Medicare billing privileges;

(2) Suspension or revocation of a license to provide health care by any State licensing authority;

(3) Revocation or suspension by an accreditation organization;

(4) A conviction of a Federal or State felony offense (as defined in § 424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; or

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(5) An exclusion or debarment from participation in a Federal or State health care program.

Institutional provider means any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (not including physician and nonphysician practitioner organizations), CMS-855S, CMS-20134, or an associated Internet-based PECOS enrollment application.

Managing employee means a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, Page 3 of 3 42 CFR 424.502

the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the provider or supplier.

NPI stands for National Provider Identifier.

Operational means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered), to furnish these items or services.

Owner means any individual or entity that has any partnership interest in, or that has 5 percent or more direct or indirect ownership of the provider or supplier as defined in sections 1124 and 1124A(A) of the Act.

PECOS stands for Internet-based Provider Enrollment, Chain, and Ownership System.

Physician or nonphysician practitioner organization means any physician or nonphysician practitioner entity that enrolls in the Medicare program as a sole proprietorship or organizational entity.

Reject/Rejected means that the provider or supplier's enrollment application was not processed due to incomplete information, or that additional information or corrected information was not received from the provider or supplier in a timely manner.

Revoke/Revocation means that the provider or supplier's billing privileges are terminated.

[Effective until Jan. 1, 2020.] State oversight board means, for purposes of §§ 424.530(a)(15) and 424.535(a)(22) only, any State administrative body or organization, such as (but not limited to) a medical board, licensing agency, or accreditation body, that directly or indirectly oversees or regulates the provision of health care within the State.

Voluntary termination means that a provider or supplier, including an individual physician or nonphysician practitioner, submits written confirmation to CMS of its decision to discontinue enrollment in the Medicare program.

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42 CFR 424.518

§ 424.518 Screening levels for Medicare providers and suppliers.

A Medicare contractor is required to screen all initial applications, including applications for a new practice location, and any applications received in response to a revalidation request based on a CMS assessment of risk and assignment to a level of "limited," "moderate," or "high."

(a) Limited categorical risk.

(1) Limited categorical risk: Provider and supplier categories. CMS has designated the following providers and suppliers as "limited" categorical risk:

(i) Physician or nonphysician practitioners (including nurse practitioners, CRNAs, occupational therapists, speech/language pathologists, and audiologists) and medical groups or clinics.

(ii) Ambulatory surgical centers.

(iii) Competitive Acquisition Program/Part B Vendors.

(iv) End-stage renal disease facilities.

(v) Federally qualified health centers.

(vi) Histocompatibility laboratories.

(vii) Home infusion therapy suppliers.

(viii) Hospitals, including critical access hospitals, Department of Veterans Affairs hospitals, and other federally owned hospital facilities.

(ix) Health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act.

(x) Mammography screening centers.

(xi) Mass immunization roster billers

(xii) Opioid treatment programs (if § 424.67(b)(3)(ii) applies).

(xiii) Organ procurement organizations.

(xiv) Pharmacies newly enrolling or revalidating via the CMS-855B application.

(xv) Radiation therapy centers.

(xvi) Religious non-medical health care institutions.

(xvii) Rural health clinics.

(xviii) Skilled nursing facilities.

(2) Limited screening level: Screening requirements. When CMS designates a provider or supplier as a "limited" categorical level of risk, the Medicare contractor does all of the following:

(i) Verifies that a provider or supplier meets all applicable Federal regulations and State requirements for the provider or supplier type prior to making an enrollment determination.

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(ii) Conducts license verifications,
including licensure verifications across State lines for physicians or nonphysician practitioners and providers and suppliers that obtain or maintain Medicare billing privileges as a result of State licensure, including State licensure in States other than where the provider or supplier is enrolling.
(iii) Conducts database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.

(b) Moderate categorical risk.

(1) Moderate categorical risk: Provider and supplier categories. CMS has designated the following providers and suppliers as "moderate" categorical risk:
(i) Ambulance service suppliers.
(ii) Community mental health centers.
(iii) Comprehensive outpatient rehabilitation facilities.
(iv) Hospice organizations.
(v) Independent clinical laboratories.
(vi) Independent diagnostic testing facilities.
(vii) Physical therapists enrolling as individuals or as group practices.
(viii) Portable x-ray suppliers.
(ix) Revalidating home health agencies.
(x) Revalidating DMEPOS suppliers.
(xi) Revalidating MDPP suppliers.
(xii)[Effective Jan. 1, 2020.] Prospective (newly enrolling) opioid treatment programs that have been fully and continuously certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) since October 23, 2018.
(xiii)[Effective Jan. 1, 2020.] Revalidating opioid treatment programs.

(2) Moderate screening level: Screening requirements. When CMS designates a provider or supplier as a "moderate" categorical level of risk, the Medicare contractor does all of the following:
(i) Performs the "limited" screening requirements described in paragraph (a)(2) of this section.
(ii) Conducts an on-site visit.

(c) High categorical risk.

(1) High categorical risk: Provider and supplier categories. CMS has designated the following home health agencies and suppliers of DMEPOS as "high" categorical risk:
(i) Prospective (newly enrolling) home health agencies.
(ii) Prospective (newly enrolling) DMEPOS suppliers.
(iii) Prospective (newly enrolling) MDPP suppliers
(iv)[Effective Jan. 1, 2020.] Prospective (newly enrolling) opioid treatment programs that have not been fully and continuously certified by SAMHSA since October 23, 2018.

(2) High screening level: Screening requirements. When CMS designates a provider or supplier as a "high" categorical level of risk, the Medicare contractor does all of the following:
(i) Performs the "limited" and "moderate" screening requirements described in paragraphs (a)(2) and (b)(2) of this section.

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(ii)

(A) Requires the submission of a set of fingerprints for a national background check from all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the provider or supplier; and

(B) Conducts a fingerprint-based criminal history record check of the Federal Bureau of Investigation's Integrated Automated Fingerprint Identification System on all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the provider or supplier.

(3) Adjustment in the categorical risk. CMS adjusts the screening level from "limited" or "moderate" to "high" if any of the following occur:

(i)CMS imposes a payment suspension on a provider or supplier at any time in the last 10 years.

(ii) The provider or supplier—

(A) Has been excluded from Medicare by the OIG; or

(B) Had billing privileges revoked by a Medicare contractor within the previous 10 years and is attempting to establish additional Medicare billing privileges by—

(1) Enrolling as a new provider or supplier; or

(2) Billing privileges for a new practice location;

(C) Has been terminated or is otherwise precluded from billing Medicaid;

(D) Has been excluded from any Federal health care program; or

(E) Has been subject to any final adverse action, as defined at § 424.502, within the previous 10 years.

(iii)CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a
Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted.

(d) Fingerprinting requirements. An individual subject to the fingerprint-based criminal history record check requirement specified in paragraph (c)(2)(ii)(B) of this section—

(1) Must submit a set of fingerprints for a national

background check. **(i)**Upon submission of a Medicare

enrollment application; or

(ii) Within 30 days of a Medicare contractor request.

(2) In the event the individual(s) required to submit fingerprints under paragraph (c)(2) of this section fail to submit such fingerprints in accordance with paragraph (d)(1) of this section, the provider or supplier will have its billing privileges—

(i) Denied under § 424.530(a)(1);

or **(ii)**Revoked under § .535(a)(1).

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42 CFR 455.450

§ 455.450 Screening levels for Medicaid providers.

A State 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," "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 State Medicaid agency designates a provider as a limited categorical risk, the State Medicaid agency must do all of the following:

(1) Verify that a provider meets any applicable Federal regulations, or State requirements for the provider type prior to making an enrollment determination.

(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 State Medicaid agency designates a provider as a "moderate" categorical risk, a State 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 State Medicaid agency designates a provider as a "high" categorical risk, a State Medicaid agency must do both of the following:

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

(2)

(i) Conduct a criminal background check; and

(ii) Require the 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 State 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 State agency must adjust the categorical risk level from "limited" or "moderate" to "high" when any of the following occurs:

(1) The State Medicaid agency imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse, the provider has an existing Medicaid

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overpayment, or the provider has been
excluded by the OIG or another State's Medicaid program within the previous 10 years.

(2) The State 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.