

## Instructions to Stakeholders

The Department is seeking feedback from providers and other stakeholders on the draft rule below. The draft rule implements the new federal provider screening regulations that were promulgated in the Federal Register (76 FR 5862). Additionally, the draft rule follows guidance published by the Centers for Medicare and Medicaid Services which further explains how states should implement these federal regulations (See [CMS/CMCS Information Bulletin](#) from December 23, 2011 with the subject “Medicaid/CHIP Provider Screening and Enrollment”).

The Department has limited flexibility in implementing new federal regulations, but the Department is seeking feedback in a few key areas where the federal government has granted some flexibility. The Department requests that stakeholders focus their feedback regarding this rule to the questions below.

- 1.) The federal regulations allow the Department to require additional screening of certain providers that is above and beyond the federal requirements (42 CFR § 455.452). Should some providers be subject to screening procedures beyond federal requirements? Which providers and what additional screening should be required?
- 2.) Federal rules require the Department to assign risk categories to Medicaid-only provider types. The draft rule below proposes risk categories for these providers based on CMS guidance and the risk of waste, fraud and abuse unique to each provider type. Following CMS’ guidance (see the Federal Register at 76 FR 5867, 5895-5896), to what screening levels should each Medicaid-only provider type be assigned?
- 3.) The draft rule does not yet include specific details regarding site visits for moderate and high risk providers. Following CMS’ guidance (see the Federal Register at 76 FR 5869, 5899) and experience from other states, what should pre- and post-enrollment site visits in Colorado consist of? Should requirements differ based on provider type? If so, what should provider-type specific requirements include and for which providers?
- 4.) Within the confines of the federal regulations and guidance, are there ways HCPF can reduce any potential issues providers may encounter with these new rules?

Please submit formal comments and questions about this rule to [providerscreeningcomments@state.co.us](mailto:providerscreeningcomments@state.co.us).

## Provider Screening Draft Rule

### 1. Definitions.

- a. Managed Care Organization has the same meaning as managed care entity as defined at 42 CFR § 455.101.
- b. Ownership information has the same meaning as defined in 42 CFR § 455.101.
- c. Enrollment is defined as the process by which an individual or entity not currently enrolled as a Colorado Medicaid provider submits a provider application, undergoes any applicable screening, and pays an application fee, as appropriate

for the provider type. Entities that have never previously enrolled as Medicaid providers or whose enrollment was previously terminated and are not currently enrolled are required to enroll.

- d. Re-validation is defined as the process by which an individual or entity currently enrolled as a Colorado Medicaid provider resubmits a provider application, undergoes a state-defined screening process, and pays an application fee, as appropriate for the provider type.

## **2. Providers designated as limited categorical risk and new provider types**

- a. Except as provided for in (b) immediately below, provider types not listed under the definitions of moderate or high categorical risk below shall be considered limited risk.
- b. Provider types not listed under the definitions of moderate or high categorical risk below that have been assigned a categorical risk level by CMS shall be assigned the same categorical risk level by the Department.

## **3. Providers designated as moderate categorical risk**

- a. Emergency Transportation including ambulance service suppliers
- b. Non-Emergency Medical Transportation
- c. Community Mental Health Center
- d. Hospice
- e. Independent Laboratory
- f. Rehabilitation Agency – Comprehensive Outpatient Rehabilitation Facility
- g. Physical Therapists, both individuals and group practices
- h. Independent Diagnostic Testing Facility
- i. Portable x-ray suppliers
- j. Re-validating Home Health agencies
- k. Re-validating Durable Medical equipment suppliers, including revalidating pharmacies that supply Durable Medical Equipment
- l. Re-validating Personal Care providers under the state plan
- m. Providers of the following services for HCBS waiver clients:
  - i. Alternative Care Facility
  - ii. Adult Day Services
  - iii. Alternative/Integrative Therapies
  - iv. Assistive Technology, if the provider is re-validating
  - v. Behavioral Programming
  - vi. Behavioral Therapies
  - vii. Behavioral Health Services
  - viii. Behavioral Services
  - ix. Community Connector
  - x. Home Accessible Adaptations
  - xi. Initial/Ongoing Treatment Evaluation (for Children with Autism)
  - xii. Post-Service Evaluation (for Children with Autism)
  - xiii. Community Transition Services

- xiv. Financial Management Services for Consumer Direct Attendant Support Services if the provider is re-validating
- xv. Home Modification
- xvi. Day Habilitation and Rehabilitation
- xvii. Expressive Therapy
- xviii. Foster Home
- xix. Group Home
- xx. Homemaker if the provider is re-validating
- xxi. Mentorship
- xxii. Personal Care if the provider is re-validating
- xxiii. Independent Living Skills Training
- xxiv. In-Home Support Services if the provider is re-validating
- xxv. Peer Mentorship
- xxvi. Non-medical Transportation
- xxvii. Mobility Van
- xxviii. Palliative/Supportive Care Skilled
- xxix. Wheelchair Van
- xxx. Pre-vocational Services
- xxxi. Personal Emergency Response System
- xxxii. Professional Services
- xxxiii. Respite Care
- xxxiv. Residential Habilitation Services
- xxxv. Respite Services
- xxxvi. Specialized Medical Equipment and Supplies if the provider is Re-validating
- xxxvii. Supported Living Program
- xxxviii. Supported Employment
- xxxix. Transitional Living Program
- xl. Therapeutic Services

**4. Providers designated as high categorical risk**

- a. Enrolling DME suppliers
- b. Enrolling Home Health agencies
- c. Enrolling Personal Care providers providing services under the state plan
- d. Enrolling providers of the following services for HCBS waiver clients:
  - i. Assistive Technology
  - ii. Financial Management Services for Consumer Direct Attendant Support Services
  - iii. Homemaker
  - iv. Personal Care
  - v. Specialized Medical Equipment and Supplies
  - vi. In-Home Support Services
- e. Providers for whom the Department has imposed a payment suspension based on credible allegation of fraud, waste, or abuse
- f. Providers that have an existing Medicaid overpayment

- g. Providers that have previously been excluded by the HHS Office of Inspector General or another State's Medicaid program within the previous 10 years
  - h. Providers applying for enrollment within six (6) months from the time that the Department or CMS lifts a temporary enrollment moratorium on the provider's enrollment type.
5. **Providers with multiple risk levels** - For the purposes of screening, the highest applicable risk level for which a provider meets the criteria will be applied.
6. **Providers with multiple locations**
- a. Providers must enroll at each location at which they provide services separately. Only claims for services at locations that are individually enrolled are eligible for reimbursement.
  - b. Each provider site will be screened separately and must pay a separate application fee.
7. **Enrollment and screening of providers**
- a. All enrolling and re-validating providers must be screened in accordance with requirements appropriate to their categorical risk level.
  - b. Notwithstanding any other provision of the Colorado Code of Regulations, providers who provide services to Medicaid clients as part of a managed care organization's provider network who would have to enroll in order to participate in fee-for-service Medicaid must enroll with the Department and be screened as Medicaid providers.
  - c. Nothing in (b) above shall require a provider who provides services to Medicaid clients as part of a managed care organization's provider network to participate in fee-for-service Medicaid.
  - d. All physicians or other professionals who order, refer, or prescribe services or items for Medicaid clients, whether as part of fee-for-service Medicaid or as part of a managed care organization's provider network under either the state plan or a waiver, must be enrolled in order for claims submitted for those ordered, referred, or prescribed services or items to be reimbursed or accepted for the calculation of managed care rates by the Department.
  - e. The department may exempt from screening any providers who have been screened by and enrolled or revalidated:
    - i. By Medicare within the last 12 months, or
    - ii. By another state's Medicaid program within the last 12 months, provided the Department has determined that the state in which the provider was enrolled or revalidated has screening requirements as comprehensive and stringent as those for Colorado Medicaid.
8. **National Provider Identifier** - As a condition of reimbursement, any claim submitted for a service or item that was ordered, referred, or prescribed for a Medicaid client must contain the National Provider Identifier (NPI) of the ordering, referring or prescribing physician or other professional.

**9. Verification of provider licenses**

- a. A provider must be licensed in accordance with the laws of the State of Colorado in order to be enrolled as a Medicaid Provider.
- b. As a condition of enrollment, any State-required provider licenses must not be expired and must have no current limitations.

**10. Re-validation**

- a. Providers who are enrolled in Medicaid as of July 1, 2015, must re-validate before March 31, 2016, and at least every five years thereafter.
- b. Providers who enroll in Medicaid after July 1, 2015, must re-validate at least every five years thereafter.
- c. Payments to a provider who fails to re-validate in accordance with the above provisions will be suspended until the provider re-validates.
- d. Providers who fail to re-validate in accordance with the above provisions may be terminated from Medicaid participation.

**11. Site visits**

- a. All providers designated as “moderate” or “high” categorical risks to the Medicaid program must consent to and pass an on-site inspection before they may be enrolled or re-validated as Colorado Medicaid providers.
- b. All enrolled providers who are designated as “moderate” or “high” categorical risks must consent to and pass a post-enrollment or post-re-validation on-site inspection. Site visits will occur anytime during the five-year period after enrollment or revalidation.
- c. All providers enrolled in the Colorado Medicaid program must permit CMS, its agents, its designated contractors, the State Attorney General’s Medicaid Fraud Control Unit or the Department to conduct unannounced on-site inspections of any and all provider locations.

**12. Criminal background checks and fingerprinting.**

- a. For providers who are designated as “high” categorical risk to the Medicaid program, a provider, and any person with a 5 percent or more direct or indirect ownership interest in the provider, must consent to criminal background checks and submit a set of fingerprints, in a form and manner to be determined by the Department.
- b. Any provider, and any person with a 5 percent or more direct or indirect ownership interest in the provider, must consent to criminal background checks and submit a set of fingerprints, in a form and manner designated by the Department, within 30 days upon request from CMS, the Department, the Department’s agents, or the Department’s designated contractors.

**13. Application fee**

- a. Enrolling and re-validating providers must submit an application fee or a formal request for a hardship exemption with their application. Application fees shall apply to all providers except:
  - i. Individual practitioners

- ii. Providers who have enrolled or re-validated in Medicare within the last 12 months
  - iii. Providers who have enrolled or re-validated in another State's Medicaid or Children's Health Insurance program within the last 12 months provided that the department has determined that the screening procedures in the state in which the provider is enrolled are as comprehensive and stringent as the screening procedures required for enrollment in Colorado Medicaid.
- b. The Department may exempt a provider from paying the applicable application fee, through a hardship exemption request or categorical fee waiver, if:
  - i. The Department determines that requiring a provider to pay an application fee would negatively impact access to care for Medicaid clients, and
  - ii. The Department receives approval from the Centers for Medicare and Medicaid Services to waive the application fee.
- c. A provider may not be enrolled or revalidated in Colorado Medicaid unless the provider has paid any applicable application fee or had their hardship exemption request approved by the Department and CMS.

#### **14. Temporary moratoria**

- a. In consultation with CMS and HHS, the Department may impose temporary moratoria on the enrollment of new providers or provider types, or impose numerical caps or other limits on providers that the Department and the Secretary of HHS identify as being a significant potential risk for fraud, waste, or abuse, unless the Department determines that such an action would adversely impact Medicaid client's access to medical assistance.
- b. Before imposing any moratoria, caps, or other limits on provider enrollment, the Department shall notify the Secretary of HHS in writing and include all details of the moratoria.
- c. The Department shall obtain the Secretary of HHS's concurrence with imposition of the moratoria, caps, or other limits on provider enrollment, before such limits shall take effect.

#### **15. Disclosures by Medicaid providers and fiscal agents: information on ownership and control**

- a. All Medicaid providers, fiscal agents, and managed care entities must provide the following federally required disclosures to the Department:
  - i. The name and address of any entity (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity having direct or indirect ownership of 5 percent or more. The address for corporate entities must include, as applicable, primary business address, every business location, and P.O. Box address.
  - ii. For individuals: Date of birth and Social Security number
  - iii. For business entities: Other tax identification number for any entity 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.

- iv. Whether the entity (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 entity (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.
  - v. 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.
  - vi. 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).
  - vii. The identity of any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Children's Health Insurance Program or the Title XX services since the inception of these programs.
  - viii. Full and complete information about 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 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.
- b. Disclosures from any provider or disclosing entity are due at any of the following times:
- i. Upon the provider or disclosing entity submitting the provider application.
  - ii. Upon the provider or disclosing entity executing the provider agreement.
  - iii. Upon request of the Department during re-validation.
  - iv. Within 35 days after any change in ownership of the disclosing entity.
- c. Disclosures from fiscal agents are due at any of the following times:
- i. Upon the fiscal agent submitting its proposal in accordance with the State's procurement process
  - ii. Upon the fiscal agent executing a contract with the State.
  - iii. Upon renewal or extension of the contract.
  - iv. Within 35 days after any change in ownership of the fiscal agent.
- d. Disclosures from managed care organizations are due at any of the following times:
- i. Upon the managed care organization submitting its proposal in accordance with the State's procurement process.
  - ii. Upon the managed care organization executing a contract with the State.
  - iii. Upon renewal or extension of the contract.
  - iv. Within 35 days after any change in ownership of the managed care entity.

- e. The Department will not reimburse any claim from an entity that fails to disclose ownership or control information as required by this section.