Appendix A- NM PP- Review of Ownership Disclosure

Code of Federal Regulation Requirements

Issue Date: 5/4/2023		Approval Date: 5/4/2023

PURPOSE/SCOPE:

Appendix A was created to clearly define the Code of Federal Regulations which coincide with the Disclosure of Ownership Policy.

PROCESS/PROCEDURE:

LIBERTY Dental Plan shall ensure that all providers are eligible for participation in the Medicaid program, consistent with provider disclosure, screening, and enrollment requirements. (42 CFR 455.100- 106; 42 CFR 455.400-470)

§ 455.100 Purpose.

This subpart implements sections 1124, 1126, 1902(a)(38), 1903(i)(2), and 1903(n) of the Social Security Act. It sets forth State plan requirements regarding—

(a) Disclosure by providers and fiscal agents of ownership and control information; and

(b) Disclosure of information on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, or the title XX services program.

The subpart also specifies conditions under which the Administrator will deny Federal financial participation for services furnished by providers or fiscal agents who fail to comply with the disclosure requirements.

§ 455.101 Definitions.

Affiliation means, for purposes of applying § 455.107, any of the following:

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

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

(c) 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.

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

(e) Any payment assignment relationship under § 447.10(g) of this chapter.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosable event means, for purposes of § 455.107, any of the following:

(a) 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;

(b) 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;

(c) 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

(d) 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.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

(b) Any Medicare intermediary or carrier; and

(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Health insuring organization (HIO) has the meaning specified in § 438.2.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managed care entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that—

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation
secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

Prepaid ambulatory health plan (PAHP) has the meaning specified in § 438.2.

Prepaid inpatient health plan (PIHP) has the meaning specified in § 438.2.

Primary care case manager (PCCM) has the meaning specified in § 438.2.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means—

(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment,
or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Termination means—

(a) For a—

(i) Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline
for appeal has expired; and

(ii) Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.

(b)

(i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary.

(ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.

(c) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to—

(i) Fraud;

(ii) Integrity; or

(iii) Quality.

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

[44 FR 41644, July 17, 1979, as amended at 51 FR 34788, Sept. 30, 1986; 76 FR 5967, Feb. 2, 2011; 84 FR 47856, Sept. 10, 2019]

§ 455.102 Determination of ownership or control percentages.

(a) ***Indirect ownership interest.*** The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

(b) ***Person with an ownership or control interest.*** In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

§ 455.103 State plan requirement.

A State plan must provide that the requirements of §§ 455.104 through 455.107 are met.

[84 FR 47856, Sept. 10, 2019]

§ 455.106 Disclosure by providers: Information on persons convicted of crimes.

(a) ***Information that must be disclosed.*** Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

(i) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(ii) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

(b) ***Notification to Inspector General.***

(i) The Medicaid agency must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.

(ii) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.

(c) ***Denial or termination of provider participation.***

(i) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.

(ii) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure.

§ 455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.

Who must provide disclosures. The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.

What disclosures must be provided. The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:

(a)

(i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

(ii) Date of birth and Social Security Number (in the case of an individual).

(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

(b) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

(c) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

(d) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

When the disclosures must be provided—

(1) *Disclosures from providers or disclosing entities.* Disclosure from any provider or disclosing entity is due at any of the following times:

(a) Upon the provider or disclosing entity submitting the provider application.

(b) Upon the provider or disclosing entity executing the provider agreement.

(c) Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414.

(d) Within 35 days after any change in ownership of the disclosing entity.

(2) ***Disclosures from fiscal agents.*** Disclosures from fiscal agents are due at any of the following times:

(a) Upon the fiscal agent submitting the proposal in accordance with the State's procurement process.

(b) Upon the fiscal agent executing the contract with the State.

(c) Upon renewal or extension of the contract.

(d) Within 35 days after any change in ownership of the fiscal agent.

(3) ***Disclosures from managed care entities.*** Disclosures from managed care entities (MCOs, PIHPs, PAHPs, and HIOs), except PCCMs are due at any of the following times:

(a) Upon the managed care entity submitting the proposal in accordance with the State's procurement process.

(b) Upon the managed care entity executing the contract with the State.

(c) Upon renewal or extension of the contract.

(d) Within 35 days after any change in ownership of the managed care entity.

(4) ***Disclosures from PCCMs.*** PCCMs will comply with disclosure requirements under paragraph (c)(1) of this section.

To whom must the disclosures be provided. All disclosures must be provided to the Medicaid agency.

Consequences for failure to provide required disclosures. Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

§ 455.105 Disclosure by providers: Information related to business transactions.

(a) ***Provider agreements.*** A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.

(b) ***Information that must be submitted.*** A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about—

(i) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(ii) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

(c) ***Denial of Federal financial participation (FFP).***

(i) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).

(ii) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

§ 455.106 Disclosure by providers: Information on persons convicted of crimes.

(a) ***Information that must be disclosed.*** Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

(i) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(ii) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

(b) ***Notification to Inspector General.***

(i) The Medicaid agency must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.

(ii) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.

(c) ***Denial or termination of provider participation.***

(i) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement
in any program established under Medicare, Medicaid or the title XX Services Program.

(ii) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

§ 455.400 Purpose.

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

(a) Provider screening and enrollment requirements.

(b) Fees associated with provider screening.

(c) Temporary moratoria on enrollment of providers.

§ 455.405 State plan requirements.

A State plan must provide that the requirements of § 455.410 through § 455.450 and § 455.470 are met.

§ 455.410 Enrollment and screening of providers.

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

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

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

(i) Medicare contractors.

(ii) Medicaid agencies or Children's Health Insurance Programs of other States.

(d) The State Medicaid agency must allow enrollment of all Medicare-enrolled providers and suppliers for purposes of processing claims to determine Medicare cost-sharing (as defined in section 1905(p)(3) of the Act) if the providers or suppliers meet all Federal Medicaid enrollment requirements, including, but not limited to, all applicable provisions of 42 CFR part 455, subparts B and E. This paragraph (d)
applies even if the Medicare-enrolled provider or supplier is of a type not recognized by the

State Medicaid Agency.

[76 FR 5968, Feb. 2, 2011, as amended at 86 FR 45521, Aug. 13, 2021]

§ 455.412 Verification of provider licenses.

The State Medicaid agency must—

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

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

§ 455.414 Revalidation of enrollment.

The State Medicaid agency must revalidate the enrollment of all providers regardless of provider type at least every 5 years.

§ 455.416 Termination or denial of enrollment.

The State Medicaid agency—

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

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

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

(d) Must terminate the provider's enrollment or deny enrollment of the provider if the provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information, unless the State Medicaid agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.

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

agency request, unless the State Medicaid agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the State Medicaid agency documents that determination in writing.

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

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

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

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

§ 455.420 Reactivation of provider enrollment.

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

§ 455.422 Appeal rights.

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

§ 455.432 Site visits.

The State Medicaid agency—

(a) Must conduct pre-enrollment and post-enrollment site visits of providers who are designated as “moderate” or “high” categorical risks to the Medicaid program. The purpose of the site visit will be to verify that the information submitted to the State Medicaid agency is accurate and to determine compliance with Federal and State enrollment requirements.

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

§ 455.434 Criminal background checks.

The State Medicaid agency—

(a) As a condition of enrollment, must require providers to consent to criminal background checks including fingerprinting when required to do so under State law or by the level of screening based on
risk of fraud, waste or abuse as determined for that category of provider.

(b) Must establish categorical risk levels for providers and provider categories who pose an increased financial risk of fraud, waste or abuse to the Medicaid program.

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

(ii) The State Medicaid agency must require a provider, or any person with a 5 percent or more direct or indirect ownership interest in the provider, to submit a set of fingerprints, in a form and manner to be determined by the State Medicaid agency, within 30 days 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)

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

(ii) 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.

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:

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

(b) Conduct license verifications, including State licensure verifications in States other than where
the provider is enrolling, in accordance with § 455.412.

(c) 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.

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:

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

(b) Conduct on-site visits in accordance with § 455.432.

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:

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

(b)

(i) Conduct a criminal background check; and

(ii) Require the submission of a set of fingerprints in accordance with § 455.434.

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—

(a) Application denied under § 455.434; or

(b) Enrollment terminated under § 455.416.

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:

(a) 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 OIG or another State's Medicaid program within the previous 10 years.

(b) 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.

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:

(a) Individual physicians or nonphysician practitioners.

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

(i) Title XVIII of the Act.

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

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

(i) A Medicare contractor; or

(ii) Another State.

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)

(i) 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.

(ii) 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.

(iii)

(1) 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.

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

(b)

(i) 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.

(ii) 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.

(iii) 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)

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

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

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

POLICY HISTORY:

Revision/Approval Date	Author	Change Level (Minor, Moderate, Extensive)	Description
05-04-2023	Alex Arguello	New	New appendix for CFR Requirements