CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicaid Provider Enrollment

Fingerprint-based Criminal Background Checks (FCBC)

42 CFR § § 455.434 &455.450

FCBC Regulations

42 CFR:	Description
455.434	State must conduct fingerprint-based criminal background checks for all "high" risk providers
455.450(c)	c) …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.

Basis for FCBC Effective Date

In the February 2, 2011 final rule, CMS indicated FCBC would be implemented 60 days following the publication of sub regulatory guidance.

Except FCBC, all screening procedures implemented under 42 CFR 455 Subparts B & E are applicable beginning on March 25, 2011.*

*76 FR 5872

2 Ways to Comply

In January 2016, CMS Issued Sub Regulatory Guidance for SMAs: FCBC (2016-002) to define 2 Pathways to comply, as follows:

1. Implement FCBC by June 1, 2016, as defined in publication 2016-002; or,

2. Submit a Compliance Plan by April 15, 2015

"Full Implementation" Defined

(Slide 1 of 2)

A SMA is in compliance with the June 1, 2016 deadline if, by that date, the SMA has:

- Notified each "high" risk provider subject to the FCBC requirement;
- Collected fingerprints and used the fingerprints to verify whether the provider has a state or national criminal history;
  - The fingerprints must be collected from any "high" risk provider enrolled or revalidated on or after August 1, 2015.

"Sub Regulatory Guidance for SMAs: FCBC (2016-002)" at https://www.medicaid.gov/affordablecareact/provisions/program-integrity.html

"Full Implementation" Defined

(Slide 2 of 2)

A SMA is in compliance with the June 1, 2016 deadline if, by that date, the SMA has:

- Taken any necessary termination action based on the criminal history data; and,
- Updated the enrollment record for a "high" risk provider subject to the FCBC requirement to indicate whether the provider passed, failed, or failed to respond to the requirement for a FCBC.
  - Those providers that fail the background check or fail to respond must be terminated by June 1, 2016 unless the SMA determines that termination is not in the best interests of the Medicaid program and documents that determination in writing.

"Sub Regulatory Guidance for SMAs: FCBC (2016-002)" at https://www.medicaid.gov/affordablecareact/provisions/program-integrity.html

Second Option to Comply: Submit a Compliance Plans

- Compliance plans are due April 15, 2016 by 11:59:59 Pacific Standard Time
  - Late plans will not be reviewed
  - If the SMA chooses not to submit a compliance plan, the SMA will be measured against the June 1, 2016 implementation deadline
- By June 1, 2016, CMS will issue compliance letters to any SMA that submitted a compliance plan by the deadline

"Sub Regulatory Guidance for SMAs: FCBC (2016-002)" at https://www.medicaid.gov/affordablecareact/provisions/program-integrity.html

Medicaid FCBC: Summary of Roles

Party	Role
CMS	Applies and interprets federal requirements at 42 CFR 455 Subpart E
FBI	Central repository for states' criminal history data. Establishes procedures to conduct identity history summary checks for non-criminal justice purposes
State Medicaid Agency	Applies the FCBC requirements to providers Makes fitness determinations based upon criminal history data
State Repository	Serves as the conduit for a SMA to access national criminal history data

FCBC Implementation

- The risk category in effect at the time of the screening determines the screening activities required
- Upon designating a provider as "high" risk, the SMA applies the FCBC.

MPEC Section 1.5.2 "When Screening is Required"
& § 1.5.4 "Screening Activities by Category"

Who Must Be Fingerprinted?

Based upon Enrollment Type	FCBC applies to:	FCBC does NOT apply to:
Individual Enrollment	"High" risk individual providers	
Organizational Enrollment	5% or more owners	• Managing employees • Officers • Directors

MPEC 1.3.D.4. "Providers Designated 'High' Risk"

Q & A

Q. A SMA is newly enrolling a municipal ambulance provider. The SMA opts to enroll ambulance at "high" risk.* Who does the SMA fingerprint?

A. If an entity has no owner(s)**, no one is subject to the FCBC requirement. CMS recommends the SMA documents this in the enrollment record.

** *"Ownership" interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity (§ 455.101).*

*In this example, the SMA applies a higher risk designation than the federal regulations require; see MPEC Section 1.3.D "Risk Levels for Provider Types Also Existing in Medicare"

“High” Risk Category Includes

- Prospective (newly enrolling):
  - Home health agencies (HHA)
  - DMEPOS
- “Bumped Up” Providers at 42 CFR 455.450(e)
- Provider types the State has categorized as “high”

MPEC 1.3.D.4. “Providers Designated ‘High’ Risk”

Medicaid "Bump Up" Criteria

(slide 1 of 2)

42 CFR 455.450(e) – Existing Providers Are "High" Risk When:		**Look back**	**Risk Remains "High"**
1.	SMA imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse	10 years	10 years beyond date of payment suspension
2.	Provider has a qualified existing Medicaid overpayment	At the time of application for enrollment or revalidation	For any enrollment or revalidation that the provider continues to have an existing overpayment

MPEC 1.3.D.4. "Providers Designated 'High' Risk"

Medicaid "Bump Up" Criteria

(slide 2 of 2)

42 CFR 455.450(e) - Existing Providers Are "High" Risk When:		Look back	Risk Remains "High"
3.	Provider has been excluded by the OIG or another State's Medicaid program within past 10 years	10 years	For 10 years beyond date of exclusion
4.	SMA or CMS, in the previous 6 months, lifted a moratorium for the particular provider type, and a provider prevented from enrolling applies for enrollment within 6 months from the date the moratorium was lifted	None	SMA stops looking at this beginning 6 months and 1 day after a moratorium is lifted

MPEC 1.3.D.4. "Providers Designated 'High' Risk"

Relying on Medicare FCBC

- Medicare screens prospective HHA and DME enrollments at the "high" risk category
- Subsequently, Medicare drops successful new HHA and DME enrollments to "moderate" risk category
- If a provider's risk category for Medicare is lower than Medicaid, SMA must conduct "gap" screening
- If the SMA can verify a FCBC was conducted by Medicare for an individual, the SMA may rely on it

MPEC Section 1.5.3 "Screening Process"

Risk Level Differences May Require SMA "Gap" Screening

Medicaid	Medicare	SMA additional screening
"Limited"	"Limited"	None
"Limited"	"Moderate"	None
"Limited"	"High"	None
"Moderate"	"Limited"	State must conduct: Site Visit
"Moderate"	"Moderate"	None
"Moderate"	"High"	None
"High"	"Limited"	State must conduct: Site Visit and FCBC
"High"	"Moderate"	State must conduct: FCBC
"High"	"High"	None

MPEC Section 1.5.3 "Screening Process"

Medicare FCBC Implementation

Medicare began fingerprinting “high” risk providers on August 6, 2014

If a provider enrolled in Medicare prior to August 6, 2014, the record will not reflect the FCBC

Medicare continues FCBC implementation on a rolling basis.

Your "High" Risk List by Category

"High" Risk Categories	
1.	Newly Enrolling HHA
2.	Newly Enrolling DME
3.	New or Revalidating that Your SMA Opts to Categorize as "High" Risk
4.	Payment Suspension History
5.	OIG Exclusion History
6.	Qualified Overpayment
7.	Applying for Enrollment Post-Moratorium (Federal or State-based)

Prospective DME & HHA

- Newly Enrolling DME and HHA are “high” risk provider types

- Upon successful enrollment, HHA and DME provider types are no longer “prospective” and may be lowered to “moderate”

Prospective DME, HHA

- The SMA may opt to maintain HHA and DME at "high" risk continuously. In this event, the SMA would need to conduct the FCBC:
  - At new enrollment
  - Upon the addition of any new 5% or more owner
  - At revalidation

HHA and DME: Relying on Medicare

For new Medicaid HHA and DME enrollments, the SMA is required to screen at "high"

If the same provider is enrolled in Medicare, PECOS will reflect a "moderate" risk category

Therefore, SMA will need to do one of two things:

- Verify Medicare conducted the FCBC, or
- Conduct the FCBC

MPEC Section 1.5.3 "Screening Process"

Did Medicare Conduct My FCBC?

Q. A SMA is newly enrolling a DME provider (at "high" risk) that Medicare first enrolled in 2015. Can the SMA rely on a Medicare FCBC?

A. Maybe: SMA must verify Medicare's FCBC.

- Medicare started fingerprinting in August 2014
- A Medicare DME enrollment will reflect a "moderate" risk category in PECOS
- SMA must verify the actual FCBC result is in PECOS in order to rely on the Medicare FCBC

Did Medicare Conduct My FCBC?

Medicaid Enrollment Scenario:

- Newly Enrolling HHA
- Positive Match, i.e. same provider is enrolled in Medicare
- Provider is in Medicare “Moderate” risk category
- Provider’s Medicare enrollment start date: 2010

Providers Your SMA Opts to Categorize as "High" Risk

- Determine when you wish "high" risk screening activity requirements to apply. At new enrollment only? At new enrollment and revalidation? Draft your regulations in accordance.
- If you opt to maintain "provider type X" at "high" risk continuously, conduct "high" risk screening:
  - At new enrollment
  - Upon the addition of any new 5% or more owner
  - At revalidation

Payment Suspensions (PS) & OIG Exclusions

- "High" risk designation based upon Medicaid PS and OIG Exclusions each have a 10 year "lookback" period

- A Medicaid "high" risk designation based upon a PS is based upon your own SMA's PS, not a Medicare PS or a PS by another SMA

Providers w/Qualified Overpayment

- The "high" risk category applies to any provider with a qualified overpayment at the time the provider applies for new enrollment or revalidation.

- In addition, SMA must determine which providers it revalidated or enrolled on or after August 1, 2015 with a qualified overpayment.
  - These providers are subject to the FCBC requirement.

MPEC 1.3.D.4. "Providers Designated 'High' Risk"

Providers Applying for Enrollment Post-Moratorium

- Refers to moratoria executed by
  - SMA under 42 CFR § 455.470
  - CMS under § 424.570

- CMS Moratoria
  - CMS has not lifted any moratoria imposed under § 424.570
  - Therefore, as of January 2016, the SMA has **no** "high" risk workload associated with CMS moratoria.
  - CMS notifies states affected by federal moratoria regarding any change in status

Providers Applying for Enrollment Post-Moratorium

- State-based Moratoria
  - If your SMA imposes a state-based moratorium under § 455.470, your contact for CMS concurrence under § 455.470(b)(3) is: providerenrollmentmoratoria@cms.hhs.gov

Providers Applying for Enrollment Post-Moratorium

- State-based Moratoria
  - Assess workload only if your SMA lifted a state-based moratorium on or after February 1, 2015 (i.e., 6 months before August 1, 2015)
  - Apply FCBC to any provider that was prevented from enrolling based on the moratorium for 6 months from the date the moratorium was lifted

Operational Highlights: FCBC Requirement

- The State Repository is the source for operational guidance.
- Providers may be responsible to pay a nominal fee at the point of fingerprinting, to offset the cost of capturing the fingerprints*
- Do not store criminal history data in a provider's enrollment record**
- At this time, the FBI does not offer "Rap Back" ongoing Screening
  - However, the state repository may offer such screening. Check with your state repository regarding availability.

*MPEC Section 1.5.5.4 Fingerprinting/Criminal Background Checks
**MPEC Section 1.7 "Documentation/Evidence of Completion"

Reviewing Criminal History Information

- The SMA has discretion to conduct a state or a national criminal history check (or both).
- The SMA uses the criminal history information returned to evaluate a provider for "fitness" for enrollment
- To do this, the SMA must have a list of criteria it uses to make a determination of fitness. This is "fitness criteria"
- Under § 431.51(c)(2), the State Medicaid Plan has the authority to set reasonable standards relating to the qualifications of providers
- CMS recommends the SMA consider promulgating fitness criteria via state regulation