

Provider Screening Draft Rule

1. Definitions.

- a. Managed Care Entity has the same meaning as managed care entity as defined at 42 CFR § 455.101.
- b. Ownership interest has the same meaning as defined in 42 CFR § 455.101.
- c. Person with an ownership or control interest has the same meaning as defined in 42 CFR § 455.101.
- d. 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, and is approved by the Department for participation in the Medicaid program. Entities that have never previously enrolled as Medicaid providers or whose enrollment was previously terminated and are not currently enrolled are required to enroll. The date of enrollment shall be considered the date that is communicated to the provider in communication from the Department or its fiscal agent verifying the provider's enrollment in Medicaid.
- e. 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, and is approved by the Department to continue participating in the Medicaid program. The date of revalidation shall be considered the date that the provider's application was submitted to the Department's fiscal agent.
- f. "Disclosing Entity" and "Other Disclosing Entity" have the same meaning as defined in 42 CFR § 455.101.

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. 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

Commented [BK1]: New enrollment type needed?

- 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 imposes a payment suspension based on credible allegation of fraud, waste, or abuse, for the duration of the suspension
- f. Providers the Department has identified as having an existing delinquent Medicaid overpayment, at the time of revalidation.
- 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** – Providers shall be screened at the highest applicable risk level for which a provider meets the criteria. Providers shall only pay one application fee per location.

6. Providers with multiple locations

- a. Providers must enroll separately each location from which they provide services. 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 entity'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 entity's provider network to participate in fee-for-service Medicaid.
 - d. All physicians or other professionals who order, prescribe, or refer services or items for Medicaid clients, whether as part of fee-for-service Medicaid or as part of a managed care entity's provider network under either the state plan, the CHP+ program, 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, prescribing or referring physician or other professional.
9. **Verification of provider licenses**
- a. If the laws of the State of Colorado require an individual to possess some license in order to lawfully practice his or her profession, then that individual must be so licensed as a condition of enrollment 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.
 - d. If a provider is suspended pursuant to 10.c, and fails to re-validate within thirty days of the initiation of the suspension, then the Department may terminate the provider's enrollment.
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 an additional on-site inspection after enrollment or

revalidation. Post-enrollment or post-revalidation on-site inspection may 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.
- d. All on-site inspections shall verify the following information:
 - i. Basic Information including business name, address, phone number, on-site contact person, National Provider Identification number and Employer Identification Number, business license, provider type, owner's name(s), and owner's interest in other medical businesses.
 - ii. Location including appropriate signage, utilities that are turned on, the presence of furniture and applicable equipment, and disability access where applicable and where clients are served at the business location
 - iii. Employees with relevant training designated employees who are trained to handle Medicaid billing, where applicable, and resources the provider uses to train employees in Medicaid billing where applicable.
 - iv. Appropriate inventory to provide services relevant for specific provider type.
 - v. Other information as designated by the Department.
- e. The Department shall provide the provider with a report detailing the discrepancies in the information provided and the criteria the provider failed to meet during the on-site inspection.
- f. Providers that are found in full compliance with the criteria in 11.d shall be recommended for approval of enrollment or revalidation, subject to the verification of other enrollment or revalidation requirements.
- g. Providers who meet that vast majority of criteria in 11.d but have small number of minor discrepancies or insufficiencies shall have 60 days from the date of the issuance of the report in 11.e to submit documentation to Department attesting that the provider has fixed the issues identified during the on-site inspection.
 - i. If the provider submits attestation within the 60 day timeframe and has met requirements, then the provider shall be recommended for enrollment, subject to the verification of other enrollment or revalidation requirements.
 - ii. If the provider fails to submit the attestation in 11.g.i within the 60 day deadline, the Department may deny the provider's application for enrollment or revalidation.
 - iii. If the provider submits an attestation within 60 days indicating that the provider is not fully compliant with criteria in 11.d, then the Department may,
 - 1. for existing providers, suspend all payments, until the provider demonstrates compliance in subsequent on-site inspection, conducted at the provider's expense
 - 2. For new providers, deny the application and require the provider to restart the enrollment process..

- h. When on-site inspections discover major discrepancies in the information provided in the enrollment application or a majority of the criteria described in 11.d are not met, the Department shall allow the provider to be re-inspected.
 - i. Additional inspections shall be conducted at the provider's expense.
 - ii. The provider shall have 14 days from the date of the issuance of the report listed in 11.e above to request an additional on-site inspection.
 - iii. The Department shall deny or terminate enrollment or revalidation of any provider subject to 11.g who does not request an additional on-site inspection within 14 days.
 - iv. If a provider is determined to not in be in full compliance upon the additional on-site inspection:
 - 1. for an existing provider, the Department shall immediately suspend all payments until a subsequent site visit demonstrates provider is in compliance.
 - 2. for new provider, deny the application and require the provider to restart the enrollment process..
- i. The Department shall deny or terminate enrollment or revalidation of any provider who refuses to allow an on-site inspection, unless the Department determines the provider or the provider's staff refused the on-site inspection in error. The provider must provide credible evidence to the Department that it refused the on-site inspection in error within in 7 days of the date of the issuance of the report in 11.e. Any provider must who does not provide credible evidence to the Department that it refused the on-site inspection in error shall be denied or terminated from enrollment or revalidation.
- j. The Department shall deny an application or terminate a provider's enrollment when an on-site inspection provides credible evidence that the provider has committed Medicaid fraud.
- k. The Department shall refer providers in 11.j to the State Attorney General.

12. Criminal background checks and fingerprinting.

- a. As a condition of provider enrollment, any person with an ownership or control interest in a provider designated as "high" categorical risk to the Medicaid program, 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 an ownership or control 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. Except when exempted in c and d below, enrolling and re-validating providers must submit an application fee or a formal request for a hardship exemption with their application.

- b. The amount of the application fee is determined by Section 6401 of the Affordable Care Act (42 USC 1395cc(j)(2)(C)) and applicable regulations promulgated annually by CMS.
- c. 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 at least as comprehensive and stringent as the screening procedures required for enrollment in Colorado Medicaid.
- d. The Department may exempt a provider, or group of providers, 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.
- e. 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.
- f. The application is non-refundable, except if submitted with one of the following:
 - i. A request for hardship exemption, under 13.d, that is subsequently approved
 - ii. An application that is rejected prior to initiation of screening processes
 - iii. An application that is subsequently denied as a result of the imposition of a temporary moratorium under 14 below.

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, managed care entities, 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 entities are due at any of the following times:
 - i. Upon the managed care entity submitting its proposal in accordance with the State's procurement process.
 - ii. Upon the managed care entity 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 any provider or entity that fails to disclose ownership or control information as required by this section. Any payment to a provider or entity that fails to report disclosures required in this section within the applicable time periods shall be considered an overpayment.
 - f. The Department may terminate or deny enrollment of any provider any provider or entity that fails to disclose ownership or control information as required by this section.

8.013.1 ENROLLMENT PROCEDURES

To receive reimbursement, all out of state providers shall be required to enroll in the Colorado Medicaid Program. Out of state providers are subject to the same enrollment and screening rules, policies and procedures as in state providers. ~~To enroll in the Colorado Medicaid Program, an out of state provider must provide the following to the fiscal agent:~~

- ~~1) Name~~
- ~~2) Address~~
- ~~3) Social Security Number or Tax Identification Number~~
- ~~4) Verification of Licensure~~

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