



# 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 revalidation of all providers enrolling with Colorado Medicaid. Since providers have not previously been screened to this extent, all providers will be screened as newly enrolling providers during the first revalidation cycle. These regulations were designed to increase provider compliance and quality of care for members, as well as to reduce the potential for Medicaid fraud. The final federal regulations were published in the [federal register](#) in February 2011. The Department of Health Care Policy and Financing (Department) will begin to fully implement these new federal regulations September 15, 2015.

## Who is affected?

All currently enrolled, newly enrolling, or re-enrolling providers must be screened in order to participate (or continue participating) in Colorado's Medicaid or CHP+ programs. Currently enrolled Colorado Medicaid and CHP+ providers will begin revalidation by enrolling into the Colorado interChange beginning September 2015. Following the Department's implementation of the new federal provider screening rules, most providers will see very little change in their enrollment process. However, some providers may be required to undergo additional screening before they can be enrolled or revalidated in Medicaid. Providers that remain enrolled in Medicaid must be revalidated (i.e., re-screened) at least every five (5) years.

## What are the revalidation deadlines?

- Providers who are enrolled in Medicaid as of September 1, 2015, must revalidate before March 31, 2016, and at least every five (5) years thereafter.
- Providers who enroll in Medicaid after September 1, 2015, must revalidate at least every five (5) years thereafter.

## How will the new screening work?

CMS has divided provider types into three (3) 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 will be assigned the same risk level by Colorado Medicaid.

Risk levels for Medicaid-only provider types (e.g., Home and Community-Based Services providers) were determined by the Department and communicated through a provider and stakeholder consultation process.

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 (fingerprinting to begin in late 2016).

All screening will be conducted by the Department, the Department's contractors, and other state departments.

### **Which providers are considered by CMS as limited risk?**

- Physicians and non-physician practitioners (e.g., dentists, optometrists, advanced practice nurses, physician assistants)
- Hospitals, federally qualified health centers, rural health clinics, skilled nursing facilities, ambulatory surgery centers
- Pharmacies that do not supply durable medical equipment
- Provider types not designated as moderate or high risk shall be considered limited risk

### **Which providers are considered by CMS as moderate risk?**

- Emergency Transportation, including ambulance service suppliers
- Non-Emergency Medical Transportation
- Community Mental Health Center
- Hospice
- Independent Laboratory
- Independent Diagnostic Testing Facility
- Comprehensive Outpatient Rehabilitation Facility
- Portable x-ray suppliers
- Physical Therapists, both individuals and group practices
- Revalidating Home Health agencies (*screened as high-risk for the first revalidation cycle*)

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- Revalidating Durable Medical Equipment suppliers, including revalidating pharmacies that supply Durable Medical Equipment (*screened as high-risk for the first revalidation cycle*)
- Revalidating Personal Care providers under the state plan (*screened as high-risk for the first revalidation cycle*)
- Providers of the following services for Home Community-Based Services (HCBS) waiver members:
  - Alternative Care Facility (ACF)
  - Adult Day Services
  - Alternative/Integrative Therapies
  - Assistive Technology, if the provider is revalidating (*screened as high-risk for the first revalidation cycle*)
  - Behavioral Programming
  - Behavioral Therapies
  - Behavioral Health Services
  - Behavioral Health Supports
  - Behavioral Services
  - Care Giver Education
  - Children's Case Management
  - Children's Habilitation Residential Program (CHRP)
  - Community Connector
  - Community Mental Health Services
  - Community Transition Services
  - Complementary and Integrative Health
  - Day Habilitation and Rehabilitation
  - Day Treatment
  - Enhanced Nursing Services
  - Expressive Therapy
  - Financial Management Services for Consumer Directed Attendant Support Services, if the provider is revalidating (*screened as high-risk for the first revalidation cycle*)
  - Foster home
  - Group home

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- Home Delivered Meals
- Home Modifications/Adaptations/Accessibility
- Home Modification
- Homemaker, if the provider is revalidating (*screened as high-risk for the first revalidation cycle*)
- Independent Living Skills Training
- In-Home Support Services (IHSS), if the provider is revalidating (*screened as high-risk for the first revalidation cycle*)
- Initial/Ongoing Treatment Evaluation (for Children with Autism)
- Intensive Care Management
- Massage Therapy
- Mentorship
- Mobility Van
- Non-Medical Transportation
- Palliative/Supportive Care-Skilled
- Peer Mentorship
- Personal Care/Homemaker Services, if the provider is revalidating (*screened as high-risk for the first revalidation cycle*)
- Personal Emergency Response System/Medication Reminder/Electronic Monitoring
- Post-Service Evaluation (for Children with Autism)
- Prevocational Services
- Professional Services
- Residential Habilitation Services
- Respite Care
- Respite Services
- Specialized Day Rehabilitation Services
- Specialized Medical Equipment and Supplies, if the provider is revalidating (*screened as high-risk for the first revalidation cycle*)
- Substance Abuse Counseling
- Supported Employment
- Supported Living Program

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- Therapeutic Services
- Therapy and Counseling
- Transitional Living Program
- Wheelchair Van

## **Which providers are considered by CMS as high risk?**

- Prospective (newly enrolling) Home Health agencies
- Prospective (newly enrolling) Durable Medical Equipment (DME) suppliers
- Prospective (newly enrolling) Personal Care providers providing services under the state plan.
- Prospective (newly enrolling) providers of the following services for HCBS waiver members:
  - Assistive Technology
  - Financial Management Services for Consumer Directed Attendant Support Services
  - Homemaker
  - Personal Care
  - Specialized Medical Equipment and Supplies
  - In-Home Support Services
- Enrolling and Revalidating providers for which the Department has suspended payments during an investigation of a credible allegation of fraud, waste, or abuse, for the duration of the suspension of payments.
- Enrolling and Revalidating providers which have a delinquent debt owed to the State arising out of Medicare, Colorado Medical Assistance, or other programs administered by the Department, not including providers which are current under a settlement or repayment agreement with the State.
- Providers that were excluded by the Health and Human Services (HHS) office of Inspector General or had their provider agreement terminated for cause by the Department, its contractors or agents or another State's Medicaid program at any time within the previous 10 years.
- 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.

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## **What should providers with multiple locations do?**

- All providers must separately enroll each location from which they provide services. Only claims for services provided at locations that are enrolled are eligible for reimbursement. Each provider site will be screened separately and must pay a separate application fee. Applicable providers pay one application fee per location.

## **Is there a cost to providers?**

Yes, **some** providers will have to pay a fee to enroll/revalidate; 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, including those who are part of a group practice or clinic.
- Providers already enrolled in Medicare that have paid an application fee and been screened by Medicare 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 \$553 and will increase annually with inflation. All fees collected are required to be used to fund the provider screening program. The application fee is non-refundable.

## **What will happen if a provider fails to comply with the requirement to revalidate by the deadline?**

- The provider agreement shall be suspended.
- If a provider fails to comply with all requirements for revalidation within 30 days of the dates of suspension, the provider agreement may be terminated. In the event that the provider agreement is terminated, any claims submitted after the date that the provider's revalidation application was due to the Department are not reimbursable.

For the latest information on provider revalidation & screening instructions and FAQs, please visit the dedicated [Provider Resources](#) website.

