

Title of Rule: Revision to the Medical Assistance, Health Information Office Rule Concerning Provider Screening Regulations, Section 8.125  
Rule Number: MSB 15-02-18-B  
Division / Contact / Phone: HIO / Chris Underwood / 3038664766

## 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).

The Department intends to implement the ACA Provider Screening Requirements as issued by CMS. This rule applies to Medicaid and CHP+ providers and is designed to prevent fraud, waste and abuse. Providers are required to revalidate enrollment at least every five years, and all current providers must be revalidated by March 2016. Ordering, referring, and prescribing providers will be required to enroll with the Department. An application fee will be required from some providers. There are three risk categories assigned to providers and based on the risk level, some providers will be required to have site visits, some will require background checks and fingerprint submissions. Licensure verifications, exclusion database checks, and meeting federal and state rules are required for all. Providers, fiscal agents, and managed care organizations will be required to disclose ownership and control interest.

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 42 CFR § 455(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**  
Proposed Effective Date **07/01/2015**

Final Adoption **05/08/2015**  
Emergency Adoption

**DOCUMENT #10**



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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. Many providers are required to pay an application fee. This application fee does not apply to: 1) individual providers, 2) providers who have enrolled or re-validated in Medicare within the last 12 months and paid the application fee, or 3) providers who have enrolled in another state's Medicaid or CHP+ within the last 12 months and paid the application fee. The Department is in the process of seeking authorization from CMS to waive the fee for as many providers as possible.

The ACA Provider Screening Rules issued by CMS applies to Medicaid and CHP+ and is designed to prevent fraud, waste and abuse. Providers are required to revalidate enrollment at least every five years, and all current providers are required to revalidate by March 2016. Ordering, referring, and prescribing providers will be required to enroll. There are three risk categories assigned to providers and based on the risk level, some providers will be required to have site visits, some will require background checks and fingerprint submissions. Licensure verifications, database checks and meeting federal and state rules is required for all. Providers, fiscal agents and managed care organizations will be required to disclose ownership and control interest.

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.

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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.

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 **8.125 PROVIDER SCREENING**

2 **8.125.1 DEFINITIONS.**

3 Managed Care Entity has the same meaning as managed care entity as defined at 42 CFR §  
4 455.101.

5 Ownership interest has the same meaning as defined in 42 CFR § 455.101.

6 Person with an ownership or control interest has the same meaning as defined in 42 CFR §  
7 455.101.

8 Enrollment is defined as the process by which an individual or entity not currently enrolled as a  
9 Colorado Medicaid provider submits a provider application, undergoes any applicable screening,  
10 and pays an application fee, as appropriate for the provider type, and is approved by the  
11 Department for participation in the Medicaid program. Entities that have never previously  
12 enrolled as Medicaid providers or whose enrollment was previously terminated and are not  
13 currently enrolled are required to enroll. The date of enrollment shall be considered the date that  
14 is communicated to the provider in communication from the Department or its fiscal agent  
15 verifying the provider's enrollment in Medicaid.

16 Re-validation is defined as the process by which an individual or entity currently enrolled as a  
17 Colorado Medicaid provider resubmits a provider application, undergoes a state-defined  
18 screening process, and pays an application fee, as appropriate for the provider type, and is  
19 approved by the Department to continue participating in the Medicaid program. The date of  
20 revalidation shall be considered the date that the provider's application was submitted to the  
21 Department's fiscal agent.

22 "Disclosing Entity" and "Other Disclosing Entity" have the same meaning as defined in 42 CFR §  
23 455.101.

24 **8.125.2 PROVIDERS DESIGNATED AS LIMITED CATEGORICAL RISK AND NEW PROVIDER**  
25 **TYPES**

26 8.125.2.A. Except as provided for in b immediately below, provider types not listed under the  
27 definitions of moderate or high categorical risk below shall be considered limited risk.

28 8.125.2.B. Provider types not listed under the definitions of moderate or high categorical risk  
29 below that have been assigned a categorical risk level by CMS shall be assigned the  
30 same categorical risk level by the Department.

31 **8.125.3 PROVIDERS DESIGNATED AS MODERATE CATEGORICAL RISK**

32 8.125.3.A. Emergency Transportation including ambulance service suppliers

33 8.125.3.B. Non-Emergency Medical Transportation

34 8.125.3.C. Community Mental Health Center

35 8.125.3.D. Hospice

36 8.125.3.E. Independent Laboratory

- 1 8.125.3.F. Comprehensive Outpatient Rehabilitation Facility
- 2 8.125.3.G. Physical Therapists, both individuals and group practices
- 3 8.125.3.H. Independent Diagnostic Testing Facility
- 4 8.125.3.I. Portable x-ray suppliers
- 5 8.125.3.J. Re-validating Home Health agencies
- 6 8.125.3.K. Re-validating Durable Medical equipment suppliers, including revalidating  
7 pharmacies that supply Durable Medical Equipment
- 8 8.125.3.L. Re-validating Personal Care providers under the state plan
- 9 8.125.3.M. Providers of the following services for HCBS waiver clients:
  - 10 1. Alternative Care Facility
  - 11 2. Adult Day Services
  - 12 3. Alternative/Integrative Therapies
  - 13 4. Assistive Technology, if the provider is re-validating
  - 14 5. Behavioral Programming
  - 15 6. Behavioral Therapies
  - 16 7. Behavioral Health Services
  - 17 8. Behavioral Services
  - 18 9. Community Connector
  - 19 10. Home Accessible Adaptations
  - 20 11. Initial/Ongoing Treatment Evaluation (for Children with Autism)
  - 21 12. Post-Service Evaluation (for Children with Autism)
  - 22 13. Community Transition Services
  - 23 14. Financial Management Services for Consumer Direct Attendant Support Services  
24 if the provider is re-validating
  - 25 15. Home Modification
  - 26 16. Day Habilitation and Rehabilitation
  - 27 17. Expressive Therapy
  - 28 18. Foster Home

- 1 19. Group Home
- 2 20. Homemaker if the provider is re-validating
- 3 21. Mentorship
- 4 22. Personal Care if the provider is re-validating
- 5 23. Independent Living Skills Training
- 6 24. In-Home Support Services if the provider is re-validating
- 7 25. Peer Mentorship
- 8 26. Non-medical Transportation
- 9 27. Mobility Van
- 10 28. Palliative/Supportive Care Skilled
- 11 29. Wheelchair Van
- 12 30. Pre-vocational Services
- 13 31. Personal Emergency Response System
- 14 32. Professional Services
- 15 33. Respite Care
- 16 34. Residential Habilitation Services
- 17 35. Respite Services
- 18 36. Specialized Medical Equipment and Supplies if the provider is Re-validating
- 19 37. Supported Living Program
- 20 38. Supported Employment
- 21 39. Transitional Living Program
- 22 40. Therapeutic Services

23 **8.125.4 PROVIDERS DESIGNATED AS HIGH CATEGORICAL RISK**

- 24 8.125.4.A. Enrolling DME suppliers
- 25 8.125.4.B. Enrolling Home Health agencies
- 26 8.125.4.C. Enrolling Personal Care providers providing services under the state plan
- 27 8.125.4.D. Enrolling providers of the following services for HCBS waiver clients:

- 1           1.     Assistive Technology
- 2           2.     Financial Management Services for Consumer Direct Attendant Support Services
- 3           3.     Homemaker
- 4           4.     Personal Care
- 5           5.     Specialized Medical Equipment and Supplies
- 6           6.     In-Home Support Services

7   8.125.4.E.     Providers for whom the Department imposes a payment suspension based on  
8                   credible allegation of fraud, waste, or abuse, for the duration of the suspension

9   8.125.4.F.     Providers the Department has identified as having an existing delinquent  
10                  Medicaid overpayment, at the time of revalidation

11 8.125.4.G.     Providers that have previously been excluded by the HHS Office of Inspector  
12                  General or another State's Medicaid program within the previous 10 years

13 8.125.4 .H.     Providers applying for enrollment within six (6) months from the time that the  
14                  Department or CMS lifts a temporary enrollment moratorium on the provider's  
15                  enrollment type

16 **8.125.5 PROVIDERS WITH MULTIPLE RISK LEVELS**

17 8.125.5.A     Providers shall be screened at the highest applicable risk level for which a  
18                  provider meets the criteria. Providers shall only pay one application fee per location.

19 **8.125.6 PROVIDERS WITH MULTIPLE LOCATIONS**

20 8.125.6.A.     Providers must enroll separately each location from which they provide services.  
21                  Only claims for services at locations that are individually enrolled are eligible for  
22                  reimbursement.

23 8.125.6.B.     Each provider site will be screened separately and must pay a separate  
24                  application fee.

25 **8.125.7 ENROLLMENT AND SCREENING OF PROVIDERS**

26 8.125.7.A.     All enrolling and re-validating providers must be screened in accordance with  
27                  requirements appropriate to their categorical risk level.

28 8.125.7.B.     Notwithstanding any other provision of the Colorado Code of Regulations,  
29                  providers who provide services to Medicaid clients as part of a managed care entity's  
30                  provider network who would have to enroll in order to participate in fee-for-service  
31                  Medicaid must enroll with the Department and be screened as Medicaid providers.

32 8.125.7.C.     Nothing in b above shall require a provider who provides services to Medicaid  
33                  clients as part of a managed care entity's provider network to participate in fee-for-service  
34                  Medicaid.

1 8.125.7.D. All physicians or other professionals who order, prescribe, or refer services or  
2 items for Medicaid clients, whether as part of fee-for-service Medicaid or as part of a  
3 managed care entity's provider network under either the state plan, the Children's Health  
4 Insurance Program, or a waiver, must be enrolled in order for claims submitted for those  
5 ordered, referred, or prescribed services or items to be reimbursed or accepted for the  
6 calculation of managed care rates by the Department.

7 8.125.7.E. The department may exempt from screening any providers who have been  
8 screened by and enrolled or revalidated:

9 1. By Medicare within the last 12 months, or

10 2. By another state's Medicaid program within the last 12 months, provided the  
11 Department has determined that the state in which the provider was enrolled or  
12 revalidated has screening requirements at least as comprehensive and stringent  
13 as those for Colorado Medicaid.

#### 14 **8.125.8 NATIONAL PROVIDER IDENTIFIER**

15 8.125.8.A. As a condition of reimbursement, any claim submitted for a service or item that  
16 was ordered, referred, or prescribed for a Medicaid client must contain the National  
17 Provider Identifier (NPI) of the ordering, prescribing or referring physician or other  
18 professional.

#### 19 **8.125.9 VERIFICATION OF PROVIDER LICENSES**

20 8.125.9.A. If the laws of the State of Colorado require an individual to possess some license  
21 in order to lawfully practice his or her profession, then that individual must be so licensed  
22 as a condition of enrollment as a Medicaid provider.

23 8.125.9.B. As a condition of enrollment, any State-required provider licenses must not be  
24 expired and must have no current limitations.

#### 25 **8.125.10 RE-VALIDATION**

26 8.125.10.A. Providers who are enrolled in Medicaid as of July 1, 2015, must re-validate  
27 before March 31, 2016, and at least every five years thereafter. The Department may  
28 terminate the enrollment of any provider who fails to re-validate by March 31, 2016 or  
29 fails to re-validate at least every five years thereafter.

30 8.125.10.B. Providers who enroll in Medicaid after July 1, 2015, must re-validate at least  
31 every five years thereafter. The Department may terminate the enrollment of any  
32 provider who fails to revalidate at least every five years thereafter.

33 8.125.10.C. Payments to a provider who fails to re-validate in accordance with the above  
34 provisions will be suspended.

35 8.125.10.D. If a provider is suspended pursuant to 10.c, and fails to re-validate within thirty  
36 days of the initiation of the suspension, then the Department may terminate the provider's  
37 enrollment.

#### 38 **8.125.11 SITE VISITS**

- 1 8.125.11.A. All providers designated as “moderate” or “high” categorical risks to the Medicaid  
2 program must consent to and pass an on-site inspection before they may be enrolled or  
3 re-validated as Colorado Medicaid providers.
- 4 8.125.11.B. All enrolled providers who are designated as “moderate” or “high” categorical  
5 risks must consent to and pass an additional on-site inspection after enrollment or  
6 revalidation. Post-enrollment or post-revalidation on-site inspection may occur anytime  
7 during the five-year period after enrollment or revalidation.
- 8 8.125.11.C. All providers enrolled in the Colorado Medicaid program must permit CMS, its  
9 agents, its designated contractors, the State Attorney General’s Medicaid Fraud Control  
10 Unit or the Department to conduct unannounced on-site inspections of any and all  
11 provider locations.
- 12 8.125.11.D. All on-site inspections shall verify the following information:
- 13 1. Basic Information including business name, address, phone number, on-site  
14 contact person, National Provider Identification number and Employer  
15 Identification Number, business license, provider type, owner’s name(s), and  
16 owner’s interest in other medical businesses.
  - 17 2. Location including appropriate signage, utilities that are turned on, the presence  
18 of furniture and applicable equipment, and disability access. where applicable  
19 and where clients are served at the business location
  - 20 3. Employees with relevant training designated employees who are trained to  
21 handle Medicaid billing, where applicable, and resources the provider uses to  
22 train employees in Medicaid billing where applicable.
  - 23 4. Appropriate inventory to provide services relevant for specific provider type.
  - 24 5. Other information as designated by the Department.
- 25 8.125.11.E. The Department shall provide the provider with a report detailing the  
26 discrepancies in the information provided and the criteria the provider failed to meet  
27 during the on-site inspection.
- 28 8.125.11.F. Providers that are found in full compliance with the criteria in 11.d shall be  
29 recommended for approval of enrollment or revalidation, subject to the verification of  
30 other enrollment or revalidation requirements.
- 31 8.125.11.G. Providers who meet that vast majority of criteria in 11.d but have small number of  
32 minor discrepancies or insufficiencies shall have 60 days from the date of the issuance of  
33 the report in 11.e to submit documentation to the Department attesting that the provider  
34 has fixed the issues identified during the on-site inspection.
- 35 1. If the provider submits attestation within the 60 day timeframe and has met  
36 requirements, then the provider shall be recommended for enrollment or  
37 revalidation, subject to the verification of other enrollment or revalidation  
38 requirements.
  - 39 2. If the provider fails to submit the attestation in 11.g.i within the 60 day deadline,  
40 the Department may deny the provider’s application for enrollment or  
41 revalidation.

- 1           3.       If the provider submits an attestation within 60 days indicating that the provider is  
2           not fully compliant with criteria in 11.d, then the Department may,
- 3           a.       for existing providers, suspend all payments, until the provider  
4           demonstrates compliance in subsequent on-site inspection, conducted at  
5           the provider's expense
- 6           b.       for new providers, deny the application and require the provider to restart  
7           the enrollment process.
- 8   8.125.11.H.   When on-site inspections discover major discrepancies in the information  
9           provided in the enrollment application or a majority of the criteria described in 11.d are  
10          not met, the Department shall allow the provider to be re-inspected.
- 11          1.       Additional inspections shall be conducted at the provider's expense.
- 12          2.       The provider shall have 14 days from the date of the issuance of the report listed  
13          in 11.e above to request an additional on-site inspection.
- 14          3.       The Department shall deny or terminate enrollment or revalidation of any  
15          provider subject to 11.g who does not request an additional on-site inspection  
16          within 14 days.
- 17          4.       If a provider is determined to not in be in full compliance upon the additional on-  
18          site inspection:
- 19           a.       for an existing provider, the Department shall immediately suspend all  
20           payments until a subsequent site visit demonstrates provider is in  
21           compliance.
- 22           b.       for new provider, deny the application and require the provider to restart  
23           the enrollment process.
- 24   8.125.11.I.   The Department shall deny or terminate enrollment or revalidation of any  
25           provider who refuses to allow an on-site inspection, unless the Department determines  
26           the provider or the provider's staff refused the on-site inspection in error. The provider  
27           must provide credible evidence to the Department that it refused the on-site inspection in  
28           error within in 7 days of the date of the issuance of the report in 11.e. Any provider who  
29           does not provide credible evidence to the Department that it refused the on-site  
30           inspection in error shall be denied or terminated from enrollment or revalidation.
- 31   8.125.11.J.   The Department shall deny an application or terminate a provider's enrollment  
32           when an on-site inspection provides credible evidence that the provider has committed  
33           Medicaid fraud.
- 34   8.125.11.K.   The Department shall refer providers in 11.j to the State Attorney General.
- 35   **8.125.12 CRIMINAL BACKGROUND CHECKS AND FINGERPRINTING.**
- 36   8.125.12.A.   As a condition of provider enrollment, any person with an ownership or control  
37           interest in a provider designated as "high" categorical risk to the Medicaid program, must consent  
38           to criminal background checks and submit a set of fingerprints, in a form and manner to be  
39           determined by the Department.

1 8.125.12.B. Any provider, and any person with an ownership or control interest in the  
2 provider, must consent to criminal background checks and submit a set of fingerprints, in a form  
3 and manner designated by the Department, within 30 days upon request from CMS, the  
4 Department, the Department's agents, or the Department's designated contractors.

#### 5 **8.125.13 APPLICATION FEE**

6 8.125.13.A. Except when exempted in c and d below, enrolling and re-validating providers  
7 must submit an application fee or a formal request for a hardship exemption with their  
8 application.

9 8.125.13.B. The amount of the application fee is determined by Section 6401 of the  
10 Affordable Care Act (42 USC § 1395cc(j)(2)(C)) and applicable regulations and notices  
11 promulgated by CMS (42 CFR § 424.514(d)).

12 8.125.13.C. Application fees shall apply to all providers except:

- 13 1. Individual practitioners
- 14 2. Providers who have enrolled or re-validated in Medicare and paid an application  
15 fee within the last 12 months
- 16 3. Providers who have enrolled or re-validated in another State's Medicaid or  
17 Children's Health Insurance program and paid an application fee within the last  
18 12 months provided that the department has determined that the screening  
19 procedures in the state in which the provider is enrolled are at least as  
20 comprehensive and stringent as the screening procedures required for  
21 enrollment in Colorado Medicaid.

22 8.125.13.D. The Department may exempt a provider, or group of providers, from paying the  
23 applicable application fee, through a hardship exemption request or categorical fee  
24 waiver, if:

- 25 1. The Department determines that requiring a provider to pay an application fee  
26 would negatively impact access to care for Medicaid clients, and
- 27 2. The Department receives approval from the Centers for Medicare and Medicaid  
28 Services to waive the application fee.

29 8.125.13.E. A provider may not be enrolled or revalidated in Colorado Medicaid unless the  
30 provider has paid any applicable application fee or had their hardship exemption request  
31 approved by the Department and CMS.

32 8.125.13.F. The application is non-refundable, except if submitted with one of the following:

- 33 1. A request for hardship exemption, under 13.d, that is subsequently approved
- 34 2. An application that is rejected prior to initiation of screening processes
- 35 3. An application that is subsequently denied as a result of the imposition of a  
36 temporary moratorium under 14 below.

#### 37 **8.125.14 TEMPORARY MORATORIA**

1 8.12514.A. In consultation with CMS and HHS, the Department may impose temporary  
2 moratoria on the enrollment of new providers or provider types, or impose numerical caps  
3 or other limits on providers that the Department and the Secretary of HHS identify as  
4 being a significant potential risk for fraud, waste, or abuse, unless the Department  
5 determines that such an action would adversely impact Medicaid client's access to  
6 medical assistance.

7 8.125.14.B. Before imposing any moratoria, caps, or other limits on provider enrollment, the  
8 Department shall notify the Secretary of HHS in writing and include all details of the  
9 moratoria.

10 8.125.14.C. The Department shall obtain the Secretary of HHS's concurrence with imposition  
11 of the moratoria, caps, or other limits on provider enrollment, before such limits shall take  
12 effect.

13 **8.125.15 DISCLOSURES BY MEDICAID PROVIDERS, MANAGED CARE ENTITIES, AND**  
14 **FISCAL AGENTS: INFORMATION ON OWNERSHIP AND CONTROL**

15 8.125.15.A. All Medicaid providers, fiscal agents, and managed care entities must provide the  
16 following federally required disclosures to the Department:

- 17 1. The name and address of any entity (individual or corporation) with an ownership  
18 or control interest in the disclosing entity, fiscal agent, or managed care entity  
19 having direct or indirect ownership of 5 percent or more. The address for  
20 corporate entities must include, as applicable, primary business address, every  
21 business location, and P.O. Box address.
- 22 2. For individuals: Date of birth and Social Security number
- 23 3. For business entities: Other tax identification number for any entity with an  
24 ownership or control interest in the disclosing entity (or fiscal agent or managed  
25 care entity) or in any subcontractor in which the disclosing entity (or fiscal agent  
26 or managed care entity) has a 5 percent or more interest.
- 27 4. Whether the entity (individual or corporation) with an ownership or control interest  
28 in the disclosing entity (or fiscal agent or managed care entity) is related to  
29 another person with ownership or control interest in the disclosing entity as a  
30 spouse, parent, child, or sibling; or whether the entity (individual or corporation)  
31 with an ownership or control interest in any subcontractor in which the disclosing  
32 entity (or fiscal agent or managed care entity) has a 5 percent or more interest is  
33 related to another person with ownership or control interest in the disclosing  
34 entity as a spouse, parent, child, or sibling.
- 35 5. The name of any other disclosing entity (or fiscal agent or managed care entity)  
36 in which an owner of the disclosing entity (or fiscal agent or managed care entity)  
37 has an ownership or control interest.
- 38 6. The name, address, date of birth, and Social Security Number of any managing  
39 employee of the disclosing entity (or fiscal agent or managed care entity).
- 40 7. The identity of any person who has an ownership or control interest in the  
41 provider, or is an agent or managing employee of the provider who has been  
42 convicted of a criminal offense related to that person's involvement in any

- 1 program under Medicare, Medicaid, Children's Health Insurance Program or the  
2 Title XX services since the inception of these programs.
- 3 8. Full and complete information about the ownership of any subcontractor with  
4 whom the provider has had business transactions totaling more than \$25,000  
5 during the 12 month period ending on the date of the request; and any significant  
6 business transactions between the provider and any wholly owned supplier, or  
7 between the provider and any subcontractor, during the 5-year period ending on  
8 the date of the request.
- 9 8.125.15.B. Disclosures from any provider or disclosing entity are due at any of the following  
10 times:
- 11 1. Upon the provider or disclosing entity submitting the provider application.  
12 2. Upon the provider or disclosing entity executing the provider agreement.  
13 3. Upon request of the Department during re-validation.  
14 4. Within 35 days after any change in ownership of the disclosing entity.
- 15 8.125.15.C. Disclosures from fiscal agents are due at any of the following times:
- 16 1. Upon the fiscal agent submitting its proposal in accordance with the State's  
17 procurement process.  
18 2. Upon the fiscal agent executing a contract with the State.  
19 3. Upon renewal or extension of the contract.  
20 4. Within 35 days after any change in ownership of the fiscal agent.
- 21 8.125.15.D. Disclosures from managed care entities are due at any of the following times:
- 22 1. Upon the managed care entity submitting its proposal in accordance with the  
23 State's procurement process.  
24 2. Upon the managed care entity executing a contract with the State.  
25 3. Upon renewal or extension of the contract.  
26 4. Within 35 days after any change in ownership of the managed care entity.
- 27 8.125.15.E. The Department will not reimburse any claim from any provider or entity that fails  
28 to disclose ownership or control information as required by this section. Any payment to  
29 a provider or entity that fails to report disclosures required in this section within the  
30 applicable time periods shall be considered an overpayment.
- 31 8.125.15.F. The Department may terminate or deny enrollment of any provider any provider  
32 or entity that fails to disclose ownership or control information as required by this section.