



PROVIDER SCREENING – NEW FEDERAL REGULATIONS

What are the new federal provider screening regulations?

New federal regulations established by the Centers for Medicare and Medicaid Services (CMS) require enhanced screening and re-validation of providers enrolling with Colorado Medicaid. These regulations are designed to reduce the potential for Medicaid fraud, waste, and abuse. The final federal regulations were published in the [federal register](#) in February 2012. The Department of Health Care Policy and Financing (Department) plans to begin to fully implement these new federal regulations in the summer of 2015.

Who is affected?

All newly enrolling, re-enrolling, and re-validating providers must be screened in order to participate in Colorado Medicaid. Following the Department's implementation of the new federal provider screening rules, most providers will see very little change in their enrollment process. Some providers may be required to undergo additional screening before they can be enrolled or re-enrolled in Medicaid. Providers that remain enrolled in Medicaid must be re-validated (i.e., re-screened) at least every five years.

How will the new screening work?

CMS has divided provider types into three categories based on risk of fraud, waste, and abuse (limited, moderate, and high). Providers that have already been assigned a Medicare risk level by CMS must be assigned the same risk level by Colorado Medicaid.

Risk levels for Medicaid-only provider types (e.g., Home and Community Based Services providers) will be determined by the Department and informed through a provider and stakeholder consultation process. More information on the consultation process will be made available in October.

Providers are screened for Medicaid enrollment based on the risk category of their provider type. The screening process for each risk category is as follows:

- Limited: federal and state provider requirements, license verifications, and federal exclusion database checks.
- Moderate: Screening for limited risk providers plus on-site inspections.



- High: Screening for moderate risk providers plus background checks and fingerprinting for owners.

Which providers are considered by CMS as limited risk?

- Physicians and non-physician practitioners (e.g., dentists, optometrists, advanced practice nurses, physician's assistants)
- Hospitals, federally qualified health centers, rural health clinics, skilled nursing facilities, ambulatory surgery centers
- Pharmacies that do not supply durable medical equipment

Which providers are considered by CMS as moderate risk?

- Ambulance Service providers
- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Hospice organizations
- Independent clinical labs
- Physical therapists (individuals and groups)
- Portable x-ray suppliers
- Currently enrolled (re-validating) home health agencies
- Currently enrolled (re-validating) durable medical equipment suppliers

Which providers are considered by CMS as high risk?

- Prospective (newly enrolling) home health agencies
- Prospective (newly enrolling) durable medical equipment suppliers

Is there a cost to providers?

Yes, some providers will have to pay a fee to enroll/re-validate; many providers will not have to pay a fee. Providers who are NOT required to pay the fee include:

- Individual physicians and non-physician practitioners (except group practices).
- Providers already enrolled in Medicare that have paid an application fee and been screened by Medicaid within the last 12 months.



- Providers already enrolled in any state's Medicaid or CHIP program that have paid an application fee and been screened by that state within the last 12 months, as long as the other state's screening requirements are consistent with Colorado's.

The application fee is approximately \$550 and will increase with inflation. All fees collected are required to be used to fund the provider screening program. If fees are collected from a provider in error, Medicaid will refund the fee.

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