

supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for such services.

(5) *Verification 5*: Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under this Section; and any payments made on behalf of the uninsured from payment adjustments under this Section has been separately documented and retained by the State.

(6) *Verification 6*: The information specified in paragraph (d)(5) of this Section includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Act. Included in the description of the methodology, the audit report must specify how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they received.

(e) *Transition Provisions*: To ensure a period for developing and refining reporting and auditing techniques, findings of State reports and audits for Medicaid State Plan years 2005–2010 will not be given weight except to the extent that the findings draw into question the reasonableness of State uncompensated care cost estimates used for calculations of prospective DSH payments for Medicaid State plan year 2011 and thereafter.

Subpart E—Provider Screening and Enrollment

SOURCE: 76 FR 5968, Feb. 2, 2011, unless otherwise noted.

§ 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:

- (1) Medicare contractors.
- (2) 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

§ 455.412

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

42 CFR Ch. IV (10–1–23 Edition)

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—

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

(2) 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.