Title of Rule: Revision to the Medical Assistance Rule concerning Non-Emergent Medical Transportation, Sections 8.014 & 8.125
Rule Number: MSB 23-11-16-A
Division / Contact / Phone: Fraud, Waste, and Abuse Division / Sarah Geduldig/ 2341

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 change is occurring because there has been an increase in suspected fraud within the Non-Emergent Medical Transportation (NEMT) benefit. This has resulted in a CMS approved temporary moratorium of newly enrolling NEMT providers for at least six (6) months. While this Moratorium is in place, the Department is working on statutes, rules, regulations and guidance to address concerns and issues that were discovered through reviewing the suspected fraud scheme. This proposed emergency rule is being put in place in order to clarify the Department's expectations of NEMT providers, reduce the risk of suspected fraud, and protect the health, safety, and welfare of our members. To do this, the proposed revisions include changes to the screening and credentialing of NEMT providers, clarifying the obligations of drivers compared to the state designated entity, and removing outdated language related to licensing requirements by the public Utilities Commission (PUC).

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:

   A current fraud scheme has brought to light that members were being solicited by drivers for either unnecessary rides or rides that did not meet the requirements of the program. Through this it was found that there was no additional credentialing for providers outside of the Denver Metro area to ensure that the vehicles being used were safe and the providers rendering services were licensed, underwent background checks, and were trained in a manner to provide safe rides to our members.

3. Federal authority for the Rule, if any:

   42 CFR 455.450(e)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);
   Section 25.5-1-802(1), C.R.S.

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.

   Providers will be impacted by the proposed rule change because under federal regulation upon enrollment or reenrollment any provider type that was subject to a moratorium in the last six months must be screened at a high-risk level, which includes requiring a fingerprint-based background check. Providers will be responsible for bearing the cost of this. Providers will also be required to take part in credentialing requirements of their drivers and vehicles, though these costs will be the responsibility of the Department.

   Members will benefit from ensuring proper screening and credentialing of providers, drivers, and vehicles used in NEMT which will increase member safety and improve members' experience of NEMT. It will also protect members from being contacted by competing transportation providers and having their member status exploited for profit.

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

   Providers may be impacted by the increased screening and credentialing requirements for the owners and the drivers, including background checks and vehicle safety inspections. However, the need to protect members' safety outweighs the associated cost and inconvenience to providers of these requirements.

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.

   The increased screening and credentialing requirements will increase costs to the Department; however these costs were included in a supplemental budget request presented to the JBC and were approved in December 2023. This rule will not result in increased costs to any other agency.

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

   Denver metro area providers will not experience additional costs because they have historically been required to perform this credentialing. However, providers outside the metro area who will now be required to perform credentialing will experience increased costs. The Department will also experience increased costs of administering these requirements. (See number 3, above.) Inaction would avoid increase costs but would result in a failure to alleviate potential risks to the health, safety, and welfare

of our members.

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

   The Department determined there were no other less costly or less intrusive methods to clarify HCPF's expectations of providers, protect member safety and reduce suspected fraud. Proper screening and credentialing of providers, drivers, and vehicles used in NEMT is the best method identified to achieve the purpose of the 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.

   Moving NEMT providers from the moderate categorical risk level to the high risk level, as necessitated by the increased fraud activity in the benefit, implicate federal regulations that require providers to conduct additional screening measures. Failure to place NEMT providers in the higher categorical risk level would fail to address the increase in fraud activity. Under the moderate categorical risk level, providers were not required to perform screening measure robust enough to avoid risks to member safety. To change the risk level associated with NEMT providers, a rule-making is necessary.

8.014 NON-EMERGENT MEDICAL TRANSPORTATION

8.014.1. DEFINITIONS

8.014.1.A. Access means the ability to make use of.

8.014.1.B. Air Ambulance means a Fixed-Wing or Rotor-Wing Air Ambulance equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.014.1.C. Ambulatory Vehicle means a passenger-carrying vehicle available for those clients able to walk and who do not rely on wheelchairs or other mobility devices, during boarding or transportation, which would necessitate a vehicle with a lift or other accommodations.

8.014.1.D. Ancillary Services mean services incurred indirectly when a client authorized to receive NEMT also requires the assistance of an Escort or financial assistance for meals or lodging.

8.014.1.E. At-Risk Adult means an adult who is unable to make personal or medical determinations, provide necessary self-care, or travel independently.

8.014.1.F. Child means a minor under the age of 18.

8.014.1.G. Day Treatment means facility-based services designed for Children with complex medical needs. Services include educational or day care services when the school or day care system is unable to provide skilled care in a school setting, or when the Child's medical needs put them at risk when around other Children.

8.014.1.H. Emergency Medical Transportation means Ground Ambulance or Air Ambulance transportation under Section 8.018 during which clients who are ill, injured, or otherwise mentally or physically incapacitated receive needed emergency medical services en route

8.014.1.I. Escort means a person who accompanies an At-Risk Adult or minor client.

8.014.1.J. Fixed-Wing Air Ambulance means a fixed wing aircraft that is certified as a Fixed-Wing Air Ambulance by the Federal Aviation Administration.

8.014.1.K. Ground Ambulance means a ground vehicle, including a water ambulance, equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.014.1.L. Medicaid Client Transport (MCT) Permit means a permit issued by the Colorado Department of Regulatory Agencies Public Utilities Commission (PUC) in accordance with the PUC statute at Section 40-10.1-302, C.R.S.

8.014.1.M. Mode means the method of transportation.

8.014.1.N. Non-Emergent Medical Transportation (NEMT) means transportation to or from medically necessary non-emergency treatment. Non-emergency care may be scheduled or unscheduled. This may include Urgent Care transportation and hospital discharge transportation.

8.014.1.O. Program of All Inclusive Care for the Elderly (PACE) is a capitated rate benefit which provides all-inclusive long-term care to certain individuals as defined in Section 8.497.

8.014.1.P. Rotor-Wing Air Ambulance means a helicopter that is certified as an ambulance by the Federal Aviation Administration.

8.014.1.Q. State Designated Entity (SDE) means the organization responsible for administering NEMT. ~~For the purposes of this rule, the responsible SDE is determined by the client's county of residence.~~

8.014.1.R. Stretcher Van means a vehicle that can legally transport a client in a prone or supine position when the client does not require medical attention en route. This may be by stretcher, board, gurney, or another appropriate device.

8.014.1.S. Taxicab means a motor vehicle operating in Taxicab Service, as defined in 4 CCR 723-6, § 6001(yyy) (2019), which is hereby incorporated by reference.

8.014.1.T. Taxicab Service has the same meaning as defined in 4 CCR 723-6, § 6001(yyy) (2019), which is hereby incorporated by reference.

8.014.1.U. Trip means one-way transportation from the point of origin to the point of destination.

8.014.1.V. Urgent Care means an appointment for a covered medical service with verification from an attending physician or facility that the client must be seen or picked up from a discharged appointment within 48 hours.

8.014.1.W. Wheelchair Vehicle means a motor vehicle designed and used for the non-emergent transportation of individuals with disabilities who use a wheelchair. These vehicles include vans modified for wheelchair Access or wheelchair accessible minivans.

8.014.2. CLIENT ELIGIBILITY AND RESPONSIBILITIES

8.014.2.A. All Colorado Medical Assistance Program clients are eligible for NEMT services unless the client falls within the following eligibility groups on the date of the Trip:

1. Qualified Medicaid Beneficiary (QMB) Only
2. Special Low Income Medicare Beneficiary (SLMB) Only
3. Medicare Qualifying Individual-1 (QI-1) Only
4. Old Age Pension- State Only (OAP-state only)

8.014.2.B. Child Health Plan Plus clients are not eligible for NEMT.

8.014.2.C. PACE clients receive transportation provided by their PACE organization and are not eligible for NEMT.

8.014.2.D. NEMT services may be denied if clients do not observe the following responsibilities:

1. Comply with applicable state, local, and federal laws during transport.
2. Comply with the rules, procedures and policies of the Department, its designees, or the SDE.
3. Obtain authorization from their SDE, if the client lives within the designated SDE area.
4. Clients must not engage in violent or illegal conduct while utilizing NEMT services.
5. Clients must not pose a direct threat to the health or safety of themselves or others, including drivers.

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6. Clients must cancel their previously scheduled NEMT Trip if the ride is no longer needed, except in emergency situations or when the client is otherwise unable to cancel.

8.014.3. PROVIDER ELIGIBILITY AND RESPONSIBILITIES

8.014.3.A. Providers must enroll with the Colorado Medical Assistance Program as an NEMT provider.

8.014.3.B. Enrolled NEMT providers must:

1. Meet all provider screening requirements in Section 8.125;

2. Comply with commercial liability insurance requirements and, if applicable, PUC financial responsibility requirements established in the PUC statute at C.R.S. § 40-10.1-107;

~~11~~ 3. ~~Refrain from attempting to~~Not directly solicit individual clients known to have already established ~~-~~ NEMT
~~12~~11 service with another provider;

~~13~~12 4. Maintain and comply with the following appropriate licensure, or exemption from
~~14~~13 licensure, requirements:

~~15~~14 a. PUC common carrier certificate as a Taxicab;

~~16~~15 ~~b.~~ ~~PUC MCT Permit as required by the PUC statute at C.R.S. § 40-10.1-302;~~

~~17~~16 b~~e~~. Ground Ambulance license as required by Department of Public Health and
~~18~~17 Environment (CDPHE) rule at 6 CCR 1015-3, Chapter Four;

~~19~~18 c~~d~~. Air Ambulance license as required by CDPHE rule at 6 CCR 1015-3, Chapter
~~20~~19 Five; or

~~21~~20 d~~e~~. Exemption from licensure requirements in accordance with PUC statute at C.R.S. § 40-10.1-105.

~~Only P~~provide only NEMT services appropriate to their current licensure(s), within applicable geographic limitations, and in accord with~~Department~~
~~22~~ statutes, rules, and guidance~~, and within the geographic limitations applicable to the licensure~~; and

~~6. Ensure that all vehicles and auxiliary equipment used to transport clients meet federal, state, and local safety inspection and maintenance requirements.~~

6. Ensure vehicles used during the provision of NEMT meet federal, state, and local statutes and regulations~~,~~. Vehicles shall be ~~and are~~ safe and in good working order. To ensure ~~the~~ safety
~~31~~ and proper functioning ~~of the vehicles~~, all vehicles must pass a ~~vehicle~~ safety inspection
~~32~~31 prior to ~~it~~ being used to render services to members.

a. Safety inspections shall include the inspection of items as described in Rules Regulating Transportation by Motor Vehicle, 4 C.C.R. 723-6; § 6104.

b. Vehicles must be inspected on a schedule commensurate with their age:

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a. Vehicles manufactured within the last five (5) years: no inspection.
b. Vehicles manufactured within the last six (6) to ten (10) years: inspected every 24 months.
c. Vehicles manufactured eleven (11) years or longer: inspected annually.
d. Vehicles for wheelchair transportation: inspected annually, regardless of the manufacture date of vehicle.

c. The vehicle inspector must be trained to conduct the inspection and be employed by an automotive repair company authorized to do business in Colorado.

d. The vehicle inspector and automative repair company must not be owned or controlled by an individual who also has an ownership or controlling interest in the NEMT provider entity.

~~d~~e. Providers must maintain liability insurance with the following automobile liability minimum limits:

~~a~~i. Bodily injury (BI) $300/$600K per person/per accident; and

1~~i~~. Property damage $50,000.

2~~ii~~. Drivers that utilize their personal vehicle on behalf of a provider agency to provide NMT must maintain the following minimum automobile insurance limits, in addition to the insurance maintained by the provider agency:

3~~iii~~. Bodily injury (BI) $25/$50K per person/per accident; and

4~~iv~~. Property damage $15,000Member Eligibility.

7. ~~Document, maintain~~Create and maintain documentation of, and train staff on, the following policies and procedures:

a. Fraud, waste, and abuse identification and preventions;

b. Compliance with 42 C.F.R. § 403.812, the Health Insurance Portability and Accountability Act (HIPAA);

c. Compliance with vehicle maintenance and safety requirements

8. Ensure that each driver meets the following requirements:

a. Drivers must be 18 years of age or older to render services;

b. Have at least one year of driving experience;

c. Possess a valid Colorado driver's license;

d. Provide a copy of their current Colorado motor driving vehicle record, with the previous seven years of driving history;

e. Complete a Colorado or National-based criminal history record check; and

f. Has received training and obtained certification in CPR and Naloxone administration.

9. Maintain documentation regarding drivers must be maintained by the provider and provided to the Department or its designees on request:

a. Name

b. Valid Driver's License

c. 10 Panel Drug screen prior to hire and annually there after

d. State sex offender check prior to hire and annually there after

e. National sex offender check prior to hire and annually there after

f. Criminal background check without disqualification found below:

a. A conviction of substance abuse occurring within the seven (7) years preceding the date the criminal history record check is completed;

b. A conviction in the State of Colorado, at any time, of any Class 1 or 2 felony under Title 18, C.R.S.;

c. A conviction in the State of Colorado, within the seven (7) years preceding the date the criminal history record check is completed, of a crime of violence, as defined in C.R.S. § 18-1.3-406(2);

d. A conviction in the State of Colorado, within the four (4) years preceding the date the criminal history record check is completed, of any Class 4 felony under Articles 2, 3, 3.5, 4, 5, 6, 6.5, 8, 9, 12, or 15 of Title 18, C.R.S.;

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e. A conviction of an offense in any other state that is comparable to any offense listed in subparagraphs (f)(II)(A) through (D) within the same time periods as listed in subparagraphs (f)(II)(A) through (D) of Rules Regulating Transportation by Motor Vehicle, 4 C.C.R. 723-6; § 6114;

f. A conviction in the State of Colorado, at any time, of a felony or misdemeanor unlawful sexual offense against a child, as defined in § 18-3-411, C.R.S., or of a comparable offense in any other state or in the United States at any time;

g. A conviction in Colorado within the two (2) years preceding the date the criminal history record check is completed of driving under the influence, as defined in § 42-4-1301(1)(f), C.R.S.; driving with excessive alcoholic content, as described in §42-4-1301(1)(g), C.R.S;

h. A conviction within the two (2) years preceding the date the criminal history record check is completed of an offense comparable to those included in subparagraph (f)(III)(B), 4 C.C.R. 723-6; § 6114 in any other state or in the United States; and

i. For purposes of 4 C.C.R. 723-6; § 6114(f)(IV), a deferred judgment and sentence pursuant to § 18-1.3-102, C.R.S., shall be deemed to be a conviction during the period of the deferred judgment and sent.

~~PUC statute at C.R.S. §§ 40-10.1-105, 40-10.1-107 and 40-10.1-302 (2019) and CDPHE rule at 6 CCR 1015-3, Chapters Four and Five (2019), are hereby incorporated by reference.~~

8.014.3.C. NEMT transportation providers must maintain a Trip report for each NEMT Trip provided and must, at a minimum, include:

1. The pick-up address;

2. The destination address;

3. Date and time of the Trip;

4. Client's name or identifier;

5. Confirmation that the driver verified the client's identity;

6. Confirmation by the client, Escort, or medical facility that the Trip occurred;

7. The actual pick-up and drop off time;

8. The driver's name; and

9. Identification of the vehicle in which the Trip was provided.

8.014.3.D. Multiple Loading

1. NEMT providers may not transport more than one client at the same time, unless the additional passenger is an Escort.

8.014.3.E. The Section 8.014.3 requirements do not apply to client reimbursement or bus or rail systems.

8.014.4. COVERED PLACES OF SERVICE

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8.014.4.A. NEMT must be provided to the closest provider available qualified to provide the service the client is traveling to receive. The closest provider is defined as a provider within a 25-mile radius of the client's residence, or the nearest provider if one is not practicing within a 25-mile radius of the client's residence.

8.014.4.B Exceptions may be made if a rationale and certification from the member's treating provider as to why the member cannot be treated by the closest provider within 25 miles of the member's residence is provided to and approved by ~~Exceptions may be made by~~ the Department, its designees, or the SDE and one of ~~in~~ the following circumstances applies:

1. If the closest provider is not willing to accept the client, the client may use NEMT to access the next closest qualified provider.

2. If the client has complex medical conditions that restrict the closest medical provider from accepting the patient, the Department, its designees, or the SDE may authorize NEMT to be used to travel to the next closest qualified provider. The treating medical provider must send the Department, its designees, or the SDE written documentation indicating why the client cannot be treated by the closest provider.

3. If a client has moved within the three (3) months preceding an NEMT transport, the client may use NEMT to their established medical provider seen in their previous locale. During these three (3) months, the client and medical provider must transfer care to the closest provider as defined at Section 8.014.4.B. or determine transportation options other than NEMT.

8.014.5. COVERED SERVICES

8.014.5.A. Transportation Modes

1. Covered Modes of transportation include:

a. Bus and public rail systems

i. Transit passes may be issued by the SDE when the cumulative cost of bus tickets exceeds the cost of a pass.

b. Personal vehicle mileage reimbursement

c. Ambulatory Vehicles

d. Wheelchair Vehicles

e. Taxicab Service

f. Stretcher Van

g. Ground Ambulance

h. Air Ambulance

i. Commercial plane

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j. Train

8.014.5.B. NEMT Services

1. NEMT is a covered service when:

a. The client does not have Access to other means of transportation, including free transportation;

b. Transportation is required to obtain a non-emergency service(s) that is medically necessary, as defined in Section 8.076.1.8.; and

c. The client is receiving a service covered by the Colorado Medical Assistance Program.

2. NEMT services may be covered for clients even if the medical procedure is paid for by an entity other than the Colorado Medical Assistance Program.

3. Non-emergent ambulance service (Ground and Air Ambulance), from the client's pickup point to the treating facility, is covered when:

a. Transportation by any other means would endanger the client's life; or

b. The client requires basic life support (BLS) or advanced life support (ALS) to maintain life and to be transported safely.

i. BLS includes:

1. Cardiopulmonary resuscitation, without cardiac/hemodynamic monitoring or other invasive techniques;

2. Suctioning en route (not deep suctioning); and

3. Airway control/positioning.

ii. ALS includes ALS Levels 1 and 2 in accordance with 42 CFR § 414.605 (2019), which is hereby incorporated by reference.

1. ALS Level 1 includes the provision of at least one ALS intervention required to be furnished by ALS personnel.

2. ALS Level 2 includes:

a. Administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or

b. The provision of at least one of the following ALS procedures:

i. Manual defibrillation/cardioversion.

ii. Endotracheal intubation.

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iii. Central venous line.

iv. Cardiac pacing.

v. Chest decompression.

vi. Surgical airway.

vii. Intraosseous line.

4. NEMT may be provided to an Urgent Care appointment under the following circumstances:

a. A provider is available;

b. The appointment is for a covered medical service with verification from an attending physician that the client must be seen within 48 hours; and

c. The client is transported to an Urgent Care facility, which may include a trauma center if it is the nearest and most appropriate facility.

8.014.5.C. Personal Vehicle Mileage Reimbursement

1. Personal vehicle mileage reimbursement is covered for a privately owned, non-commercial vehicle when used to provide NEMT services in accordance with Section 8.014.5.B and owned by:

a. A client, a client's relative, or an acquaintance; or

b. A volunteer or organization with no vested interest in the client.

2. Personal vehicle mileage reimbursement will only be made for the shortest Trip length in miles as determined by an internet-based map, Trip planner, or other Global Positioning System (GPS).

a. Exceptions can be made by the SDE if the shortest distance is impassable due to:

i. Severe weather;

ii. Road closure; or

iii. Other unforeseen circumstances outside of the client's control that severely limit using the shortest route.

b. If an exception is made under Section 8.014.5.C.2.a., the SDE must document the reason and pay mileage for the actual route traveled.

3. To be reimbursed for personal vehicle mileage, the client must provide the following information to the SDE within forty-five (45) calendar days of the final leg of the Trip:

a. Name and address of vehicle owner and driver (if different from owner);

b. Name of the insurance company and policy number for the vehicle; and

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c. Driver's license number and expiration date.

8.014.5.D. Ancillary Services

1. Escort

a. The Colorado Medical Assistance Program may cover the cost of transporting one Escort when the client is:

i. A Child.

1. An Escort is required to accompany a client if the client is under thirteen (13) years old, unless the Child:

a. Is traveling to a Day Treatment program (Children are not eligible for NEMT travel to and from school-funded day treatment programs);

b. The parent or guardian signs a written release;

c. An adult will be present to receive the Child at the destination and return location; and

d. The Day Treatment program and the parents approve of the NEMT provider used.

2. Clients who are at least thirteen (13) years old, but younger than eighteen (18) years old, may travel without an Escort if:

a. The parent or guardian signs a written release; andAn adult will be present to receive the Child at the destination and return location.

ii. An At-Risk Adult unable to make personal or medical determinations, or to provide necessary self-care, as certified in writing by the client's attending Colorado Medical Assistance Program enrolled NEMT provider.

b. The Escort must be physically and cognitively capable of providing the needed services for the client.

i. If a client's primary caregiver has a disability that precludes the caregiver from providing all of the client's needs during transport or extended stay, a second Escort may be covered under Section 8.014.5.D.1.c.ii.

c. The Colorado Medical Assistance Program may cover the cost of transporting a second Escort for the client, if prior authorized under Section 8.014.7. A second Escort will only be approved if:

i. The client has a behavioral or medical condition which may cause the client to be a threat to self or to others if only one Escort is provided; or

ii. The client's primary caregiver Escort has a disability that precludes the caregiver from providing all of the client's needs during transport or extended stay.

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2. Meals and Lodging

a. Meals and lodging for in-state treatment may be reimbursed when:

i. Travel cannot be completed in one calendar day; or

ii. The client requires ongoing, continuous treatment and:

1. The cost of meals and lodging is less than or equal to the cost of traveling to and from the treatment facility and the client's residence; or

2. The client's treating medical professional determines that traveling to and from the client's residence would put the client's health at risk.

b. Meals and lodging may be covered for the Escort(s) when the client is a Child or an At-Risk Adult who requires the Escort's continued stay under Section 8.014.5.D.1.

c. Reimbursement will only be made for meals and lodging for which clients and Escorts are actually charged, up to the per diem rate established by the Colorado Medical Assistance Program.

d. Meals and lodging will not be paid or reimbursed when those services are included as part of an inpatient stay.

8.014.6. NON-COVERED NEMT SERVICES AND GENERAL LIMITATIONS

8.014.6.A. The following services are not covered or reimbursable to NEMT providers as part of a NEMT service:

1. Services provided only as a convenience to the client.

2. Charges incurred while client is not in the vehicle, except for lodging and meals in accordance with Section 8.014.5.D.2.

3. Transportation to or from non-covered medical services, including services that do not qualify due to coverage limitations..

4. Waiting time.

5. Cancellations.

6. Transportation which is covered by another entity.

7. Metered taxi services.

8. Charges for additional passengers, including siblings or Children, not receiving a medical service, except when acting as an Escort under Section 8.014.5.D.1.

9. Transportation for nursing facility or group home residents to medical or rehabilitative services required in the facility's program, unless the facility does not have an available vehicle.

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10. Transportation to emergency departments to receive emergency services. See Section 8.018 for Emergency Medical Transportation services.

11. Providing Escorts or the Escort's wages.

12. Trips to receive Home and Community Based Services

a. Non-medical transportation should be utilized if other transportation options are not available to the client.

8.014.6.B. General Limitations

1. The Provider and the SDE are~~is~~ responsible for ensuring that the client utilizes the least costly Mode of transportation available that is suitable to the client's condition. This must be documented and available upon request by the Department, its designees, or the SDE.

8.014.7. AUTHORIZATION

8.014.7.A. If the Provider is rendering services in the SDE area, all~~All~~ NEMT services must be authorized as required by the SDE.

1. Authorization requests submitted more than three months after an NEMT service is rendered will be denied.

2. NEMT services may be denied if proper documentation is not provided to the SDE.

8.014.7.B. If a client requests transportation via Wheelchair Vehicle, Stretcher Van, or ambulance, the SDE must verify the service is medically necessary with the client's medical provider

1. Medical or safety requirements must be the basis for transporting a client in the prone or supine position.

8.014.7.C. Out-of-State NEMT

1. NEMT to receive out of state treatment is permissible only if treatment is not available in the state of Colorado.

2. The following border towns are not considered out of state for the purposes of NEMT prior authorization:

a. Arizona: Flagstaff and Teec Nos Pos.

b. Kansas: Elkhart, Goodland, Johnson, Sharon Springs, St. Francis, Syracuse, Tribune.

c. Nebraska: Benkelman, Cambridge, Chappell, Grant, Imperial, Kimball, Ogallala, and Sidney.

d. New Mexico: Aztec, Chama, Farmington, Raton, and Shiprock.

e. Oklahoma: Boise City.

f. Utah: Monticello and Vernal.

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g. Wyoming: Cheyenne and Laramie.

8.014.7.D. Prior Authorization

1. The following services require prior authorization by Colorado Medical Assistance Program:

a. Out-of-state travel, except to the border towns identified at section 8.014.7.C.2.

b. Air travel, both commercial air and Air Ambulance.

c. Train travel via commercial railway.

d. Second Escort.

2. Prior authorization requests require the following information:

a. NEMT prior authorization request form completed by SDE and member's physician and submitted to Colorado Medical Assistance Program according to form instructions.

i. The Colorado Medical Assistance Program will return requests completed by non-physicians and incomplete requests to the SDE.

ii. The Colorado Medical Assistance Program's determination will be communicated to the SDE. If additional information is requested, the SDE must obtain the information and submit to the Colorado Medical Assistance Program. If the request is denied, the SDE must send the client a denial notice.

8.014.8. INCORPORATIONS BY REFERENCE

The incorporation by reference of materials throughout section 8.014 excludes later amendments to, or editions of, the referenced materials. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours, at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

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8.125 PROVIDER SCREENING

8.125.1 DEFINITIONS.

Managed Care Entity is defined at 42 CFR § 455.101.

Ownership interest is defined at 42 CFR § 455.101.

Person with an ownership or control interest is defined at 42 CFR § 455.101.

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, 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.

Revalidation is defined as the process by which an individual or entity actively enrolled as a Colorado Medicaid provider resubmits a provider application, undergoes a state-defined screening process, pays an application fee, as appropriate for the provider type, and is approved by the Department to continue participation in the Medicaid program.

Disclosing Entity and Other Disclosing Entity are defined at 42 CFR § 455.101.

8.125.2 PROVIDERS DESIGNATED AS LIMITED CATEGORICAL RISK AND NEW PROVIDER TYPES

8.125.2.A. Except as provided for in Section 8.125.2.B, provider types not designated as moderate or high categorical risk at Sections 8.125.3 or 8.125.4 shall be considered limited risk.

8.125.2.B. The risk category for each provider type designated by CMS shall be the risk category for purposes of this rule regardless of whether a provider type may be listed in Sections 8.125.3 or 8.125.4.

8.125.3 PROVIDERS DESIGNATED AS MODERATE CATEGORICAL RISK

8.125.3.A. Emergency Transportation including ambulance service suppliers

~~8.125.3.B. Non-Emergency Medical Transportation~~

8.125.3.B~~C~~. Community Mental Health Center

8.125.3.C~~D~~. Hospice

8.125.3.D~~E~~. Independent Laboratory

8.125.3.E~~F~~. Comprehensive Outpatient Rehabilitation Facility

8.125.3.F~~G~~. Physical Therapists, both individuals and group practices

8.125.3.G~~H~~ X-Ray Facilities

8.125.3.H~~I~~. Revalidating Home Health agencies

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8.125.3.IJ. Revalidating Durable Medical equipment suppliers, including revalidating pharmacies that supply Durable Medical Equipment

8.125.3.JK. Revalidating Personal Care Agencies under the state plan

8.125.3.KL. Providers of the following services for HCBS waiver members:

1. Alternative Care Facility
2. Adult Day Services
3. Assistive Technology, if the provider is revalidating
4. Behavioral Programing
5. Behavioral Therapies
6. Behavioral Health Supports
7. Behavioral Services
8. Care Giver Education
9. Children's Case Management
10. Children's Habilitation Residential Program (CHRP)
11. Community Connector
12. Community Mental Health Services
13. Community Transition Services
14. Complementary and Integrative Health
15. Day Habilitation
16. Day Treatment
17. Expressive Therapy
18. Home Delivered Meals
19. Home Modifications/Adaptations/Accessibility
20. Independent Living Skills Training
21. In-Home Support Services, if the provider is revalidating
22. Intensive Case Management
23. Massage Therapy
24. Mentorship

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25. Non-Medical Transportation

26. Palliative/Supportive Care Skilled

27. Peer Mentorship

28. Personal Care/Homemaker Services, if the provider is revalidating

29. Personal Emergency Response System/Medication Reminder/Electronic Monitoring

30. Prevocational Services

31. Professional Services

32. Residential Habilitation Services

33. Respite

34. Specialized Day Rehabilitation Services

35. Specialized Medical Equipment and Supplies, if the provider is revalidating

36. Substance Abuse Counseling

37. Supported Employment

38. Supported Living Program

39. Therapy and Counseling

40. Transitional Living Program

41. Youth Day Services

8.125.3.L~~M~~. Medicare Only Providers

1. Independent Diagnostic Testing Facility

2. Revalidating Medicare Diabetes Prevention Program Supplier

3. Newly enrolling Opioid Treatment Program that has been fully and continuously certified by Substance Abuse and Mental Health Services Administration (SAMHSA) since October 24, 2018.

4. Revalidating Opioid Treatment Program

8.125.4 PROVIDERS DESIGNATED AS HIGH CATEGORICAL RISK

8.125.4.A. Enrolling DME Suppliers

8.125.4.B. Enrolling Home Health Agencies

8.125.4.C. Enrolling Personal Care Agencies providing services under the state plan

8.125.4.D. Enrolling providers of the following services for HCBS waiver members:

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1. Assistive Technology

2. Personal Care/Homemaker Services

3 Specialized Medical Equipment and Supplies

4 In-Home Support Services

8.125.4.E. Non-Emergent Medical Transportation

8.125.4.F. Medicare Only Providers

1. Enrolling Medicare Diabetes Prevention Program Supplier

2. Enrolling Opioid Treatment Program that has not been fully and continuously certified by SAMHSA since October 24, 2018.

8.125.4.GF. Enrolling and revalidating providers for which the Department has suspended payments during an investigation of a credible allegation of fraud, for the duration of the suspension of payments.

8.125.4.HG. 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.

8.125.4.IH. Providers that were excluded by the 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.

8.125.4.JI. 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.

8.125.5 PROVIDERS WITH MULTIPLE RISK LEVELS

8.125.5.A 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.

8.125.6 PROVIDERS WITH MULTIPLE LOCATIONS

8.125.6.A. Providers must enroll separately each location from which they provide services. Only claims for services provided at locations that are enrolled are eligible for reimbursement.

8.125.6.B. Each provider site will be screened separately and must pay a separate application fee. Providers shall only pay one application fee per location.

8.125.7 ENROLLMENT AND SCREENING OF PROVIDERS

8.125.7.A. All enrolling and revalidating providers must be screened in accordance with requirements appropriate to their categorical risk level.

8.125.7.B. Notwithstanding any other provision of the Colorado Code of Regulations, providers who provide services to Medicaid members as part of a managed care entity's provider network who

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would have to enroll in order to participate in fee-for-service Medicaid must enroll with the Department and be screened as Medicaid providers.

8.125.7.C. Nothing in Section 8.125.7.B shall require a provider who provides services to Medicaid members as part of a managed care entity's provider network to participate in fee-for-service Medicaid.

8.125.7.D. All physicians or other professionals who order, prescribe, or refer services or items for Medicaid members, 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 Children's Health Insurance 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.

8.125.7.E. The Department may exempt certain providers from all or part of the screening requirements when certain providers have been screened, approved and enrolled or revalidated:

1. By Medicare within the last 5 years, or

2. By another state's Medicaid program within the last 5 years, provided the Department has determined that the state in which the provider was enrolled or revalidated has screening requirements at least as comprehensive and stringent as those for Colorado Medicaid.

8.125.7.F. The Department may deny a Provider's enrollment or terminate a Provider agreement for failure to comply with screening requirements.

8.125.7.G. The Department may terminate a Provider agreement or deny the Provider's enrollment if CMS or the Department determines that the provider has falsified any information provided on the application or cannot verify the identity of any provider applicant.

8.125.8 NATIONAL PROVIDER IDENTIFIER FOR ORDERING, PRESCRIBING, REFERRING

8.125.8.A. As a condition of reimbursement, any claim submitted for a service or item that was ordered, referred, or prescribed for a Medicaid member must contain the National Provider Identifier (NPI) of the ordering, prescribing or referring physician or other professional.

8.125.9 VERIFICATION OF PROVIDER LICENSES

8.125.9.A. If a provider is required to possess a license or certification in order to provide services or supplies in the State of Colorado, then that provider must be so licensed as a condition of enrollment as a Medicaid provider.

8.125.9.B. Required licenses must be kept current and active without any current limitations throughout the term of the agreement.

8.125.10 REVALIDATION

8.125.10.A. Actively enrolled providers must complete all requirements for revalidation at least every 5 years as established by the Department, or upon request from the Department for an off cycle review.

8.125.10.B. The date of revalidation shall be considered the date that the provider's application was initially approved plus 5 years, or by an off-cycle request from the Department.

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8.125.10.C. If a provider fails to comply with any requirement for revalidation by the deadlines established by Sections 8.125.10.A. or 8.125.10.B., the provider agreement may be terminated. In the event that the provider agreement is terminated pursuant to this section, any claims for dates of service submitted after deadlines established by Sections 8.125.10.A. or 8.125.10.B., are not reimbursable beginning on the day after the date indicated by Section 8.125.10.B.

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

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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.

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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;

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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.

8.125.14 TEMPORARY MORATORIA

8.125.14.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 members' access to medical assistance.

8.125.14.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.

8.125.14.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.

8.125.15 DISCLOSURES BY MEDICAID PROVIDERS, MANAGED CARE ENTITIES, MEDICARE PROVIDERS AND FISCAL AGENTS

8.125.15.A. All providers, disclosing entities, fiscal agents, and managed care entities must provide the following federally required disclosures to the Department:

1. 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.

2. For individuals: Date of birth and Social Security number

3. 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.

4. 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.

5. 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.

6. 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).

7. 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

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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.

8. 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.

8.125.15.B. Disclosures from any provider or disclosing entity are due at any of the following times:

1. Upon the provider or disclosing entity submitting the provider application.

2. Upon the provider or disclosing entity executing the provider agreement.

3. Upon request of the Department during revalidation.

4. Within 35 days after any change in ownership of the disclosing entity.

8.125.15.C. Disclosures from fiscal agents are due at any of the following times:

1. Upon the fiscal agent submitting its proposal in accordance with the State's procurement process.

2. Upon the fiscal agent executing a contract with the State.

3. Upon renewal or extension of the contract.

4. Within 35 days after any change in ownership of the fiscal agent.

8.125.15.D. Disclosures from managed care entities are due at any of the following times:

1. Upon the managed care entity submitting its proposal in accordance with the State's procurement process.

2. Upon the managed care entity executing a contract with the State.

3. Upon renewal or extension of the contract.

4. Within 35 days after any change in ownership of the managed care entity.

8.125.15.E. The Department will not reimburse any claim from any provider or entity or make any payment to an entity that fails to disclose ownership or control information as required by 42 CFR § 455.104. The Department will not reimburse any claim from any provider or entity or make any payment to an entity that fails to disclose information related to business transactions as required by 42 CFR § 455.105 beginning on the day following the date the information was due and ending on the day before the date on which the information was supplied. Any payment made to a provider or entity that is not reimbursable in accordance with this section shall be considered an overpayment.

8.125.15.F. The Department may terminate the agreement of any provider or entity or deny enrollment of any provider that fails to disclose information when requested or required by 42 CFR § 455.100-106.

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