

Title of Rule: Revision to the Medical Assistance, Health Information Office Rule Concerning Enrollment Procedures, Section 8.013.1
Rule Number: MSB 15-02-18-C
Division / Contact / Phone: Provider Payment / Laurie Stephens / 3038663283

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

Out of state providers attempt to enroll with a limited amount of information due to the existing rule found at 8.013.1. Due to CMS provider screening rules, we must treat out of state providers the same as in state and follow the same enrollment requirements.

2. An emergency rule-making is imperatively necessary

- to comply with state or federal law or federal regulation and/or
 for the preservation of public health, safety and welfare.

Explain:

3. Federal authority for the Rule, if any:

42 CFR § 455 (b) and (e)

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2014);

Initial Review

04/10/2015

Final Adoption

05/08/2015

Proposed Effective Date

07/01/2015

Emergency Adoption

DOCUMENT #07



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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

This rule applies to all Medicaid and CHP+ providers. The ACA Provider Screening Rules issued by CMS applies to Medicaid and CHP+ and is designed to prevent fraud, waste and abuse. Ordering, referring, and prescribing providers will be required to enroll.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

The Department may lose Medicaid and CHP+ providers who do not wish to pay the application fee and revalidate with the Department. Providers are categorized into three risk levels: limited, moderate and high. Some moderate and high risk providers must undergo site surveys, fingerprinting, and background checks. Providers who do not wish to undergo these preliminaries cannot enroll with the Department.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

Enhanced federal funds are available for the Department to implement the Colorado interChange, which will be used to provide an online application for providers.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

By implementing the ACA Provider Screening Rule the Department will be in compliance with federal regulations, otherwise the Department may lose federal match funding. The ACA Provider Screening Rules is designed to prevent fraud, waste and abuse.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

ACA Provider Screening Rule limits the Department's flexibility in implementing the rule. The Department is in the process of seeking authorization from CMS to waive the fee for as many providers as possible.

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6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

ACA Provider Screening Rule limits the Department's flexibility in implementing the rule.

1 **8.013.1 ENROLLMENT PROCEDURES**

2 To receive reimbursement, all out of state providers shall be required to enroll in the Colorado
3 Medicaid Program. Out of state providers are subject to the same enrollment and screening rules,
4 policies and procedures as in state providers, as specified in Section 8.125 Provider Screening.
5 To enroll in the Colorado Medicaid Program, an out of state provider must provide the following to
6 the fiscal agent:

7

8 _____ 1.) _____ Name

9 _____ 2.) _____ Address

10 _____ 3.) _____ Social Security Number or Tax Identification Number

11 _____ 4.) _____ Verification of Licensure

12

13 This information must be on file with the fiscal agent before providers can receive payment. Once
14 approved, out of state providers will receive a Colorado Medicaid provider number. This number
15 is necessary in order for claims to be processed.