STATE OF MAINE
ONE HUNDRED AND THIRTIETH LEGISLATURE
COMMITTEE ON HEALTH AND HUMAN SERVICES

MEMORANDUM

TO: Senator Anne M. Carney, Chair
Representative Thom Harnett, Chair
Joint Standing Committee on Judiciary

FROM: Senator Ned Claxton, Chair NC (ATB)
Representative Michele Meyer, Chair MM (ATB)
Joint Standing Committee on Health and Human Services

DATE: April 5, 2021

SUBJECT: Public Record Exception Review
LD 121, An Act To Require a Background Check for High-Risk Health Care Providers under the MaineCare Program

The Joint Standing Committee on Health and Human Services is requesting the Joint Standing Committee on Judiciary's review, pursuant to 1 MRSA §434, of a confidentiality provision included in LD 121, An Act to Require a Background Check for High-Risk Health Care Providers under the MaineCare Program. This bill was submitted by the Department of Health and Human Services. The bill had a public hearing on March 2 and was voted OTP-A on March 9. The Committee voted unanimously in favor of this bill with a clarifying amendment. The bill and the amendment are attached.

LD 121 requires certain categories of MaineCare providers who are determined "high-risk" to undergo fingerprint-based criminal background checks. The background check must include criminal history record information from the Maine Criminal Justice Information System and the Federal Bureau of Investigation as well as a fingerprint check. The background check information is to be used by the Department of Health and Human Services for screening in the application process and is available to the provider applicant but is otherwise considered confidential in the proposed 22 MRSA §5307, sub-§2, ¶F. It is this paragraph F that triggers your review. The record under this new proposed subsection would be confidential but the bill does not affect any other records that are currently public information in a different setting. The language in paragraph F is as follows:

> F. Information obtained pursuant to this subsection is confidential. The results of background checks received by the department are for official use only and may not be disseminated to any other person or entity.

Federal law and regulations require states to run fingerprint-based criminal background checks for Medicaid providers that are considered "high risk" as defined in federal law. High risk providers are defined as: newly enrolling home health agencies; newly enrolling durable medical equipment providers; newly enrolling Medicare diabetes prevention programs; and newly enrolling opioid treatment programs that have not been fully and continuously certified by the federal Substance Abuse and Mental Health Services Administration since October 23, 2018. In addition to those provider categories that are "high risk", providers may be elevated to the "high risk" category based upon the occurrence of certain events. The "high risk" relates to the risk of fraud, waste and abuse. Maine is not currently compliant with the federal regulations and LD 121 would remedy that.

Reviewing the statutory criteria for the proposed exception to public records, we have the following comment.

A. Need to collect the information. The Department of Health and Human Services would request a fingerprint-based criminal background check for Medicaid provider applicants considered "high risk" as defined in federal regulations and subsequent state rules. "High risk" also includes any provider who would have been "limited" or "moderate" risk except that there was an incident in the previous 10 years that resulted in the exclusion from Medicare by the Office of the Inspector General, billing privileges for Medicare or Medicaid being revoked or terminated, or were subject to any final adverse action as defined in the federal regulations. The regulations specifically require fingerprints and a fingerprint-based criminal history record check on all individuals who maintain a 5% or greater direct or indirect ownership interest in the provider or supplier. It applies to owners and not to staff unless a staff member is (1) also required to be individually enrolled as a MaineCare provider and (2) has been elevated to the "high risk" category.

B. Value in maintaining information. Maintenance of the information by the Department of Health and Human Services under §5307, sub§-2 is essential for compliance with federal law. The proposed bill includes a process for a provider whose enrollment as a MaineCare provider has expired and is not renewing participation, to request removal of the fingerprints from the State Bureau of Identification's fingerprint file.

C. Federal and state law. 42 CFR §455.450 establishes the screening requirements for Medicaid provider applicants, including the criminal background checks and fingerprints for high risk applicants. 42 CFR §424.502 and §424.518 define who is required to be fingerprinted and which providers are categorized as "high risk." LD 121 is drafted using very similar language as 22 MRSA §8302-C. This section requires child care providers to undergo fingerprint-based criminal background checks (also required by the federal government). (These sections are all attached.)

D. Balancing the individual's privacy rights and the public interest. The proposed exception protects the privacy rights of MaineCare provider applicants. Fingerprints provided by the applicant and the criminal background check of state and federal databases is required by federal regulations for the purpose of approving enrollment as a provider in MaineCare. However, there is no purpose to the background check

information being disseminated to other persons or entities. Therefore the bill has been drafted to ensure that the records are used by the department for official use only.

E. Balancing the effect of disclosure on business competition against the public interest. We are unaware of any connection between this information and competitive disadvantages of any business in this State. All providers – which are private businesses – are subject to this background check requirement if they fall under the federal definition of "high risk."

F. Interfering in public negotiations. We are unaware of any connection between this information and negotiations involving a public body.

G. Balancing the public interest and potential jeopardy to public safety or a member of the public. High risk, in this circumstance, applies to the risk of fraud, waste and abuse, not risk to MaineCare members receiving services. We are unaware of any potential jeopardy to public safety or members of the public.

H. Narrowness of the exception. The exception to public access has been drawn to appropriately protect individual and company privacy while permitting the Department of Health and Human Services the ability to comply with the law and have the necessary information to approve the applications of MaineCare providers.

I. Any other criteria that assist the review committee in determining the value of the proposed exception as compared to the public's interest in the record protected by the proposed exception.

Thank you for reviewing this proposed public records exception. If you have any questions, please don't hesitate to contact us.

130th MAINE LEGISLATURE

FIRST REGULAR SESSION-2021

Legislative Document **No. 121**

S.P. 51 In Senate, January 21, 2021

An Act To Require a Background Check for High-risk Health Care Providers under the MaineCare Program

Submitted by the Department of Health and Human Services pursuant to Joint Rule 204. Received by the Secretary of the Senate on January 19, 2021. Referred to the Committee on Health and Human Services pursuant to Joint Rule 308.2 and ordered printed.

DAREK M. GRANT
Secretary of the Senate

Presented by Senator CLAXTON of Androscoggin.

Printed on recycled paper

(5)

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §5307 is enacted to read:

§5307. Background check for high-risk provider applicants under the MaineCare program

1. Definition. As used in this section, unless the context otherwise indicates, "State Police" means the Department of Public Safety, Bureau of State Police.

2. Background check. The department shall request a background check for MaineCare provider applicants who are high-risk providers or in high-risk provider categories as those terms are defined by department rule. The background check must include criminal history record information obtained from the Maine Criminal Justice Information System and the Federal Bureau of Investigation.

A. The criminal history record information obtained from the Maine Criminal Justice Information System must include a record of public criminal history record information as defined in Title 16, section 703, subsection 8.

B. The criminal history record information obtained from the Federal Bureau of Investigation must include other state and national criminal history record information.

C. A provider applicant shall submit to having fingerprints taken. The State Police, upon payment by the provider applicant, shall take or cause to be taken the applicant's fingerprints and shall forward the fingerprints to the State Bureau of Identification so that bureau can conduct state and national criminal history record checks. Except for the portion of the payment, if any, that constitutes the processing fee charged by the Federal Bureau of Investigation, all money received by the State Police for purposes of this paragraph must be paid over to the Treasurer of State. The money must be applied to the expenses of administration incurred by the Department of Public Safety.

D. The subject of a Federal Bureau of Investigation criminal history record check may obtain a copy of the criminal history record check by following the procedures outlined in 28 Code of Federal Regulations, Sections 16.32 and 16.33. The subject of a state criminal history record check may inspect and review the criminal history record information pursuant to Title 16, section 709.

E. State and national criminal history record information of a provider applicant may be used by the department for the purpose of screening that provider applicant.

F. Information obtained pursuant to this subsection is confidential. The results of background checks received by the department are for official use only and may not be disseminated to any other person or entity.

G. An individual whose enrollment as a MaineCare provider has expired and who has not applied for renewal may request in writing that the State Bureau of Identification remove the individual's fingerprints from the bureau's fingerprint file. In response to a written request, the bureau shall remove the individual's fingerprints from the fingerprint file and provide written confirmation of that removal.

3. Rules. The department, following consultation with the State Bureau of Identification, shall adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 2. 25 MRSA §1542-A, sub-§1, ¶V is enacted to read:

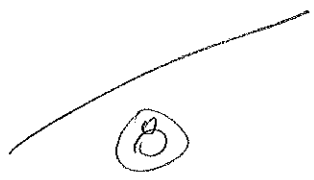
V. Who is required to have a criminal history record check under Title 22, section 5307.

Sec. 3. 25 MRSA §1542-A, sub-§3, ¶U is enacted to read:

U. The State Police shall take or cause to be taken the fingerprints of the person named in subsection 1, paragraph V at the request of that person or the Department of Health and Human Services pursuant to Title 22, section 5307.

SUMMARY

This bill requires MaineCare provider applicants who are high-risk providers or who are in high-risk provider categories to undergo criminal history background checks.



130th Maine Legislature
An Act To Require a Background Check for High-risk Health Care Providers under the MaineCare Program
L.D. 121

Committee: HHS
Drafter: ATB
File Name:
LR (item)#: 007302
New Title?: No
Add Emergency?: No
Date: April 5, 2021

SEE PARAGRAPH E FOR AMENDMENT

Committee Amendment " " to LD 121,An Act To Require a Background Check for High-risk Health Care Providers under the MaineCare Program

Be it enacted by the People of the State of Maine as follows:

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A. The criminal history record information obtained from the Maine Criminal Justice Information System must include a record of public criminal history record information as defined in Title 16, section 703, subsection 8.

B. The criminal history record information obtained from the Federal Bureau of Investigation must include other state and national criminal history record information.

C. A provider applicant shall submit to having fingerprints taken. The State Police, upon payment by the provider applicant, shall take or cause to be taken the applicant's fingerprints and shall forward the fingerprints to the State Bureau of Identification so that bureau can conduct state and national criminal history record checks. Except for the portion of the payment, if any, that constitutes the processing fee charged by the Federal Bureau of Investigation, all money received by the State Police for purposes of this paragraph must be paid over to the Treasurer of State. The money must be applied to the expenses of administration incurred by the Department of Public Safety.

D. The subject of a Federal Bureau of Investigation criminal history record check may obtain a copy of the criminal history record check by following the procedures outlined in 28 Code of Federal Regulations, Sections 16.32 and 16.33. The subject of a state criminal history record check may inspect and review the criminal history record information pursuant to Title 16, section 709.

E. State and national criminal history record information of a provider applicant ~~may be used~~ is to be used by the department for the purpose of screening that provider applicant.

F. Information obtained pursuant to this subsection is confidential. The results of background checks received by the department are for official use only and may not be disseminated to any other person or entity.

G. An individual whose enrollment as a MaineCare provider has expired and who has not applied for renewal may request in writing that the State Bureau of Identification remove the individual's fingerprints from the bureau's fingerprint file. In response to a written request, the bureau shall remove the individual's fingerprints from the fingerprint file and provide written confirmation of that removal.

3. Rules. The department, following consultation with the State Bureau of Identification, shall adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

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V. Who is required to have a criminal history record check under Title 22, section 5307.

Sec. 3. 25 MRSA §1542-A, sub-§3, ¶U is enacted to read:

U. The State Police shall take or cause to be taken the fingerprints of the person named in subsection 1, paragraph V at the request of that person or the Department of Health and Human Services pursuant to Title 22, section 5307.

SUMMARY

This amendment requires the Department of Health and Human Services to use the fingerprint-based background check information in the approval process of MaineCare provider applicants who are high-risk providers.

upon request from CMS or the State Medicaid agency.

§455.436 Federal database checks.

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

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

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

§455.440 National Provider Identifier.

The State 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 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 overpayment, or the provider has been excluded by the

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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.

§ 455.452 Other State screening methods.

Nothing in this subpart must restrict the State 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, States 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:

(1) Individual physicians or nonphysician practitioners.

(2)(i) Providers who are enrolled in either of the following:

(A) Title XVIII of the Act.

(B) Another State's title XIX or XXI plan.

(ii) Providers that have paid the applicable application fee to—

(A) A Medicare contractor; or

(B) 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 State agency must return that portion of the fees to the Federal government.

§ 455.470 Temporary moratoria.

(a)(1) The Secretary consults with any affected State 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.

(2) The State 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.

(3)(i) The State Medicaid agency is not required to impose such a moratorium if the State Medicaid agency determines that imposition of a temporary moratorium would adversely affect beneficiaries' access to medical assistance.

(ii) If a State Medicaid agency makes such a determination, the State Medicaid agency must notify the Secretary in writing.

(b)(1) A State Medicaid agency may impose temporary moratoria on enrollment of new providers, or impose numerical caps or other limits that the State Medicaid agency identifies as having a significant potential for fraud, waste, or abuse and that the Secretary has identified as being at high risk for fraud, waste, or abuse.

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

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

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

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

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

Subpart F—Medicaid Recovery Audit Contractors Program

SOURCE: 76 FR 57843, Sept. 16, 2011, unless otherwise noted.

§ 455.500 Purpose.

This subpart implements section 1902(a)(42)(B) of the Act that establishes the Medicaid Recovery Audit Contractor (RAC) program.

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these enrollment requirements to bill either the Medicare program or its beneficiaries for Medicare covered services or supplies.

§ 424.502 Definitions.

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

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.

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.

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.

Enroll/Enrollment means the process that Medicare uses to establish eligibility to submit claims for Medicare covered services and supplies. The process includes—

(1) Identification of a provider or supplier;

(2) Validation of the provider's 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) Granting the provider or supplier Medicare billing privileges.

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

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, 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.

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.

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.

§ 424.505 Basic enrollment requirement.

To receive payment for covered Medicare items or services from either Medicare (in the case of an assigned claim) or a Medicare beneficiary (in the case of an unassigned claim), a provider or supplier must be enrolled in the Medicare program. Once enrolled, the provider or supplier receives billing privileges and is issued a valid billing number effective for the date a claim was submitted for an item that was

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furnished or a service that was rendered. (See 45 CFR Part 162 for information on the National Provider Identifier and its use as the Medicare billing number.)

§424.510 Requirements for enrolling in the Medicare program.

(a) Providers and suppliers must submit enrollment information on the applicable enrollment application. Once the provider or supplier successfully completes the enrollment process, including, if applicable, a State survey and certification or accreditation process, CMS enrolls the provider or supplier into the Medicare program. To be enrolled, a provider or supplier must meet enrollment requirements specified in paragraph (c) of this section.

(b) The effective dates for reimbursement are specified in §489.13 of this chapter for providers and suppliers requiring State survey or certification or accreditation, §424.5 and §424.44 for non-surveyed or certified/accredited suppliers, and §424.57 and section 1834(j)(1)(A) of the Act for DMEPOS suppliers.

(c) The effective date for reimbursement for providers and suppliers seeking accreditation from a CMS-approved accreditation organization as specified in §489.13(d).

(d) Providers and suppliers must meet the following enrollment requirements:

(1) *Submittal of the enrollment application.* A provider or supplier must submit a complete enrollment application and supporting documentation to the designated Medicare fee-for-service contractor.

(2) *Content of the enrollment application.* Each submitted enrollment application must include the following:

(i) Complete, accurate, and truthful responses to all information requested within each section as applicable to the provider or supplier type.

(ii) Submission of all documentation required by CMS under this or other statutory or regulatory authority, or under the Paperwork Reduction Act of 1995, to uniquely identify the provider or supplier. This documentation may include, but is not limited to, proof of the legal business name, practice location, social security number (SSN), tax identification number (TIN), National Provider Identifier (NPI), if issued, and owners of the business.

(iii) Submission of all documentation, including all applicable Federal and State licensure and regulatory requirements that apply to the specific provider or supplier type that relate to providing health care services, required by CMS under this or other statutory or regulatory authority, or under the Paperwork Reduction Act of 1995, to establish the provider or supplier's eligibility to furnish Medicare covered items or services to beneficiaries in the Medicare program.

(3) *Signature(s) required on the enrollment application.* The certification statement found on the enrollment application must be signed by an individual who has the authority to bind the provider or supplier, both legally and financially, to the requirements set forth in this chapter. This person must also have an ownership or control interest in the provider or supplier, as that term is defined in section 1124(a)(3) of the Act, such as, the general partner, chairman of the board, chief financial officer, chief executive officer, president, or hold a position of similar status and authority within the provider or supplier organization. The signature attests that the information submitted is accurate and that the provider or supplier is aware of, and abides by, all applicable statutes, regulations, and program instructions.

(i) *Requirements.* The signature requirements specified in paragraphs (d)(3)(i)(A) through (C) of this section outline who must sign the enrollment application for an enrolling provider or supplier. In the case of—

(A) An individual practitioner, the applying practitioner.

(B) A sole proprietorship, the applying sole proprietor.

(C) A corporation, partnership, group, limited liability company, or other organization (hereafter referred to collectively in this section as an organization), an authorized official, as defined in §424.502. When an authorized official signs the certification statement on behalf of an organization, the signed statement is considered legally binding upon the organization.

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(2) *Medicare Part B providers.* CMS determines, upon review, that the supplier meets any of the following conditions:

(i) Is unable to furnish Medicare-covered items or services.

(ii) Has failed to satisfy any or all of the Medicare enrollment requirements.

(iii) Has failed to furnish Medicare covered items or services as required by the statute or regulations.

(b) [Reserved]

[73 FR 66940, Nov. 19, 2008]

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

(viii) 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.

(ix) Mammography screening centers.

(x) Mass immunization roster billers

(xi) Organ procurement organizations.

(xii) Pharmacies newly enrolling or revalidating via the CMS–855B application.

(xiii) Radiation therapy centers.

(xiv) Religious non-medical health care institutions.

(xv) Rural health clinics.

(xvi) 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.

(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.

(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:

(15)

(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.

(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.

(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 §424.535(a)(1).

[76 FR 5963, Feb. 2, 2011]

§424.520 Effective date of Medicare billing privileges.

(a) *Surveyed, certified or accredited providers and suppliers.* The effective date for billing privileges for providers and suppliers requiring State survey, certification or accreditation is specified in §489.13 of this chapter. If a provider or supplier is seeking accreditation from a CMS-approved accreditation organization, the effective date is specified in §489.13.

(b) *Independent Diagnostic Testing Facilities.* The effective date for billing privileges for IDTFs is specified in §410.33(i) of this chapter.

(c) *DMEPOS suppliers.* The effective date for billing privileges for DMEPOS suppliers is specified in §424.57(b) of this subpart and section 1834(j)(1)(A) of the Act.

(d) *Physicians, nonphysician practitioners, and physician and nonphysician*

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current law
(used as model)

Title 22: HEALTH AND WELFARE
Subtitle 6: FACILITIES FOR CHILDREN AND ADULTS
Chapter 1673: CHILD CARE FACILITIES

§8302-C. Investigation

A child care provider and any child care staff member subject to a criminal background check pursuant to sections 8302-A and 8302-B must pass a background check conducted in accordance with this section and rules adopted by the department under section 8302-A (../22/title22sec8302-A.html). As used in this section, "child care provider" means a person who provides child care in a child care facility, a family child care provider and a person who provides day care in that person's home for one or 2 children whose care is paid for by state or federal funds. As used in this section, "child care staff member" has the same meaning as described in section 8302-A (../22/title22sec8302-A.html), subsection 1, paragraph J and section 8302-A (../22/title22sec8302-A.html), subsection 2, paragraph K. [PL 2017, c. 457, §9 (NEW).]

1. Investigation. In accordance with the rules adopted by the department, the department shall request a criminal background check for a child care provider and child care staff members of the child care provider. The criminal background check must include criminal history record information obtained from the Maine Criminal Justice Information System and the Federal Bureau of Investigation. The following provisions apply.

A. The criminal history record information obtained from the Maine Criminal Justice Information System must include a record of public criminal history record information as defined in Title 16, section 703 (../16/title16sec703.html), subsection 8. [PL 2017, c. 457, §9 (NEW).]

B. The criminal history record information obtained from the Federal Bureau of Investigation must include other state and national criminal history record information. [PL 2017, c. 457, §9 (NEW).]

C. A person subject to a criminal background check under this section shall submit to having fingerprints taken. The State Police, upon payment of the fee, shall take or cause to be taken the person's fingerprints and shall forward the fingerprints to the State Bureau of Identification so that the bureau can conduct state and national criminal history record checks. Except for the portion of the payment, if any, that constitutes the processing fee charged by the Federal Bureau of Investigation, all money received by the State Police for purposes of this paragraph must be paid over to the Treasurer of State. The money must be applied to the expenses of administration incurred by the Department of Public Safety. [PL 2017, c. 457, §9 (NEW).]

D. The subject of a Federal Bureau of Investigation criminal history record check may obtain a copy of the criminal history record check by following the procedures outlined in 28 Code of Federal Regulations, Sections 16.32 and 16.33. The subject of a state criminal history record check may inspect and review the criminal history record information pursuant to Title 16, section 709 (../16/title16sec709.html). [PL 2017, c. 457, §9 (NEW).]

(17)

E. State and federal criminal history record information may be used by the department for the purpose of screening a child care provider or child care staff member in accordance with this chapter. [PL 2017, c. 457, §9 (NEW).]

F. Information obtained pursuant to this subsection is confidential. The results of criminal background checks received by the department are for official use only and may not be disseminated to any other person or entity. [PL 2017, c. 457, §9 (NEW).]

G. If a person is no longer subject to this chapter that person may request in writing that the State Bureau of Identification remove the person's fingerprints from the bureau's fingerprint file. In response to a written request, the bureau shall remove the person's fingerprints from the fingerprint file and provide written confirmation of that removal. [PL 2017, c. 457, §9 (NEW).]

The department, with the State Bureau of Identification, shall adopt rules to implement this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2017, c. 457, §9 (NEW).]

SECTION HISTORY
PL 2017, c. 457, §9 (NEW).