THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revisions to the Medicaid Eligibility Rules Governing Citizenship and Identity Documentation to Comply with the Children's Health Insurance Program Reauthorization Act of 2009 (10 CCR 2505-10 Sections 8.100.1 and 8.100.3.H)

Rule Number: MSB 09-02-18-A

Div/Contact/Phone: Legal / Brian Zolynas / 2814

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-02-18-A, Revisions to the Medicaid Eligibility Rules Governing Citizenship and Identity Documentation to Comply with the Children's Health Insurance Program Reauthorization Act of 2009 (10 CCR 2505-10 Sections 8.100.1 and 8.100.3.H)
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.1, 8.100.3.H., Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text with new text provided:

- **beginning at §8.100.1 Definitions and ending with the paragraph in this section that begins with "Burial Spaces are burial plots, gravesites, crypts, mausoleums . . ." and ending with ". . . arrangements for opening and closing the gravesite for burial of the deceased." This paragraph immediately precedes the paragraph the begins "Burial Trusts are irrevocable pre-need funeral agreements . . ."**

- **all of §8.100.3.H beginning at §8.100.3.H through the end of §8.100.3.H.10.a. (**An individual's verbal statement describing his or her efforts at securing the required documentation should be accepted without further verification unless the accuracy or truthfulness of the statement is questionable. The individual's good faith efforts should be documented in the case file and are subject to all record retention requirements.)

*to be completed by MSB Board Coordinator

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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).

   The purpose of this rule change is to revise the citizenship and identity documentation requirements for the Medicaid program to comply with the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3) which was enacted on February 4, 2009.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3, enacted February 4, 2009)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);
   25.5-4-104(1), C.R.S. (2008)

Initial Review — Final Adoption **06/12/2009**

Proposed Effective Date **07/30/2009** — Emergency Adoption

DOCUMENT #01

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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.

   The proposed rule changes will affect Native American individuals who have declared that they are citizens or nationals of the United States and who are currently receiving or who are applying for Medicaid by expanding the list of acceptable documents that a Native American can use to establish his or her citizenship and identity. The rule change will also affect children born to mothers who were eligible for and receiving Medicaid on the date of the child's birth. These children will be deemed to have met the citizenship and identity documentation requirements and will not be required to provide any documentary evidence of their citizenship and identity at any time in the future.

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

   It is not possible to quantify the net effect of the proposed rule changes because the Department does not have any data on the number of Medicaid applicants and clients who may not have been able to provide the required citizenship and identity documentation under the old rules but who could qualify under the new rules.

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 Department does not have any data at this time with which to quantify the net effect of the proposed changes.

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

   Inaction would result in the Department not being in compliance with federal law and could result in the loss of federal financial participation.

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 rules.

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. The rule changes are necessary for the Department to remain in compliance with federal law.

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.1 Definitions

1619b is section 1619b of the Social Security Act which allows individuals who are eligible for Supplemental Security Income (SSI) to continue to be eligible for Medical Assistance coverage after they return to work.

1931 Medical Assistance is a Medical Assistance category for families, qualified pregnant women and children with limited income provided under section 1931 of Title XIX of the Social Security Act.

AB - Aid to the Blind is a program which provides financial assistance to low-income blind persons.

ABD - Aged, Blind and Disabled Medical Assistance is a group of Medical Assistance categories for individuals that have been deemed to be aged, blind, or disabled by the Social Security Administration or the Department.

AND - Aid to Needy Disabled is a program which provides financial assistance to low-income persons over age 18 who have a total disability which is expected to last six months or longer and prevents them from working.

AFDC - Aid to Families with Dependent Children is the Title IV federal assistance program in effect from 1935 to 1997 which was administered by the United States Department of Health and Human Services. This program provided financial assistance to children whose families had low or no income.

AP-5615 is the form used to determine the patient payment for clients in nursing facilities receiving Long Term Care.

Alien is a person who was not born in the United States ~~this country~~ and who is not a naturalized citizen.

Ambulatory Services is any medical care delivered on an outpatient basis.

Annuity is an investment vehicle whereby an individual establishes a right to receive fixed for periodic payments, either for life or a term of years.

Applicant is a person who has submitted an application for public benefits.

Application Date is the date the application is received and date-stamped by the eligibility site or the date the application was received and date-stamped by an Application Assistance site or Presumptive Eligibility site. In the absence of a date-stamp, the application date is the date that the application was signed by the client.

Blindness is defined in this volume as the total lack of vision or vision in the better eye of 20/200 or less with the use of a correcting lens and/or tunnel vision to the extent that the field of vision is no greater than 20 degrees.

Burial Spaces are burial plots, gravesites, crypts, mausoleums, urns, niches and other customary and traditional repositories for the deceased's bodily remains provided such spaces are owned by the individual or are held for his or her use, including necessary and reasonable improvements or additions to or upon such burial spaces such as: vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased.

8.100.3 Medical Assistance General Eligibility Requirements

8.100.3.H. Citizenship and Identity Documentation Requirements

1. For determinations of initial eligibility and redeterminations of eligibility for Medical Assistance made on or after July 1, 2006, applicants/clients shall provide satisfactory documentary evidence of citizenship or nationality and identity unless such satisfactory documentary evidence has already been provided, as described in 8.100.3.H.4.b. This requirement applies to an individual who declares or who has previously declared that he or she is a citizen or national of the United States.

   This requirement does not apply to the following groups:

   a. Individuals who are entitled to or who are enrolled in any part of Medicare.

   b. Individuals who receive Supplemental Security Income (SSI).

   c. Individuals who receive child welfare services under Title IV-B of the Social Security Act on the basis of being a child in foster care.

   d. Individuals who receive adoption or foster care assistance under Title IV-E of the Social Security Act.

   e. Individuals who receive Social Security Disability Insurance (SSDI).

   f. Children born to a woman who has applied for, has been determined eligible, and is receiving Medical Assistance on the date of the child's birth, as described in 8.100.4.G.5. This includes instances where the labor and delivery services were provided before the date of application and were covered by the Medical Assistance Program as an emergency service based on retroactive eligibility.

      i) A child meeting the criteria described in 8.100.3.H.1.f. shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence at any time in the future, regardless of any subsequent changes in the child's eligibility for Medical Assistance.

      ii) Special Provisions for Retroactive Reversal of a Previous Denial

         1) If a child described at 8.100.3.H.1.f. was previously determined to be ineligible for Medical Assistance solely for failure to meet the citizenship and identity documentation requirements, the denial shall be reversed. Eligibility shall be effective retroactively to the date of the child's birth provided all of the following criteria are met:

            a) The child was determined to be ineligible for Medical Assistance during the period between July 1, 2006 and October 1, 2009 solely for failure to meet the citizenship and identity documentation requirements as they existed during that period;

            b) The child would have been determined to be eligible for Medical Assistance had 8.100.3.H.1.f. and/or

8.100.3.H.1.f.ii.1) been in effect during the period from July 1, 2006 through October 1, 2009; and

c) The child's parent, caretaker relative, or legally appointed guardian or conservator requests that the denial of eligibility for Medical Assistance be reversed. The request may be verbal or in writing.

2) A child for whom denial of eligibility for Medical Assistance has been retroactively reversed shall be subject to the eligibility redetermination provisions described at 8.100.3.Q.1. Such redetermination shall occur twelve months from the retroactive eligibility date determined when the denial was reversed pursuant to this subsection 1.

3) A child granted retroactive eligibility for Medical Assistance shall be subject to the requirements described at 8.100.4.G.5. for continued eligibility.

g. Individuals receiving Medical Assistance during a period of presumptive eligibility.

2. Satisfactory documentary evidence of citizenship or nationality includes the following:

a. Primary Evidence of Citizenship and Identity. The following evidence shall be accepted as satisfactory documentary evidence of both identity and citizenship:

i) A U.S. passport issued by the U.S. Department of State that:

1) includes the applicant or recipient, and

2) was issued without limitation. A passport issued with a limitation may be used as proof of identity, as outlined in 8.100.3.H.3. ~~8.100.53.A2.3.~~

ii) A Certificate of Naturalization (DHS Forms N-550 or N-570) issued by the Department of Homeland Security (DHS) for naturalized citizens.

iii) A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561) issued by the Department of Homeland Security for individuals who derive citizenship through a parent.

iv) A document issued by a federally recognized Indian tribe, evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).

1) Special Provisions for Retroactive Reversal of a Previous Denial

a) For a member of a federally recognized Indian tribe who was determined to be ineligible for Medical Assistance solely for failure to meet the citizenship and identity documentation requirements, the denial of eligibility shall be reversed and eligibility shall be effective as of the date on which the individual was determined to be ineligible provided all of the following criteria are met:

(1) The individual was determined to be ineligible for Medical Assistance on or after July 1, 2006 solely on the basis of not meeting the citizenship and identity documentation requirements as they existed during that period;

(2) The individual would have been determined to be eligible for Medical Assistance had 8.100.3.H.2.a.iv) been in effect on or after July 1, 2006; and

(3) The individual or a legally appointed guardian or conservator of the individual requests that the denial of eligibility for Medical Assistance be reversed. The request may be verbal or in writing.

b) A member of a federally recognized Indian tribe for whom denial of eligibility for Medical Assistance has been retroactively reversed shall be subject to the eligibility redetermination provisions described at 8.100.3.Q.1. Such redetermination shall occur twelve months from the retroactive eligibility date determined when the denial was reversed as provided in this subsection 2.

b. Secondary Evidence of Citizenship. If primary evidence from the list in 8.100.3.H.2.a. is unavailable, an applicant or recipient shall provide satisfactory documentary evidence of citizenship from the list specified in this section to establish citizenship AND satisfactory documentary evidence from the documents listed in section 8.100.3.H.3.~~2.f.~~ to establish identity. Secondary evidence of citizenship includes:

i) A U.S. public birth certificate.

1) The birth certificate shall show birth in any one of the following:

a) One of the 50 States,

b) The District of Columbia,

c) Puerto Rico (if born on or after January 13, 1941),

d) Guam (if born on or after April 10, 1899),

e) The Virgin Islands of the U.S. (if born on or after January 17, 1917),

f) American Samoa,

g) Swain's Island, or

h) The Northern Mariana Islands (NMI) (if born after November 4, 1986 (NMI local time)).

2) The birth record document shall have been issued by the State, Commonwealth, Territory or local jurisdiction.

3) The birth record document shall have been recorded before the person was 5 years of age. A delayed birth record document that is recorded at or after 5 years of age is considered fourth level evidence of citizenship, as described in 8.100.3.H.2.d.

ii) A Certification of Report of Birth (DS-1350) issued by the U.S. Department of State to U.S. citizens who were born outside the U.S. and acquired U.S. citizenship at birth.

iii) A Report of Birth Abroad of a U.S. Citizen (Form FS-240) issued by the U.S. Department of State consular office overseas for children under age 18 at the time of issuance. Children born outside the U.S. to U.S. military personnel usually have one of these.

iv) A Certification of birth issued by the U.S. Department of State (Form FS-545 or DS-1350) before November 1,1990.

v) A U.S. Citizen I.D. card issued by the U.S. Immigration and Naturalization Services (INS):

1) Form I-179 issued from 1960 until 1973, or

2) Form I-197 issued from 1973 until April 7, 1983.

vi) A Northern Mariana Identification Card (I-873) issued by INS to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986.

vii) An American Indian Card (I-872) issued by the Department of Homeland Security with the classification code "KIC."

viii) A final adoption decree that:

1) shows the child's name and U.S. place of birth, or

2) a statement from a State approved adoption agency that shows the child's name and U.S. place of birth. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

ix) Evidence of U.S. Civil Service employment before June 1, 1976. The document shall show employment by the U.S. government before June 1, 1976.

x) U.S. Military Record that shows a U.S. place of birth such as a DD-214 or similar official document showing a U.S. place of birth.

xi) Data verification with the Systematic Alien Verification for Entitlements (SAVE) Program for naturalized citizens.

xii) Child Citizenship Act. Adopted or biological children born outside the United States may establish citizenship obtained automatically under

section 320 of the Immigration and Nationality Act (8 USC § 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000). section 320 of the Immigration and Nationality Act (8 USC § 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000) is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspections from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

Documentary evidence must be provided at any time on or after February 27, 2001, if the following conditions have been met:

1) At least one parent of the child is a United States citizen by either birth or naturalization (as verified under the requirements of this part);

2) The child is under the age of 18;

3) The child is residing in the United States in the legal and physical custody of the U.S. citizen parent;

4) The child was admitted to the United States for lawful permanent residence (as verified through the Systematic Alien Verification for Entitlements (SAVE) Program); and

5) If adopted, the child satisfies the requirements of section 101(b)(1) of the Immigration and Nationality Act (8 USC § 1101(b)(1)) pertaining to international adoptions (admission for lawful permanent residence as IR-3 (child adopted outside the United States)), or as IR-4 (child coming to the United States to be adopted) with final adoption having subsequently occurred. 8 USC § 1101(b)(1) is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspections from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

c. Third Level Evidence of U.S. Citizenship. Third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when neither primary nor secondary evidence is available. Third level evidence shall be used only when primary evidence cannot be obtained within 10 business days, secondary evidence does not exist or cannot be obtained, and the applicant or recipient alleges being born in the U.S. A second document from the list in 8.100.3.H.3.~~2.f~~ to establish identity shall also be presented.

i) Extract of a hospital record on hospital letterhead.

1) The record shall have been established at the time of the person's birth;

2) The record shall have been created at least 5 years before the initial application date; and

3) The record shall indicate a U.S. place of birth;

4) For children under 16 the document shall have been created near the time of birth or at least 5 years before the date of application.

5) Souvenir "birth certificates" issued by a hospital are not acceptable.

ii) Life, health, or other insurance record.

1) The record shall show a U.S. place of birth; and

2) The record shall have been created at least 5 years before the initial application date.

3) For children under 16 the document must have been created near the time of birth or at least 5 years before the date of application.

iii) Religious record.

1) The record shall have been recorded in the U.S. within 3 months of the date of the individual's birth;

2) The record shall show that the birth occurred in the U.S.;

3) The record shall show either the date of birth or the individual's age at the time the record was made; and

4) The record shall be an official record recorded with the religious organization.

iv) Early school record that meets the following criteria:

1) The school record shows the name of the child;

2) The school record shows the child's date of admission to the school;

3) The school record shows the child's date of birth;

4) The school record shows a U.S. place of birth for the child; and

5) The school record shows the name(s) and place(s) of birth of the applicant's parents.

d. Fourth Level Evidence of Citizenship. Fourth level evidence of citizenship is documentary evidence of the lowest reliability. Fourth level evidence shall only be used in the rarest of circumstances. This level of evidence is used only when primary evidence is unavailable, both secondary and third level evidence do not exist or cannot be obtained within 10 business days, and the applicant alleges

U.S. citizenship. The affidavit process described in 8.100.3.H.2.d.ii.5. may be used by U.S. citizens or nationals born inside or outside the U.S. In addition, a second document establishing identity shall be presented as described in 8.100.3.H.3.

i) Federal or State census record showing U.S. citizenship or a U.S. place of birth and the applicant's age.

ii) One of the following documents that shows a U.S. place of birth and was created at least 5 years before the application for The Medical Assistance Program. For children under 16 the document must have been created near the time of birth or at least 5 years before the date of application.

1) Seneca Indian tribal census record;

2) Bureau of Indian Affairs tribal census records of the Navajo Indians;

3) U.S. State Vital Statistics official notification of birth registration;

4) A delayed U.S. public birth record that is recorded more than 5 years after the person's birth;

5) Statement signed by the physician or midwife who was in attendance at the time of birth; or

6) The Roll of Alaska Natives maintained by the Bureau of Indian Affairs.

iii) Institutional admission papers from a nursing facility, skilled care facility or other institution created at least 5 years before the initial application date that indicate a U.S. place of birth.

iv) Medical (clinic, doctor, or hospital) record.

1) The record shall have been created at least 5 years before the initial application date; and

2) The record shall indicate a U.S. place of birth.

3) An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.

4) For children under 16 the document shall have been created near the time of birth or at least 5 years before the date of application.

v) Written affidavit. Affidavits shall only be used in rare circumstances. They may be used by U.S. citizens or nationals born inside or outside the U.S. If documentation is by affidavit, the following rules apply:

1) There shall be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's

or recipient's claim of citizenship (the two affidavits could be combined in a joint affidavit);

2) At least one of the individuals making the affidavit cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient;

3) In order for the affidavit to be acceptable the persons making them shall provide proof of their own U.S. citizenship and identity.

4) If the individual(s) making the affidavit has (have) information which explains why documentary evidence establishing the applicant's claim of citizenship does not exist or cannot be readily obtained, the affidavit shall contain this information as well;

5) The applicant/recipient or other knowledgeable individual (guardian or representative) shall provide a separate affidavit explaining why the evidence does not exist or cannot be obtained; and

6) The affidavits shall be signed under penalty of perjury pursuant to 18 U.S.C. §1641 and Title 18 of the Criminal Code article 8 part 5 and need not be notarized.

e. Evidence of Citizenship for Collectively Naturalized Individuals. If a document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. A second document from 8.100.3.H.3.~~8.100.53.A2.3.~~ to establish identity shall also be presented.

i) Puerto Rico:

1) Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; OR

2) Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

ii) US Virgin Islands:

1) Evidence of birth in the U.S. Virgin Islands, and the applicant's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; OR

2) The applicant's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; OR

3) Evidence of birth in the U.S. Virgin Islands and the applicant's statement indicating residence in the U.S., a U.S. possession or Territory or the Canal Zone on June 28, 1932.

iii) Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

1) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); OR

2) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); OR

3) Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).

4) If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile, and the individual is not a U.S. citizen.

3. The following documents shall be accepted as proof of identity and shall accompany a document establishing citizenship from the groups of documentary evidence outlined in 8.100.3.H.2.b. through e.

a) A driver's license issued by a State or Territory either with a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;

b) School identification card with a photograph of the individual;

c) U.S. military card or draft record;

d) Identification card issued by the Federal, State, or local government with the same information included on driver's licenses;

e) Military dependent's identification card;

f) U.S. Coast Guard Merchant Mariner card;

g) Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual. The document is acceptable if it carries a photograph of the individual or has other personal identifying information relating to the individual such as age, weight, height, race, sex, and eye color; or

h) Three or more documents that together reasonably corroborate the identity of an individual provided such documents have not been used to establish the

individual's citizenship and the individual submitted evidence of citizenship listed under 8.100.3.H.2.b. or 8.100.3.H.2.c. The following requirements must be met:

i) No other evidence of identity is available to the individual;

ii) The documents must at a minimum contain the individual's name, plus any additional information establishing the individual's identity; and

iii) All documents used must contain consistent identifying information.

iv) These documents include, but are not limited to, employer identification cards, high school and college diplomas from accredited institutions (including general education and high school equivalency diplomas), marriage certificates, divorce decrees, and property deeds/titles.

i) Special identity rules for children. For children under 16, the following records are acceptable:

i) Clinic, doctor, or hospital records; or

ii) School records.

1) The school record may include nursery or daycare records and report cards; and

2) The school, nursery, or daycare record must be verified with the issuing school, nursery, or daycare.

3) If clinic, doctor, hospital, or school records are not available, an affidavit may be used if it meets the following requirements:

a) It shall be signed under penalty of perjury by a parent or guardian;

b) It shall state the date and place of birth of the child; and

c) It cannot be used if an affidavit for citizenship was provided.

d) The affidavit is not required to be notarized.

e) An affidavit may be accepted on behalf of a child under the age of 18 in instances when school ID cards and drivers' licenses are not available to the individual until that age.

j) Special identity rules for disabled individuals in institutional care facilities.

i) An affidavit may be used for disabled individuals in institutional care facilities if the following requirements are met:

1) It shall be signed under penalty of perjury by a residential care facility director or administrator on behalf of an institutionalized individual in the facility; and

2) No other evidence of identity is available to the individual.

3) The affidavit is not required to be notarized.

k) Expired identity documents.

i) Identity documents do not need to be current to be acceptable. An expired identity document shall be accepted as long as there is no reason to believe that the document does not match the individual.

4. Documentation Requirements

a. Effective January 1, 2008, all citizenship and identity documents must either be originals or copies certified by the issuing agency, except as provided in 8.100.3.H.4.b. Uncertified copies, including notarized copies, are not acceptable.

b. Individuals who submitted notarized copies of citizenship and identity documents as part of an application or redetermination before January 1, 2008 shall not be required to submit originals or copies certified by the issuing agency for any application or redetermination processed on or after January 1, 2008.

c. All citizenship and identity documents shall be presumed to be genuine unless the authenticity of the document is questionable.

d. Individuals shall not be required to submit citizenship and identity documentation in person. Documents shall be accepted from a Medical Assistance applicant or client or from his or her guardian or authorized representative in person or by mail.

i) Individuals are strongly encouraged to use alternatives to mailing original documents to counties, such as those described in 8.100.3.H.4.e.

e. Individuals may present original citizenship and identity documents or copies certified by the issuing agency to Medical Assistance (MA) sites, School-based Medical Assistance sites, Presumptive Eligibility (PE) sites, Federally Qualified Health Centers (FQHCs), Disproportionate Share Hospitals (DSHs), or any other location designated by the Department by published agency letter.

i) Staff at these locations shall make a copy of the original documents and shall complete a "Citizenship and Identity Documentation Received" form, stamp the copy, or provide other verification that identifies that the documents presented were originals. The verification shall include the name, telephone number, organization name and address, and signature of the individual who reviewed the document(s). This form, stamp, or other verification shall be attached to or directly applied to the copy.

ii) Upon request by the client or eligibility site, the copy of the original document with the "Citizenship and Identity Documentation Received" form, stamp, or other verification as described in 8.100.3.H.4.e.i)~~1~~ shall be mailed or delivered directly to the eligibility site within five business days.

f. Counties shall accept photocopies of citizenship and identity documents from any location described in 8.100.3.H.4.e provided the photocopies include the form, stamp, or verification described in 8.100.3.H.4.e.i). ~~8.100.53.A2.4.e.1.~~

g. Counties shall develop procedures for handling original citizenship and identity documents to ensure that these documents are not lost, damaged, or destroyed.

i) Upon receiving the original documents, eligibility site staff shall make a copy of the original documents and shall complete a "Citizenship and Identity Documentation Received" form, stamp the copy, or provide other verification that identifies that the documents presented were originals, as described in 8.100.3.H.4.e.i)~~1~~. This form, stamp, or other verification shall be attached to or directly applied to the copy.

ii) The original documents shall be sent by mail or returned to the individual in person within five business days of the date on which they were received.

iii) To limit the risk of original documents being lost, damaged, or destroyed, counties are strongly encouraged to make copies of documents immediately upon receipt and to return original documents to the individual while he or she is present.

h. Once an individual has provided the required citizenship and identity documentation, he or she shall not be required to submit the documentation again unless:

i) Later evidence raises a question about the individual's citizenship or identity; or

ii) There is a gap of more than five years between the ending date of the individual's last period of eligibility and a subsequent application for The Medical Assistance Program and the eligibility site has not retained the citizenship and identity documentation the individual previously provided.

5. Record Retention Requirements

a. The eligibility site shall retain a paper or electronically scanned copy of an individual's citizenship and identity documentation, including any verification described in 8.100.3.H.4.e.i)~~1~~, for at least five years from the ending date of the individual's last period of Medical Assistance eligibility.

6. Name Change Provisions

a. An individual who has changed his or her last name for reasons including, but not limited to, marriage, divorce, or court order shall not be required to produce any additional documentation concerning the name change unless:

i) With the exception of the last name, the personal information in the citizenship and identity documentation provided by the individual does not match in every way;

ii) In addition to changing his or her last name, the individual also changed his or her first name and/or middle name; or

iii) There is a reasonable basis for questioning whether the citizenship and identity documents belong to the same individual.

7. Reasonable Level of Assistance

a. The eligibility site shall provide a reasonable level of assistance to applicants and clients in obtaining the required citizenship and identity documentation.

b. Examples of a reasonable level of assistance include, but are not limited to:

i) Providing contact information for the appropriate agencies that issue the required documents;

ii) Explaining the documentation requirements and how the client or applicant may provide the documentation; or

iii) Referring the applicant or client to other agencies or organizations which may be able to provide further assistance.

c. The eligibility site shall not be required to pay for the cost of obtaining required documentation.

8. Individuals Requiring Additional Assistance

a. The eligibility site shall provide additional assistance beyond the level described in 8.100.3.H.7 to applicants and clients in obtaining the required citizenship and identity documentation if the client or applicant:

i) Is unable to comply with the requirements due to physical or mental impairments or homelessness; and

ii) The individual lacks a guardian or representative who can provide assistance.

b. Examples of additional assistance include, but are not limited to:

i) Contacting any known family members who may have the required documentation;

ii) Contacting any known current or past health care providers who may have the required documentation; or

iii) Contacting other social services agencies that are known to have provided assistance to the individual.

c. The eligibility site shall document its efforts to provide additional assistance to the client or applicant. Such documentation shall be subject to the record retention requirements described in 8.100.3.H.5.a.

9. Reasonable Opportunity Period

a. If a Medical Assistance applicant or recipient does not have the required documentation, he or she must be given a reasonable opportunity period to provide the required documentation. If the applicant or recipient does not provide the required documentation within the reasonable opportunity period, then:

i) the applicant's Medical Assistance application shall be denied, or

ii) the recipient's Medical Assistance benefits shall be terminated.

b. The reasonable opportunity period for Family Programs covered under 8.100.3.H is 14 calendar days. For the purpose of this section, Family Programs are defined as the following:

Commonly Used Program Name	Rule Citation
1931 Medical Assistance	8.100.4.G.2
Transitional Medical Assistance	8.100.4.I.1-7
Four Month Extended Medical Assistance	8.100.4.I.8
Institutionalized under age 21	8.100.4.H.1.a
Parents Plus Program	8.100.4.G.8
Qualified Child	8.100.4.G.6
Expanded Child	8.100.4.G.6
Ribicoff Child	8.100.4.G.7
Qualified Pregnant	8.100.4.G.9
Expanded Pregnant	8.100.4.G.9

c. The reasonable opportunity period for Adult Programs covered under 8.100.3.F. ~~8.100.53.A2~~ is 70 calendar days. For the purpose of this rule, Adult Programs are defined as the following:

Commonly Used Program Name	Rule Citation
Old Age Pension A (OAP-A)	8.100.3.F.1.c
Old Age Pension B (OAP-B)	8.100.3.F.1.c
Qualified Disabled Widow/Widower	8.100.3.F.1.e
Pickle	8.100.3.F.1.e
Long-Term Care	8.100.3.F.1.f-h
Breast and Cervical Cancer Program (BCCP)	8.715

10. Good Faith Effort

a. In some cases, a Medical Assistance client or applicant may not be able to obtain the required documentation within the applicable reasonable opportunity period. If the client or applicant is making a good faith effort to obtain the required documentation, then the reasonable opportunity period should be extended. The amount of time given should be determined on a case-by-case basis and should be based on the amount of time the individual needs to obtain the required documentation.

Examples of good faith effort include, but are not limited to:

i) Providing verbal or written statements describing the individual's effort at obtaining the required documentation;

ii) Providing copies of emails, letters, applications, checks, receipts, or other materials sent or received in connection with a request for documentation; or

iii) Providing verbal or written statements of the individuals' efforts at identifying people who could attest to the individual's citizenship or identity, if citizenship and/or identity are included in missing documentation.

An individual's verbal statement describing his or her efforts at securing the required documentation should be accepted without further verification unless the accuracy or truthfulness of the statement is questionable. The individual's good faith efforts should be documented in the case file and are subject to all record retention requirements.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medicaid Rules Concerning the Nature of the Department's Agreements with Health Care Providers
Rule Number:	MSB 09-04-27-A
Division / Contact / Phone:	Legal / Jennifer Evans / 5499

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-04-27-A, Revisions to the Medicaid Rules Concerning the Nature of the Department's Agreements with Health Care Providers
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.040, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text beginning at §8.040 RECOVERIES FROM PROVIDERS through the end of through the end of §8.042 "Electronically submitted claims must have a certification field indicating that the sender has verified that the claim information transmitted is true and correct. A hard copy of this transmittal will be kept on file at the provider's or billing service's place of business. All claim transmissions which require a state authorized attachment for the purposes of reimbursement or certification of service, will be submitted on hard copy (i.e., paper) and maintained with the providers' original source documents for a period of six years." **With the new text attached.**

This rule change is effective 07/30/2009

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medicaid Rules Concerning the Nature of the Department's Agreements with Health Care Providers
Rule Number:	MSB 09-04-27-A
Division / Contact / Phone:	Legal / Jennifer Evans / 5499

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).

   Making clear that under the circumstances described in the rule the Department provides an open invitation to providers to enter into agreements for the provision of services to the populations served by the Department's programs will clarify for providers the terms of these agreements under state law.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 USC §1396a(a)(5)
   42 CFR 431.10(e)
   42 CFR 431.107(b)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);
   25.5-4-104(1), C.R.S. (2008); 25.5-1-104(4), C.R.S. (2008); 25.5-1-201(1)(a), C.R.S. (2008)

Initial Review		Final Adoption	**06/12/2009**
Proposed Effective Date	**07/30/2009**	Emergency Adoption	

DOCUMENT #06

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medicaid Rules Concerning the Nature of the Department's Agreements with Health Care Providers
Rule Number:	MSB 09-04-27-A
Division / Contact / Phone:	Legal / Jennifer Evans / 5499

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.

   The proposed rule is not expected to result in any cost to any class of persons. It is expected to benefit clients, as it will help preserve provider enrollment in the Medicaid program.

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

   It is not possible to quantify the net effect of the proposed rule changes because the Department does not have any data on the number of providers who have not enrolled in the Medicaid program or who may disenroll from the Medicaid program due to the uncertainty resulting from the absence of rules addressing the nature of their agreements with the Department.

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.

   Implementation and enforcement of the proposed rule is not expected to have any cost to the Department or to any other state agency. It is not expected to have any effect on state revenues.

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

   Inaction could potentially cause a decrease in client access to health care providers and health care services.

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 methods 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.

8.040 RECOVERIES FROM PROVIDERS [Eff. 12/30/2008]

In the event that an audit or other competent evidence (e.g. information provided by another government agency) reveals that a provider is indebted to the State for any reason, the Department shall recover this amount either through a repayment agreement with the provider; or by offsetting the amount owed against current and future claims of the provider; or through litigation; or by any other appropriate action within its legal authority.

Providers shall have the right to appeal pursuant to the provisions of 8.050.

8.040.1 ENROLLMENT OF PROVIDERS

Before claims can be accepted for payment for goods and services provided to eligible clients, the provider of goods and services shall be enrolled in the Medical Assistance program and assigned a provider number.

8.040.1.5 NATURE OF DEPARTMENT'S AGREEMENTS WITH HEALTH CARE PROVIDERS

A. Pursuant to its authority under 25.5-1-104(4), C.R.S. and 25.5-1-201(1)(a), C.R.S., the Department enters into agreements with qualified health care providers for the provision of and payment for medical care, goods, and services to eligible persons. The Department has extended, and continues to extend, an open invitation to all qualified health care providers to enter into such agreements. This regulation clarifies that the Department's duty to comply with federal law requires that it enter into agreements with qualified health care providers to create a mechanism for payment to those providers, be they individuals or entities, who provide goods to or perform services for the eligible persons served by the Department's programs.

B. Each qualified provider that enters into a "qualified agreement" shall be deemed to have participated in an open, public invitation (to more than three parties) to provide services to the eligible persons served by the Department's programs.

C. For the purposes of this regulation, a "qualified agreement" means an agreement for the provision of or payment for medical care, goods, or services, to the eligible persons served by the Department's programs, by and between the Department and a qualified health care provider and, for these purposes, a "qualified health care provider" means an individual or an entity that:

1) Has been assigned a Medicaid provider number for the purpose of allowing a payment through the Medicaid Management Information System;

2) Has been assigned a CHP+ provider number; or

3) Is otherwise approved by the Department to receive payments for the provision of medical care, goods, or services through the Department's fiscal agent(s).

8.040.2 SUBMISSION OF CLAIMS

Effective July 1, 1994, all Medical Assistance program providers shall be required to transmit in an approved electronic format to the fiscal agent for the Department all claims for goods and services which are benefits of the Medical Assistance program provided to eligible clients. Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department.

A transaction fee shall be required for each electronic claim transmission. This transaction fee shall be collected from the provider against current and future claims of the provider through a reduction in claim reimbursement and shall be so described on the Medicaid Remittance Statement.

Required information concerning the recipient, the service, charges, and provider shall be submitted in the prescribed format. Records verifying the type of service provided, the signed state approved certification statements and agreements which serve as a contractual basis for payment, and required client information or additional documentation which can be matched to the claim for services shall be retained in the provider's file for six years. This documentation shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the Department, and the Medicaid Fraud Control Unit and their authorized agents.

A. Hard Copy Claims

Hard copy (i.e., paper) claim forms shall be submitted only by authorization of the Department. The state approved certification statements contained on the claim form become effective and serve as a contractual basis for payment when the provider signs the form.

B. Automated Medical Payments System/Electronic Transfer of Claims

All providers shall be required to transmit claims for goods and services in the approved electronic format to the fiscal agent for the Department. Only those electronic formats which have been approved by the fiscal agent will be accepted for Automated Medical Payments System.

Before a provider can submit claims electronically, either directly to the fiscal agent or through a vendor or billing service, state approved provider certification agreements which contain all state approved certification statements and conditions shall be signed and accepted by both the provider and the Department. The state approved certification statements become effective and serve as a contractual basis for payment once the provider signs the form. A billing service shall also have a state approved billing service agreement signed and accepted by the Department before any claims will be accepted. The content of the agreements shall be determined by the Department.

If a provider chooses to submit claims for payment directly to the fiscal agent, source documents and source records used to create the claims shall be maintained in such a way that all electronic media claims can be readily associated and identified. These source documents, in addition to any work papers and records used to create electronic media claims, shall be retained by the provider for six years and shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the Department, and the Medicaid Fraud Control Unit and their authorized agents.

A corporation composed of satellite facilities with a common ownership may be considered as a primary provider and bill as such even though each individual facility has a provider number. However, the submitted claims shall identify the facility providing the services. Original source documents used to create the claims transmission shall be maintained at the facility for six years.

If a provider utilizes a billing service to transmit claims, the provider shall provide source documents and any other data transfer materials necessary to create the electronic claim. The billing service shall retain the source documents and data transfer materials for a six year period except when these items are maintained by the provider. Original source documents and data transfer materials shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the Department, and the Medicaid Fraud Control Unit and their authorized agents. If the provider furnishes the information to the billing service on a computer disc or some other method of electronic transmission, then the source documents used to create the disc or transmission shall be retained by the provider for six years and made readily available and produced upon request.

If the billing service goes out of business, then upon cessation of business, the billing service shall immediately return all documents to each individual provider.

Upon receipt of the electronic transmission, the fiscal agent will process the claims to the M.M.I.S. If the transmission is rejected, the fiscal agent shall send an electronic acknowledgement of rejection to the sender. Claims denied through the M.M.I.S. shall be described on the Medicaid remittance statement.

Electronic transmission of claims shall be required of any provider or billing service. The Department also reserves the right to reject any electronic claims transmission methods.

Failure of the provider or billing service to maintain and certify appropriate records as required by the state approved provider agreements constitutes breach of the state approved provider agreement, and entitles the Department to recover any payments for goods and services made to the provider and to terminate any state approved provider agreement. Thirty day written notice by registered mail shall be used by either party to terminate a state approved provider agreement unless the Department determines that good cause as defined in 8.076.1.7. exists in which immediate termination is necessary. Recovery may be accomplished by withholding the amount from future payments or requiring the provider to make payments directly to the Department as described in 8.040.

Electronically submitted claims must have a certification field indicating that the sender has verified that the claim information transmitted is true and correct. A hard copy of this transmittal will be kept on file at the provider's or billing service's place of business. All claim transmissions which require a state authorized attachment for the purposes of reimbursement or certification of service, will be submitted on hard copy (i.e., paper) and maintained with the providers' original source documents for a period of six years.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to Provider Participation Rules to Require Providers to Screen Employees and Contractors for Excluded Individuals and Entities
Rule Number:	MSB 09-02-03-A
Division / Contact / Phone:	Legal / Nancy Downes / 5241 and Brian Zolynas 2814

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-02-03-A, Revisions to Provider Participation Rules to Require Providers to Screen Employees and Contractors for Excluded Individuals and Entities
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.130, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please insert new text provided - **§8.130.35 SCREENING FOR EXCLUDED EMPLOYEES AND CONTRACTORS** - after current text at §8.130.3.D. "Providers shall provide education for staff and the patient/client community on issues concerning advance directives." and before text at **§8.130.4 TERMINATION.**

This rule change is effective 07/30/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to Provider Participation Rules to Require Providers to Screen Employees and Contractors for Excluded Individuals and Entities
Rule Number:	MSB 09-02-03-A
Division / Contact / Phone:	Legal / Nancy Downes / 5241 and Brian Zolynas 2814

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).

   The purpose of this rule is to revise the requirements for provider participation in the Medicaid program to include provisions outlining a provider's obligation to determine whether any of the provider's employees or contractors have been excluded from participation in the Medicaid program by the US Department of Health and Human Services Office of the Inspector General. The change is necessary to comply with instructions from the Centers for Medicare and Medicaid Services outlined in a letter to state Medicaid directors dated January 16, 2009.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 1001.1901(b)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);
   25.5-4-301(2)

Initial Review	**05/08/2009**	Final Adoption	**06/12/2009**
Proposed Effective Date	**08/01/2009**	Emergency Adoption	

DOCUMENT #07

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to Provider Participation Rules to Require Providers to Screen Employees and Contractors for Excluded Individuals and Entities
Rule Number:	MSB 09-02-03-A
Division / Contact / Phone:	Legal / Nancy Downes / 5241 and Brian Zolynas 2814

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.

   The proposed changes will affect providers enrolled in the Medicaid program. Providers will benefit from the proposed rules, as the rules outline the steps a provider can take to avoid the risk of federal civil monetary penalties for employing individuals or contractors who have been excluded from participation in Medicaid by the US Department of Health and Human Services Office of the Inspector General.

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

   The Department does not have data on the number of providers enrolled in the Colorado Medicaid program who have been subject to federal civil monetary penalties as a result of employing or contracting with individuals or entities that have been excluded from participation in the Medicaid program. As a result, it is not possible to estimate the amount of civil monetary penalties providers could avoid by complying with the proposed rule.

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.

   Implementation and enforcement of the proposed rule is not expected to result in any cost or have any effect on state revenues.

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

   Inaction would result in the Department not being in compliance with the instructions from the Centers for Medicare and Medicaid Services outlined in their January 16, 2009 letter to state Medicaid directors.

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 rules.

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 rules.

8.130 PROVIDER PARTICIPATION

8.130.3.D. Providers shall provide education for staff and the patient/client community on issues concerning advance directives.

8.130.35 SCREENING FOR EXCLUDED EMPLOYEES AND CONTRACTORS

A. As a condition of enrollment in the medical assistance program, each provider shall comply with the following requirements for screening for employees and contractors who have been excluded from participation in Medicaid and Medicare by the US Department of Health & Human Services Office of Inspector General:

1. Each provider shall utilize the US Department of Health & Human Services Office of Inspector General's List of Excluded Individuals/Entities (www.oig.hhs.gov) to determine if a prospective employee or newly signed contractor has been excluded from participation in Medicaid.

a. Such screening should be performed within five (5) business days of the date on which the new employee was hired or new contractor was signed.

2. Each provider shall screen its employees and contractors against the List of Excluded Individuals/Entities at least monthly to capture any exclusions or reinstatements that have occurred since the last search of the database.

3. If a provider determines that an employee or contractor of the provider has been excluded, then the provider shall report this to the Department within five (5) business days of the date of discovery.

B. Except as otherwise provided in federal law, if the Medical Assistance program pays for any goods or services furnished, ordered, or prescribed by an excluded individual or entity that is employed by or has contracted with a provider, such payment shall constitute an overpayment, as defined at 8.076.1.8. and shall be subject to the overpayment recovery provisions of 8.076.3. if the provider knew or should have known of the exclusion. Such provider may also be subject to sanctions by the Department including the termination of the provider agreement, as described at 8.076.5. The provider may also be subject to civil and monetary penalties imposed by the Department of Health and Human Services.

1. To the extent that such amount can be traced, the amount of the overpayment shall include any funds expended by the Medical Assistance program to pay the excluded individual's or contractor's salary, expenses, or fringe benefits.

C. Subject to federal law and the Department's discretion, failure of provider to comply with the screening requirements listed at 8.130.35.A. may constitute good cause sufficient to justify termination of the provider agreement, as described at 8.076.5.

8.130.4 TERMINATION