

## Comments on the draft rule implementing new Federal Provider Screening regulations

Below, the Department summarizes and responds to stakeholder feedback on the draft rule posted in November of 2014 that would implement the federal provider screening regulations. Comments summarized below reflect comments received in writing via [providerscreeningcomments@state.co.us](mailto:providerscreeningcomments@state.co.us) and those received informally through stakeholder meetings, phone calls, and individual correspondence with providers and other stakeholders.

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*Comment:* Commenters noted that home and community based service providers provide services in hundreds of locations across their service areas, often providing services in individual client's homes. These providers were concerned that they would need to separately enroll and pay an application at each residence or site they provide services.

*Response:* In accordance with federal regulations and guidance, providers must enroll each of the facilities from which they provide service. For example, a federally qualified health center with several locations across a given city or cities would need to enroll separately at each location. However, providers who provide home and community based care need not enroll separately at the residence of each client for whom they provide care. They need only enroll the offices or locations from which their staff provide services and are based and from which they submit claims to Medicaid. We have updated the rule at 6.a to clarify this requirement.

*Comment:* Commenters were concerned that the Regional Care Collaborative Organizations (RCCOs) would be responsible for conducting provider screening under this rule. Commenters were interested in whether the RCCOs would be able to be reimbursed for screening providers under this rule.

*Response:* RCCOs will not be responsible for screening providers under this rule. All screening pursuant to this rule will be conducted by the Department, the Department's contractors, and other state departments.

*Comment:* Commenters noted that while the draft rule requires existing Medicaid providers to have revalidated their enrollment by 3/31/2016, other information published by the Department indicated that providers would have until 6/30/2016 to revalidate their enrollment.

*Response:* Thank you for pointing out this inconsistency. Existing providers will have until March 31, 2016 to revalidate their enrollment. The Department apologizes for the confusion.

*Comment:* Commenters had questions about whether a clinic or other provider who was enrolled in Medicare would be required to pay the application fee.

*Response:* All providers must pay a Medicaid application fee when they enroll or revalidate unless they are an individual physician or other practitioner, have enrolled with Medicare within the last 12 months, or have enrolled with another state within the last 12 months. A provider who has enrolled with Medicare within the last 12 months will not be required to pay an application fees but a provider who enrolled with Medicare prior to the 12 months before their application date will be subject to the application fee and screening by the Department.

*Comment:* Commenters stated that safety net clinics and rural clinics should be exempt from the fee.

*Response:* The Department recognizes that the application fee may be a financial hardship for some existing providers or provider types. The federal regulations do not allow the Department to waive the application for any individual provider or provider types without CMS approval. The draft rule allows the Department to develop a process allowing individual providers to apply for a waiver of the application fee when the Department determines that requiring a provider to pay an application fee would negatively impact access to care for Medicaid clients, and the Department receives approval from the Centers for Medicare and Medicaid Services to waive the application fee. Additionally, the Department plans to seek CMS approval for fee waivers for particular provider types in regions where imposing a fee may negatively impact access to care for Medicaid clients.

*Comment:* Commenters stated that it would be most efficient to only screen those providers who are not licensed or monitored by state professional licensing departments. Commenters suggested that licensed providers are often nationally certified and licensed through other state oversight.

*Response:* Federal law and regulations require the Department to screen all providers according the provisions of the federal provider screening rule. Providers have been assigned a risk category by the federal Centers for Medicare and Medicaid Services, or, for Medicaid only providers, by the Department, based on their perceived risk of waste, fraud, and abuse, including the level of existing oversight and licensure that each provider type requires. Under federal regulations, the risk level to which each provider type is assigned dictates the provider's screening requirements.

*Comment:* Commenters noted that many behavioral healthcare providers are regulated by several state agencies. Commenters stated that the federal provider screening regulations overlap with existing regulations and oversight, creating a significant regulatory burden on providers. Commenters asked the State to prioritize streamlining these regulatory requirements, not adding new ones. Specifically, regarding community mental health centers, Commenters stated that site visits should be no more stringent than visits by the Department of Human Services' Office of

Behavioral health. Commenters supported combining site visits to reduce regulatory burden on behavioral health providers.

*Response:* The Department is actively working with other agencies to potentially streamline site visits and other screening under the Federal provider screening rule. The rule requires the Department to conduct site visits before and after enrollment to verify information contained within the Medicaid application, ensure that prospective providers meet enrollment requirements, and verify that current providers remain operational while continuing to meet required provider standards. Because these site visits will have a different purpose than existing site surveys performed by other state agencies, the Department may collect different information during these visits for the purposes of complying with these federal requirements. These federal requirements also require HCPF to conduct site visits in addition to those already performed, even while working with other agencies to coordinate site visits where possible.

*Comment:* Commenters supported the placement of Behavioral Health Organizations (BHOs) in the limited risk category.

*Response:* We appreciate the commenters' support.

*Comment:* Commenters urged the Department to subject providers who are unlicensed by the state of Colorado to additional screening.

*Response:* The Department has designated providers with the same risk category as Medicare in accordance with the risk of waste, fraud, and abuse determined by the federal Centers for Medicare and Medicaid Services and in order to promote consistency of requirements and screening procedures across programs. The Department has assigned risk levels to Medicaid only providers, including many providers who are unlicensed by the state Colorado, in part based on several criteria. For example, the Department considered providers with little additional oversight from other agencies or professional organizations for higher risk levels. A provider type's risk level was based on a holistic assessment of multiple criteria, weighed against each other based on the unique circumstances of each provider type.

*Comment:* Commenters asked the Department to expand language in the rule to include all primary and specialty care providers, such as, Advance Practice RNs. Specifically, Commenters requested the rule be changed to require "all licensed primary care providers and prescribers" to be enrolled in Colorado Medicaid in order to order refer or prescribe for Medicaid patients.

*Response:* The Department appreciates the need for applying this requirement to all providers who order, refer or prescribe for Medicaid clients. Mimicking the federal regulations, the rule includes language applying this requirement to "all physicians or other professionals who order, refer, or prescribe services for Medicaid clients," which includes all licensed primary care providers and prescribers.

*Comment:* Commenters disagreed with designating physical therapists as “moderate risk.” They argued that Physical therapists are licensed professional that are subject to continuing education requirements and were concerned that some other professionals were considered low risk.

*Response:* The Department does not have the authority to designate physical therapists at a risk level lower than moderate. The final federal regulations designate physical therapists as moderate risk providers based on the federal Centers for Medicare and Medicaid Services experience as well as insights from studies conducted by the U.S. Department of Health and Human Services’ Office of Inspector General, the Government Accountability Office and other sources. The federal regulations require the Department to designate physical therapists as at least moderate risk.

*Comment:* Commenters stated that the fee would be cost prohibitive for some providers. They noted that no other payer requires a fee to join a provider network and that a Medicaid enrollment fee could harm access to care for Medicaid clients.

*Response:* Federal law (see Sec. 6401 of the Affordable Care Act) requires many providers to pay an application fee and sets this fee at \$553 for 2015. Individual providers (doctors and professionals who enroll as individuals) and providers who have enrolled with Medicare or another state Medicaid or CHIP program within the last 12 months are not required to pay the fee.

The Department recognizes that the application fee may be a financial hardship for some existing providers or provider types. The federal regulations do not allow the Department to waive the application for any individual provider or provider types without CMS approval. The draft rule allows the Department to develop a process allowing individual providers to apply for a waiver of the application fee when the Department determines that requiring a provider to pay an application fee would negatively impact access to care for Medicaid clients, and the Department receives approval from the Centers for Medicare and Medicaid Services to waive the application fee. Additionally, the Department plans to seek CMS approval for fee waivers for particular provider types in regions where imposing a fee may negatively impact access to care for Medicaid clients.

*Comment:* Commenters were concerned that the requirements for additional screening under this rule was unclear.

*Response:* The rule divides providers into categories based predominantly on CMS’ assessment of the risk of waste fraud and abuse for a given provider type. Different screening requirements are applied to each risk level. Limited risk provider must meet federal and state rules and regulations, have their provider license verified (where applicable) and not be excluded from Medicaid or Medicare participation by federal and state databases. Moderate risk providers are

subject to the limited screening requirements plus pre- and post-enrollment site visits. High risk providers are subject to fingerprinting and criminal background checks of their owners. More information about the rule can be found under the Federal Provider Screening Regulations” section of <https://www.colorado.gov/pacific/hcpf/provider-implementations>.

*Comment:* One commenter suggested that on-site visits take into account the size, location, and patient funding mix of each provider-type. The commenter suggested that large facilities that process large numbers of claims should be subject to on-site visits while independent providers who operate under the oversight of other programs be exempted from site visit requirements.

*Response:* The federal provider screening regulations require that all moderate and high risk providers undergo a site visit prior to enrolling or revalidating with Colorado Medicaid. These requirements apply regardless of the size, location, or patient mix of a given provider.

*Comment:* Commenters asked whether providers who provide non-medical services under one of the HCBS waivers are subject to the screening described in the draft rule.

*Response:* Yes, all providers are enrolled and bill Medicaid for services under the state plan or a waiver must be screened under this rule.

*Comment:* One commenter was concerned that in home support services, personal care services, and homemaker services are singled out from other waiver services as high categorical risk.

*Response:* The Department has designated providers with the same risk category as Medicare in accordance with the risk of waste, fraud, and abuse determined by the federal Centers for Medicare and Medicaid Services and in order to promote consistency of requirements and screening procedures across programs. The Department has assigned risk levels to Medicaid only providers based on several criteria. For example, the Department considered providers with little additional oversight from other agencies or professional organizations for higher risk levels. A provider type’s risk level was based on a holistic assessment of multiple criteria, weighed against each other based on the unique circumstances of each provider type.