DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

SMD# 15-002
ACA# 33

June 01, 2015

Re: Medicaid/CHIP Provider Fingerprint-Based Criminal Background Check

Dear State Medicaid Director:

This guidance is part of a series relating to the implementation of Section 6401 of the Affordable Care Act, Provider Screening and Other Enrollment Requirements under Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Section 6401(a) of the Affordable Care Act amended section 1866(j) (2) of the Social Security Act (the Act) to require the Secretary, in consultation with the Office of the Inspector General, to establish procedures for screening providers and suppliers under Medicare, Medicaid, and CHIP. The Secretary was directed to determine the level of screening to be conducted according to the level of risk for fraud, waste, and abuse for each category of provider.

Section 6401(b) of the Affordable Care Act amended section 1902 of the Act to require states to comply with the procedures established by the Secretary for screening providers and suppliers. The Centers for Medicare & Medicaid Services (CMS) implemented these requirements with federal regulations at 42 CFR Part 455 subpart E. These regulations were published as a final rule in the *Federal Register*, Vol. 76, February 2, 2011, and were effective March 25, 2011.

On December 23, 2011, CMS issued an Informational Bulletin to offer further information to states regarding the requirements of these regulations. The Informational Bulletin, which may be found at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-12-23-11.pdf, referenced additional sub regulatory guidance on fingerprint-based criminal background checks (FCBCs). This letter represents that guidance.

Implementation of Fingerprint-Based Criminal Background Checks

42 CFR 455.410(a) provides that a state Medicaid agency must require all enrolled providers to be screened according to the provisions of Part 455 subpart E. Under 42 CFR 455.450, a state Medicaid agency is required to screen all applications, including initial applications, applications for a new practice location, and applications for re-enrollment or

revalidation, based on a categorical risk level of "limited," "moderate," or "high." Under 42 CFR 455.434, a state Medicaid agency 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. When the agency determines that a provider's categorical risk level is "high," or when the agency is otherwise required to do so under State law, the agency must require providers to consent to criminal background checks, including fingerprinting.

42 CFR 455.450(c) requires that when a state Medicaid agency designates a provider as a "high" categorical risk, the agency must do all of the following:

- Perform the "limited" and "moderate" screening requirements specified at 42 CFR 455.450(a) and (b);
- Require the submission of a set of fingerprints in accordance with 42 CFR 455.434; and
- Conduct a criminal background check.

Under 42 CFR 455.434(b), the requirement to submit fingerprints applies to both the "high" risk provider and any person with a 5 percent or more direct or indirect ownership interest in the provider, as those terms are defined in 455.101.

FCBCs are part of the enhanced screening and enrollment provisions included in the Provider Screening and Enrollment State Plan Amendment. This guidance implements the timeframe discussed in the preamble to the February 2011 final rule and in the December 2011 Informational Bulletin. States have 60 days from the date of this letter to begin implementation of the FCBC requirement. States must complete implementation of the FCBC requirement within 12 months of the date of this letter. Implementation means that the state Medicaid agency has conducted an FCBC with respect to each provider that the agency has designated as "high" risk. This includes all "high" risk providers newly enrolling in Medicaid, "high" risk providers seeking re-enrollment in Medicaid, and currently enrolled "high" risk providers at the time of revalidation required under 42 CFR 455.414.

To avoid unnecessary cost and burden, a state Medicaid agency is not required to conduct an FCBC on a "high" risk provider if that provider is considered a "high" risk provider by Medicare and the provider has been enrolled by Medicare. (Under 42 CFR 424.518(c), Medicare considers newly-enrolling home health agencies and suppliers of DMEPOS to be "high" categorical risk). Under 42 CFR 455.410(c), states may rely on a provider's Medicare enrollment even if Medicare has not conducted an FCBC with respect to that provider. States should confirm through the Provider Enrollment, Chain, and Ownership System (PECOS) whether a provider is currently enrolled in Medicare, whether an FCBC has been conducted with respect to the provider, and whether the provider passed or failed the FCBC. A state Medicaid agency may also rely on the results of an FCBC conducted by another state Medicaid or CHIP agency if the provider is enrolled in the other state Medicaid or CHIP program and has met the revalidation requirement of 42 CFR 455.414.

The state Medicaid agency may determine the form and manner for submission of fingerprints. It may require a "high" risk provider to pay the costs associated with obtaining fingerprints. States also have discretion to decide the type and extent of their criminal background checks. We recommend conducting a FBI criminal history record check, which provides information that is national in scope. States may wish to leverage existing protocols for obtaining FCBCs that are used in the state for other purposes, such as hiring, licensing, or screening employees. States may also wish to leverage activities and procedures implemented under the CMS National Background Check Program for Long-Term Care Facilities and Providers. The specific procedures a state Medicaid agency elects to follow will determine the applicable security and privacy requirements under state or federal law.

Under 42 CFR 455.416, a state Medicaid agency must terminate or deny enrollment of a provider if the provider, or any person with a 5% or greater direct or indirect ownership interest, who is required to submit fingerprints:

- fails to submit them within 30 days of the Medicaid agency's request;
- fails to submit them in the form and manner requested by the Medicaid agency; or
- has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid or CHIP program in the last 10 years.

In all three cases, the agency may allow the provider to enroll if the agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and documents that determination in writing.

Please contact Christine Gerhardt, Deputy Director, Division of State Systems, at 410-786-0693, or by email at Christine.Gerhardt@cms.hhs.gov if you have any questions. We look forward to continuing our work together as we implement this important provision of the Affordable Care Act.

Sincerely,

/s/

Victoria Wachino
Director

Enclosure: Frequently Asked Questions: Medicaid/CHIP Provider Fingerprint-Based Background Checks

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State and Territorial Health Officials

Council of State Governments

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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid/CHIP Provider Fingerprint-Based Criminal Background Checks (FCBCs) Frequently Asked Questions

June 1, 2015

Q1: Is provider and supplier screening in Medicaid and CHIP required by statute?

A1: Yes. Section 6401(a) of the Affordable Care Act amended section 1866(j) (2) of the Social Security Act (the Act) to require the Secretary, in consultation with the HHS Office of Inspector General, to establish procedures for screening providers and suppliers under Medicare, Medicaid, and CHIP. The Secretary was directed to determine the level of screening to be conducted according to the level of risk for fraud, waste, and abuse for each category of provider. Section 6401(b) of the Affordable Care Act amended section 1902 of the Act to require state Medicaid programs to comply with the procedures established by the Secretary for screening providers and suppliers. Section 6401(c) of the Affordable Care Act amended section 2107(e) of the Act to make the provider and supplier screening requirements under section 1902 applicable to CHIP.

Q2: Has CMS implemented this statutory requirement by regulation?

A2: Yes. CMS implemented provider screening requirements with federal regulations at 42 CFR Part 455 subpart E and at 42 CFR §457.990, which makes Part 455 subpart E applicable to CHIP. These regulations were published as a final rule in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011.

Q3: Has CMS issued any previous guidance related to these regulations?

A3: Yes. CMS issued an Informational Bulletin on December 23, 2011, which may be found at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-12-23-11.pdf.

Q4: Why is CMS releasing this guidance on Fingerprint-based Criminal Background Checks (FCBCs)?

A4: The December 23, 2011 Informational Bulletin, as well as the preamble to the February 2011 final rule, made clear that states would not be required to implement the FCBC requirements until 60 days following the publication of sub regulatory guidance. These FAQs, and the accompanying state Medicaid Director letter, constitute that guidance. The Medicare program began conducting FCBCs for providers and suppliers designated to be in the "high" risk category in September, 2014. See "Implementation of Fingerprint-based Background Checks," https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1417.pdf.

CMS intends for Medicaid and CHIP programs to make sure "high" risk providers are subject to screening procedures that are equally as effective as those applied to "high" risk providers in Medicare.

Q5: Why does a state Medicaid agency have to conduct FCBCs?

A5: The federal regulation at 42 CFR 455.410(a) provides that a state Medicaid agency must require all enrolled providers to be screened according to the provisions of Part 455 subpart E. These provisions require the agency to screen all provider applications for enrollment, including initial applications, applications for a new practice location, and applications for re-enrollment or revalidation, based on a categorical risk level of "limited," "moderate," or "high" (42 CFR 455.450). The agency 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. When the agency determines that a provider's categorical risk level is "high," or when the agency is otherwise required to do so under state law, the agency must require providers to consent to criminal background checks, including fingerprinting (42 CFR 455.434).

Q6: How should a state Medicaid agency determine whether a provider or a category of providers is "high" risk?

A6: In general, state Medicaid agencies should make their own determinations as to which providers, and which categories of providers, pose a "high" risk of fraud, waste, or abuse to the Medicaid program. However, there are certain providers and categories of providers that an agency must designate as "high" risk.

If a provider or provider category is designated as "high" risk by Medicare, the agency must apply the same "high" risk designation for Medicaid purposes. (If Medicare designates a provider or provider category as "moderate" or "limited" risk, the agency must, at a minimum apply that Medicare screening level to the provider or provider category; the agency may, however, apply a higher screening level than that applied by Medicare).

Under Medicare regulations at 42 CFR 424.518(c), newly enrolling home health agencies and newly enrolling Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers are designated as "high" risk. In addition, CMS adjusts a provider's screening level to "high" under certain circumstances (for example, the provider or supplier has been subject to a payment suspension or has had billing privileges revoked at any time in the last 10 years).

Under 42 CFR 455.450(e), a Medicaid agency is required to adjust a provider's screening level to "high" risk in the following circumstances: (1) the agency imposes a payment suspension; (2) the provider has an existing overpayment; (3) the provider has been excluded by the OIG or another state's Medicaid program; (4) the agency or CMS in the

previous 6 months lifted a temporary moratorium for the particular provider type and a provider prevented from enrolling during the moratorium applies for enrollment within 6 months from the date the moratorium was lifted.

In the case of provider types that exist only in Medicaid or CHIP and do not have a Medicare screening designation, state Medicaid agencies must determine the risk posed by a particular provider or provider type. In general, state agencies should use similar criteria to those used in Medicare in making this screening designation. As outlined in the preamble to the final rule, 76 Fed. Reg. at 5895-5896 (February 2, 2011), physicians and non-physician practitioners, medical groups, and clinics that are state-licensed would generally be categorized as "limited" risk; provider types that are highly dependent on Medicare, Medicaid and CHIP to pay salaries and other operating expenses and are not subject to additional governmental or professional oversight would be considered "moderate" risk; and those identified as being especially vulnerable to improper payments would be considered "high" risk.

Q7: When a state Medicaid agency designates a provider or provider category as "high" risk, what is required by the agency?

A7: Under 42 CFR 455.450(c), when a state Medicaid agency designates a provider as a "high" categorical risk, the agency must:

- Perform the "limited" and "moderate" screening requirements specified at 42 CFR 455.450(a) and (b);
- Require the submission of a set of fingerprints in accordance with 42 CFR 455.434; and
- Conduct a criminal background check.

The screening requirements for "limited" risk providers, found at 42 CFR 455.450(a), are: (1) verify that the provider meets all federal and state requirements applicable to the provider type; (2) verify licensure; and (3) conduct federal database checks. The screening requirements for "moderate" risk providers, found at 42 CFR 455.450(b), are: (1) perform "limited" screening; and (2) conduct an on-site visit.

Note that "high" risk providers, like any other providers who enroll in Medicaid, must enter into a provider agreement with the state Medicaid agency. Under 42 CFR 431.107(b) (5), the provider must furnish its National Provider Identifier (NPI) and include the NPI on all claims submitted to the Medicaid program.

Q8: Who is required to submit fingerprints?

A8: If a state Medicaid agency designates a provider as a "high" risk, the provider, and any person with 5 percent or more direct or indirect ownership interest in the provider, must submit fingerprints and undergo a criminal background check, per 42 CFR

455.434(b). An "ownership interest" is defined in 42 CFR 455.101 as the possession of equity in the capital, the stock, or the profits of the provider. An "indirect ownership interest" means an ownership interest in an entity that has an ownership interest in the provider.

Q9: How should a state Medicaid agency collect fingerprints?

A9: The agency may determine the form and manner for submission of fingerprints. State agencies interested in learning about the process that providers must follow for Medicare screening purposes should refer to http://www.cmsfingerprinting.com.

Q10: How should a state Medicaid agency conduct criminal background checks?

A10: Each state Medicaid agency may decide the type and extent of its criminal background check. CMS recommends conducting a FBI criminal history record check, which provides information that is national in scope and therefore would be more complete than a state-specific background check. This is the approach used by Medicare, as described in https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1417.pdf. A Medicare contractor, Accurate Biometrics, receives the fingerprint submission from the provider and 5 percent or greater owners, collects the associated fee(s), electronically forwards the fingerprint submissions to the FBI Criminal Justice Information Services (CJIS) Division for a national Identity History Summary check, and receives the electronic summary check results and transmits them to the Medicare Administrative Contractor (MAC). See http://www.fbi.gov/about-us/cjis/identity-history-summary-checks/fbi-approved-channelers.

Some aspects of the Medicare approach, such as use of MACs or Medicare's fingerprinting contractor, will not be relevant to state agencies. CMS does, however, recommend that state agencies implement the following elements of the Medicare process:

(1) Notify "high" risk providers in writing of the requirement to submit fingerprints, listing all individuals required to be fingerprinted, and the steps they will need to follow. The notification should identify 3 convenient locations where individuals can be fingerprinted; provide the Medicaid agency's point of contact to address provider questions, and set a deadline for compliance no later than 30 days of the request for fingerprints.

(2) Once the fingerprints have been received by the state agency or by its contractor, electronically transmit the fingerprints to the FBI or state law enforcement for processing.

(3) Upon receipt of the criminal background check results, make an enrollment, denial, or termination determination with respect to the provider.

(4) Store all fingerprint data consistent with applicable security and privacy requirements under state or federal law and with state records retention laws and procedures.

State Medicaid agencies may wish to leverage existing protocols for obtaining FCBCs that are used in the state for other purposes, such as hiring, licensing, or screening employees. States may also wish to leverage procedures implemented under the CMS National Background Check Program for Long-Term Care Facilities and Providers, http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/BackgroundCheck.html. The specific procedures a state Medicaid agency elects to follow will determine the applicable security and privacy requirements under state or federal law.

Q11: In the case of a "high" risk provider that is enrolled in Medicare, is the state Medicaid agency required to conduct an FCBC if the provider wants to enroll (or re-enroll) in Medicaid or seeks to revalidate its current enrollment?

A11: No. To avoid unnecessary cost and burden, a state Medicaid agency is not required to conduct an FCBC on a "high" risk provider if that provider is considered a "high" risk provider by Medicare and the provider has been enrolled by Medicare. Under 42 CFR 455.410(c), state agencies may rely on a provider's Medicare enrollment even if Medicare has not conducted an FCBC with respect to that provider. State agencies should confirm through the Provider Enrollment, Chain, and Ownership System (PECOS) whether a provider is currently enrolled in Medicare.

Q12: How can a state Medicaid agency confirm a Medicare FCBC using PECOS?

A12: Access to the PECOS Application Interface (AI) can be granted by contacting Peggy Haire at (410) 786-6944 or Peggy.Haire@cms.hhs.gov to obtain the needed application forms for submission to CMS. Once access is granted, the PECOS AI can be accessed via the following link: https://pecosai.cms.hhs.gov/. Within the PECOS AI, state agencies can view Medicare provider information that identifies whether or not a background check was conducted and whether the provider is enrolled. An individual's criminal history, if any, is not available for review in PECOS.

Q13: In the case of a "high" risk provider that is enrolled in another state's Medicaid or CHIP program, may the state Medicaid agency rely on the FCBC conducted by the other state's Medicaid or CHIP agency?

A13: Under 42 CFR 455.410(c), a state Medicaid agency may rely on the results of the provider screening performed by Medicaid agencies or CHIP programs of other states, including the screening of "high" risk providers using a FCBC.

Q14: What if a provider or a 5 percent owner doesn't submit fingerprints when requested to do so by a state Medicaid agency?

A14: Under 42 CFR 455.416, a state Medicaid agency must terminate or deny enrollment of a provider if the provider, or any person with a 5 percent or greater direct or indirect ownership interest, who is required to submit fingerprints:

- fails to submit them within 30 days of the Medicaid agency's request; or
- fails to submit them in the form and manner requested the Medicaid agency.

In both cases, the agency may allow the provider to enroll if the agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and documents that determination in writing.

Q15: What if the results of a FCBC indicate that a provider or 5 percent owner has a criminal record?

A15: Under 42 CFR 455.416, a state Medicaid agency must terminate or deny enrollment of a provider if the provider, or any person with a 5 percent or greater direct or indirect ownership interest, who is required to submit fingerprints has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid or CHIP program in the last 10 years. The types of convictions that warrant denial of enrollment are at the discretion of the agency. The agency may allow the provider to enroll if the agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and documents that determination in writing that is available to CMS or OIG upon request.

Q16: When must state Medicaid agencies implement the fingerprint-based criminal background checks?

A16: This guidance implements the timeframe discussed in the preamble to the February 2011 final rule and in the December 2011 Informational Bulletin. States have 60 days from the date of this letter to begin implementation of the FCBC requirement. States must complete implementation of the FCBC requirement within 12 months of the date of this letter. Implementation means that the state Medicaid agency has conducted an FCBC with respect to each provider that the agency has designated as "high" risk. This includes all "high" risk providers newly enrolling in Medicaid, "high" risk providers seeking re-enrollment in Medicaid, and currently enrolled "high" risk providers at the time of revalidation required under 42 CFR 455.414.

While the state agency must complete an FCBC with respect to each "high" risk provider (and any person with a 5 percent or more direct or indirect ownership interest) during the 12 month implementation period, the agency may do so using its own timeframe. If a "high" risk provider seeks to enroll in Medicaid for the first time before the agency has its FCBC process in place, the agency may enroll the provider (assuming the provider is otherwise qualified) without completing an FCBC at the time of initial enrollment. The agency would, however, have to conduct the FCBC on that provider prior to the expiration of the 12-month implementation period. Similarly, if a "high" risk provider seeks revalidation of enrollment before the state FCBC process is operational, the agency may revalidate the provider's Medicaid enrollment without completing an FCBC at that time, so long as the agency completes the FCBC for that provider before the end of the 12-month implementation period.

Q17: Who is responsible for the cost of conducting FCBCs for "high" risk providers?

A17: Under 42 CFR 455.460(a), state Medicaid agencies must collect application fees prior to executing a provider agreement with a prospective or re-enrolling institutional provider, unless the provider is enrolled in Medicare or another state's Medicaid or CHIP program. In addition, 42 CFR 455.414 requires that states revalidate the enrollment of all providers, regardless of provider type, every 5 years. As explained in the preamble to the final rule, 76 Fed. Reg. at 5908 (February 2, 2011), revalidation includes rescreening as well as the collection of updated disclosure information, so institutional providers seeking revalidation are subject to an application fee. The application fee is intended to cover the costs associated with a state's Medicaid provider screening program, including the costs of conducting an FCBC on "high" risk providers.

However, state Medicaid agencies may require the "high" risk provider to pay the costs associated with obtaining fingerprints. As explained in the preamble to the final rule, 76 Fed. Reg. at 5915 (February 2, 2011), CMS expects that the costs associated with processing the fingerprints and conducting the criminal background checks will be funded by the amounts collected by the state agency from the imposition of the application fee that applies to all institutional providers that are newly enrolling, are re-enrolling, or are revalidating their enrollment in Medicaid or CHIP, regardless of the provider's screening risk level. If the cost of a state's provider screening program exceeds the amount of the application fees collected, then the state Medicaid agency can claim federal financial participation for the excess cost.

In the case of "high" risk providers enrolled in Medicare, or in another state's Medicaid or CHIP program, the state Medicaid agency should not be incurring costs relating to conducting FCBCs because it will be able to rely on the screening conducted by these other programs.

Q18: Do the FCBC requirements that apply to state Medicaid programs also apply to CHIP programs?

A18: Yes. Under 42 CFR 457.990(a), the Medicaid provider screening and enrollment rules at Part 455, subpart E, including the FCBC requirements discussed in these FAQs, apply to a state CHIP program just as they apply to the state's Medicaid program