Title of Rule: Revision to the Medical Assistance Rule concerning Provider Enrollment, Sections 8.125.11, 8.125.12, 8.125.13
Rule Number: MSB 20-05-01-A
Division / Contact / Phone: Medicaid Operations Office / Clint Eatmon / 720-819-6409

## STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule revision will temporarily remove current requirements for providers to comply with: Fingerprint Criminal Background Checks (10 CCR 2505-10 8.125.12), Site-Visits (10 CCR 2505-10 8.125.11) and payment of Application Fee's (10 CCR 2505-10 8.125.13), during the provider enrollment process. Alleviating these requirements will expedite the processing of provider-enrollment applications.

   These proposed changes bring Colorado regulations into alignment with the approved 1135 waiver which was granted by CMS, temporarily waiving these requirements at the Federal Level. If passed, the rule will become effective on the date the board adopts it and it will expire after 120 days. However, the Department has the option to bring the rule to MSB a second time within the 120 days to reinstate or further extend the timeframe, depending on prevailing conditions and current guidance at that time.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☒ for the preservation of public health, safety and welfare.

   Explain:

   Removing these requirements will expedite the processing of provider enrollment applications during the COVID-19 pandemic, thereby increasing the number of approved providers during this emergency period.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019);

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## REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Those seeking to be approved Medicaid providers and our member population will benefit from this proposed rule.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Those seeking to become approved providers will benefit from a streamlined provider enrollment process. Members will benefit from increased access to care as more providers are enrolled and available to offer treatment and services.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no costs to the Department or to an other agency to implement and enforce the proposed rule.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   There are no probable costs to providers.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly or less intrusive methods for achieving the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for achieving the purpose of the proposed rule.

## 8.125 PROVIDER SCREENING

~~**8.125.11 SITE VISITS**~~

~~8.125.11.A. All providers designated as "moderate" or "high" categorical risks to the Medicaid program must consent to and pass a site visit before they may be enrolled or re-validated as Colorado Medicaid providers. The purpose of the site visit is to verify that the information submitted to the state department is accurate and to determine compliance with federal and state enrollment requirements.~~

~~8.125.11.B. All enrolled providers who are designated as "moderate" or "high" categorical risks must consent to and pass an additional site visit after enrollment or revalidation. The purpose of the site visit is to verify that the information submitted to the state department is accurate and to determine compliance with federal and state enrollment requirements. Post-enrollment or post-revalidation site visits may occur anytime during the five-year period after enrollment or revalidation.~~

~~8.125.11.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~~

~~8.125.11.D. All site visits shall verify the following information:~~

~~1. 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.~~

~~2. 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.~~

~~3. 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.~~

~~4. Appropriate inventory necessary to provide services for specific provider type.~~

~~5. Other information as designated by the Department.~~

~~8.125.11.E. The Department shall give the provider a report detailing the discrepancies or insufficiencies in the information disclosed by the provider and the criteria the provider failed to meet during the site visit.~~

~~8.125.11.F. Providers that are found in full compliance shall be recommended for approval of enrollment or revalidation, subject to other enrollment or revalidation requirements.~~

~~8.125.11.G. Providers who meet the vast majority of criteria in 8.125.11.D but have small number of minor discrepancies or insufficiencies shall have 60 days from the date of the issuance of the report in 8.125.11.E to submit documentation to the Department attesting that the provider has corrected the issues identified during the site visit.~~

~~1. If the provider submits attestation within the 60 day timeframe and has met requirements, then the provider shall be recommended for enrollment or revalidation, subject to the verification of other enrollment or revalidation requirements.~~

~~2. If the provider fails to submit the attestation in 8.125.11.G.1 within the 60 day deadline, the Department may deny the provider's application for enrollment or revalidation.~~

~~3. If the provider submits an attestation within 60 days indicating that the provider is not fully compliant with criteria in 8.125.11.D, then the Department may,~~

~~a. For existing providers, suspend the provider, until the provider demonstrates compliance in a subsequent site visit, conducted at the provider's expense; or~~

~~b. For new providers, deny the application and require the provider to restart the enrollment process.~~

~~8.125.11.H. When site visits reveal major discrepancies or insufficiencies in the information provided in the enrollment application or a majority of the criteria described in 8.125.11.D are not met, the Department shall allow for an additional site visit for the provider.~~

~~1. Additional site visits shall be conducted at the provider's expense.~~

~~2. The provider shall have 14 days from the date of the issuance of the report listed in 8.125.11.E above to request an additional site visit.~~

~~3. The Department shall deny or terminate enrollment or revalidation of any provider subject to 8.125.11.G who does not request an additional site visit within 14 days.~~

~~4. If the Department determines that a provider is not in full compliance upon the additional site visit:~~

~~a. for a revalidating provider, the Department shall immediately suspend the provider until a subsequent site visit demonstrates provider is in compliance.~~

~~b. for an enrolling provider, deny the application and require the provider to restart the enrollment process.~~

~~8.125.11.I. The Department shall deny or terminate enrollment or revalidation of any provider who refuses to allow a site visit, 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 8.125.11.E. Any provider 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.~~

~~8.125.11.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.~~

~~8.125.11.K. The Department shall refer providers in 8.125.11.J to the State Attorney General.~~

## ~~8.125.12 CRIMINAL BACKGROUND CHECKS AND FINGERPRINTING~~

~~8.125.12.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.~~

~~8.125.12.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.~~

## ~~8.125.13 APPLICATION FEE~~

~~8.125.13.A. Except when exempted in Sections 8.125.13.C and 8.125.13.D, enrolling and re-validating providers must submit an application fee or a formal request for a hardship exemption with their application.~~

~~8.125.13.B. The amount of the application fee is the amount calculated by CMS in accordance with 42 CFR § 424.514(d).~~

~~8.125.13.C. Application fees shall apply to all providers except:~~

~~1. Individual practitioners~~

~~2. Providers who have enrolled or re-validated in Medicare and paid an application fee within the last 12 months~~

~~3. Providers who have enrolled or re-validated in another State's Medicaid or Children's Health Insurance Program and paid an application fee 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.~~

~~8.125.13.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:~~

~~1. The Department determines that requiring a provider to pay an application fee would negatively impact access to care for Medicaid clients, and~~

~~2. The Department receives approval from the Centers for Medicare and Medicaid Services to exempt the application fee.~~

~~8.125.13.E. A provider may not be enrolled or revalidated unless the provider has either paid any applicable application fee or obtained an exemption described at Section 8.125.13.D.~~

~~8.125.13.F. The application fee is non-refundable, except if submitted with one of the following:~~

~~1. A request for hardship exemption described at Section 8.125.13.D, that is subsequently approved;~~

~~2. An application that is rejected prior to initiation of screening processes;~~

~~3. An application that is subsequently denied as a result of the imposition of a temporary moratorium as described at Section 8.125.14.~~