Rule Summary and Fiscal Analysis
Part A - General Questions

Rule Number: 5160-1-17.4

Rule Type: Amendment

Rule Title/Tagline: Revalidation of provider agreements.

Agency Name: Ohio Department of Medicaid

Division:

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I. Rule Summary

1. **Is this a five year rule review?** Yes

   A. **What is the rule's five year review date?** 1/29/2021

2. **Is this rule the result of recent legislation?** No

3. **What statute is this rule being promulgated under?** 119.03

4. **What statute(s) grant rule writing authority?** 5164.02; 5164.32

5. **What statute(s) does the rule implement or amplify?** 5162.03; 5164.02; 5164.32

6. **What are the reasons for proposing the rule?**

   OAC rule 5160-1-17.4, entitled "Revalidation of provider agreements," is being proposed for amendment to extend flexibilities to address the pandemic as well as to create options to reduce costs for the department.

7. **Summarize the rule's content, and if this is an amended rule, also summarize the rule's changes.**

   The rule sets forth substantive and procedural policies for how and when a provider will revalidate its provider agreement with the department and the consequences for failure to revalidate in a timely manner. This rule also addresses how a delay by a

governmental entity impacts a revalidation application, the effective date of the new provider agreement, hearing rights and on-site reviews.

This rule provides the process ODM follows when notifying providers that revalidation is required, identifies the methods in which the provider will be contacted and what type of information will be included in the notice. This rule requires the provider to submit all required information and any applicable fees before the revalidation deadline specified in the notice. This rule prohibits providers from revalidating their agreement prior to receiving a revalidation notice and confirms the reporting of changes is the provider's responsibility and does not constitute the initiation of revalidation.

This rule addresses the potential penalties when the provider fails to revalidate or does not revalidate in a timely manner. This rule describes circumstances under which providers may continue operating under an expired provider agreement, and the impact of not timely obtaining renewal of licensure, certification, accreditation or registration due to delay in processing renewals by another government entity.

Related topics such as how agreement effective dates are determined, provider hearing rights afforded, and on-site reviews of providers are addressed in this rule.

This rule requires provider agreements to be revalidated when the risk level of a provider changes or no later than five years from the effective date of the most current provider agreement.

The changes to this rule are to allow for the Centers for Medicare and Medicaid Services (CMS) to waive or modify the federally mandated timeline for revalidation of provider agreements such as during a state of emergency. Language concerning revalidation timeframes related to licensure and certification was removed due to no longer being applicable. Also, the requirement that the department send the notices of an upcoming revalidation by regular mail was expanded to allow the notification to occur via email as well as updating an outdated reference to the CFR.

8. **Does the rule incorporate material by reference?** Yes

9. **If the rule incorporates material by reference and the agency claims the material is exempt pursuant to R.C. 121.75, please explain the basis for the exemption and how an individual can find the referenced material.**

This rule incorporates one or more references to another rule or rules of the Ohio Administrative Code. This question is not applicable to any incorporation by reference to another Ohio Administrative Code rule because such reference is exempt from compliance with RC 121.71 to 121.74 pursuant to RC 121.75(A)(1)(d).

This rule incorporates one or more dated references to the Code of Federal Regulations (CFR). This question is not applicable to any dated incorporation by reference to the CFR because such reference is exempt from compliance with RC 121.71 to 121.74 in accordance with RC 121.75(A)(2)(d).

10. If revising or re-filing the rule, please indicate the changes made in the revised or re-filed version of the rule.

The language in paragraph (A) concerning the Center for Medicare and Medicaid Services (CMS) modification or waiver of provider agreement deadlines was revised to clarify that the Ohio Department of Medicaid may choose whether to implement this CMS authorized deadline change.

II. Fiscal Analysis

11. Please estimate the increase / decrease in the agency's revenues or expenditures in the current biennium due to this rule.

This will decrease revenues.

$12,600

The email notification option will result in savings on printing and postage costs to the department.

12. What are the estimated costs of compliance for all persons and/or organizations directly affected by the rule?

Rule 5160-1-17.4 requires Ohio Medicaid providers to renew and revalidate its provider agreement every five years or sooner when certain circumstances apply. This rule requires provider agreements to be revalidated when the risk level of a provider changes or no later than five years from the effective date of the most current provider agreement barring waiver or modification by CMS.

This rule requires the provider to meet all conditions for participation as an eligible provider and submit all required information and any applicable fees before the revalidation deadline specified in the notice.

The information, documentation, and fees required in the revalidation process will vary based on provider type and whether it is for an individual provider, group practice or a facility-based provider. Individual providers are not subject to an application fee while institutional and group providers are required to pay a $595 application fee. This

fee may be waived if certain exemptions apply and the required documentation of evidence is provided. The reporting of the re-enrollment information may require the individual or staff to gather necessary documentation to be reported and submitted with the re-enrollment application.

According to the Bureau of Labor Statistics, the average salary (with fringe benefits) for a First-Line Supervisor of a Physician's Office is $57,240. Based on this figure, the estimated ten (10) minutes it takes to complete the revalidation application, report information, or provide documentation would cost the provider approximately $4.59 to revalidate the provider agreement. This cost would be incurred once during a period not to exceed every five (5) years unless the provider has changes to report before the next revalidation period.

For providers who fail to timely and properly revalidate, this rule indicates what actions ODM may take including denying the re-enrollment application and terminating the provider agreement. The cost of this sanction will vary by provider. It will depend on the number of Medicaid recipients being served in the facility as the facility will no longer be eligible to receive reimbursement from ODM for services provided to Medicaid recipients.

This rule requires providers to disclose any changes to its existing provider agreement in accordance with Administrative Code rule 5160-1-17.3. The reporting of changes that occur to an existing provider agreement may result in additional administrative costs that will vary based on the provider type and required changes. The costs will be determined by the amount of time required to disclose the changes and the hourly rate of the disclosing employee.

As part of the revalidation process, providers may be subject to an on-site review at the provider's facility, place of business, or both, as ODM deems necessary to ensure program integrity.

The provider may experience additional administrative costs in this case. These costs may include staff time required to prepare for on-site review and staff time lost if the reviewer requires a provider representative to be present or available during the review to answer the reviewer's questions and provide information needed for the review. The exact cost cannot be quantified because it will vary greatly depending on the circumstances of the on-site review but will include the time to gather and provide the information requested, the time to complete the review and the personnel required to assist.

13. **Does the rule increase local government costs? (If yes, you must complete an RSFA Part B).** Yes

14. **Does the rule regulate environmental protection? (If yes, you must complete an RSFA Part C).** No

15. **If the rule imposes a regulation fee, explain how the fee directly relates to your agency's cost in regulating the individual or business.**

    The revalidation application fee is directly used to fund enrollment and screening staff for the purpose of preventing fraud and ensuring the safety of Ohio Medicaid recipients.

III. Common Sense Initiative (CSI) Questions

16. **Was this rule filed with the Common Sense Initiative Office?** Yes

17. **Does this rule have an adverse impact on business?** Yes

    A. **Does this rule require a license, permit, or any other prior authorization to engage in or operate a line of business?** Yes

    A Medicaid provider cannot operate without a provider agreement and the provider agreement must be revalidated every five years, or sooner when certain circumstances apply. This rule requires provider agreements to be revalidated when the risk level of a provider changes or no later than five years from the effective date of the most current provider agreement.

    B. **Does this rule impose a criminal penalty, a civil penalty, or another sanction, or create a cause of action, for failure to comply with its terms?** Yes

    This rule requires providers that want to continue to participate in the Medicaid program to revalidate their provider agreement. If they should fail to comply with the requirements as prescribed in the rule, ODM will deny the application for revalidation and terminate their provider agreement.

    C. **Does this rule require specific expenditures or the report of information as a condition of compliance?** Yes

    This rule requires providers to submit information to the department in order to revalidate a Medicaid provider agreement. This rule requires providers to disclose any changes to its existing provider agreement in accordance with Administrative Code rule 5160-1-17.3. In addition, there is a revalidation fee at the time of revalidation. The department began collecting this fee in March, 2013. The fee applies to organizational providers only; it does not apply to

individual providers and practitioners or practitioner groups. This fee will not be required if the revalidating organizational provider has paid the fee to either Medicare or another state's Medicaid provider enrollment within the past two years. The fee for 2020 is $595 per application.

D. Is it likely that the rule will directly reduce the revenue or increase the expenses of the lines of business of which it will apply or applies? Yes

The expenses would increase for providers that are subject to the application fee and on-site review. These expenses are not new and should already be incorporated into provider's cost or running the lines of business subject to these fees. These are federally mandated requirements to prevent fraud and support program integrity efforts.

IV. Regulatory Restrictions (This section only applies to agencies indicated in R.C. 121.95 (A))

18. Are you adding a new or removing an existing regulatory restriction as defined in R.C. 121.95? Yes

A. How many new regulatory restrictions do you propose adding? 0

B. How many existing regulatory restrictions do you propose removing? 1

(A) ...If a provider's license or certification from its licensing board expires less than five years from the effective date of its provider agreement, the provider agreement must be revalidated prior to the expiration of the license or certification...

Rule Summary and Fiscal Analysis
Part B - Local Governments Questions

1. **Does the rule increase costs for:**

A. Public School Districts	Yes
B. County Government	Yes
C. Township Government	Yes
D. City and Village Governments	Yes

2. **Please estimate the total cost, in dollars, of compliance with the rule for the affected local government(s). If you cannot give a dollar cost, explain how the local government is financially impacted.**

This rule requires Ohio Medicaid providers to renew and revalidate its provider agreement every five years or sooner when certain circumstances apply. This rule requires provider agreements to be revalidated when the risk level of a provider changes or no later than five years from the effective date of the most current provider agreement barring waiver or modification by CMS.

This rule requires the provider to meet all conditions for participation as an eligible provider and submit all required information and any applicable fees before the revalidation deadline specified in the notice.

The information, documentation, and fees required in the revalidation process will vary based on provider type and whether it is for an individual provider, group practice or a facility-based provider. Individual providers are not subject to an application fee while institutional and group providers are required to pay a $595 application fee. This fee may be waived if certain exemptions apply and the required documentation of evidence is provided. The reporting of the re-enrollment information may require the individual or staff to gather necessary documentation to be reported and submitted with the re-enrollment application.

According to the Bureau of Labor Statistics, the average salary (with fringe benefits) for a First-Line Supervisor of a Physician's Office is $57,240. Based on this figure, the estimated ten (10) minutes it takes to complete the revalidation application, report information, or provide documentation would cost the provider approximately $4.59 to revalidate the provider agreement. This cost would be incurred once during a period

not to exceed every five (5) years unless the provider has changes to report before the next revalidation period.

For providers who fail to timely and properly revalidate, this rule indicates what actions ODM may take including denying the re-enrollment application and terminating the provider agreement. The cost of this sanction will vary by provider. It will depend on the number of Medicaid recipients being served in the facility as the facility will no longer be eligible to receive reimbursement from ODM for services provided to Medicaid recipients.

This rule requires providers to disclose any changes to its existing provider agreement in accordance with Administrative Code rule 5160-1-17.3. The reporting of changes that occur to an existing provider agreement may result in additional administrative costs that will vary based on the provider type and required changes. The costs will be determined by the amount of time required to disclose the changes and the hourly rate of the disclosing employee.

As part of the revalidation process, providers may be subject to an on-site review at the provider's facility, place of business, or both, as ODM deems necessary to ensure program integrity.

The provider may experience additional administrative costs in this case. These costs may include staff time required to prepare for on-site review and staff time lost if the reviewer requires a provider representative to be present or available during the review to answer the reviewer's questions and provide information needed for the review. The exact cost cannot be quantified because it will vary greatly depending on the circumstances of the on-site review but will include the time to gather and provide the information requested, the time to complete the review and the personnel required to assist.

3. **Is this rule the result of a federal government requirement?** Yes

   A. **If yes, does this rule do more than the federal government requires?** Yes

   B. **If yes, what are the costs, in dollars, to the local government for the regulation that exceeds the federal government requirement?**

      The federal requirement for revalidation of provider agreements is at least every five years. For providers that are deemed a higher fraud risk by our screening, ODM requires revalidation sooner than five years in order to ensure these providers that are at higher risk of fraudulent behavior or at risk of not being qualified to perform the medical services are screened to ensure the safety of the recipients and protect the taxpayer investment into the program

from fraud. The cost in dollars would be the $595 application fee every three years instead of every five as well as the costs associated with on-site visits for applicable providers.

4. Please provide an estimated cost of compliance for the proposed rule if it has an impact on the following:

A. Personnel Costs

This rule requires Ohio Medicaid providers to renew and revalidate its provider agreement every five years or sooner when certain circumstances apply. This rule requires provider agreements to be revalidated when the risk level of a provider changes or no later than five years from the effective date of the most current provider agreement barring waiver or modification by CMS.

This rule requires the provider to meet all conditions for participation as an eligible provider and submit all required information and any applicable fees before the revalidation deadline specified in the notice.

The reporting of the re-enrollment information may require the individual or staff to gather necessary documentation to be reported and submitted with the re enrollment application.

According to the Bureau of Labor Statistics, the average salary (with fringe benefits) for a First-Line Supervisor of a Physician's Office is $57,240. Based on this figure, the estimated ten (10) minutes it takes to complete the revalidation application, report information, or provide documentation would cost the provider approximately $4.59 to revalidate the provider agreement. This cost would be incurred once during a period not to exceed every five (5) years unless the provider has changes to report before the next revalidation period.

This rule requires providers to disclose any changes to its existing provider agreement in accordance with Administrative Code rule 5160-1-17.3. The reporting of changes that occur to an existing provider agreement may result in additional administrative costs that will vary based on the provider type and required changes. The costs will be determined by the amount of time required to disclose the changes and the hourly rate of the disclosing employee.

As part of the revalidation process, providers may be subject to an on-site review at the provider's facility, place of business, or both, as ODM deems necessary to ensure program integrity.

The provider may experience additional administrative costs in this case. These costs may include staff time required to prepare for on-site review and staff time lost if the reviewer requires a provider representative to be present or available during the review to answer the reviewer's questions and provide information needed for the review. The exact cost cannot be quantified because it will vary greatly depending on the circumstances of the on-site review but will include the time to gather and provide the information requested, the time to complete the review and the personnel required to assist.

B. New Equipment or Other Capital Costs

No new equipment or capital costs are required.

C. Operating Costs

Individual providers are not subject to an application fee while institutional and group providers are required to pay a $595 application fee. This fee may be waived if certain exemptions apply and the required documentation of evidence is provided.

D. Any Indirect Central Service Costs

No indirect central service costs are required.

E. Other Costs

For providers who fail to timely and properly revalidate, this rule indicates what actions ODM may take including denying the revalidation application and terminating the provider agreement. The cost of this sanction will vary by provider. It will depend on the number of Medicaid recipients being served in the facility as the facility will no longer be eligible to receive reimbursement from ODM for services provided to Medicaid recipients.

5. Please explain how the local government(s) will be able to pay for the increased costs associated with the rule.

The federally mandated requirements that have a cost on local governments have not changed with this amendment. The amended rule does not impose new requirements.

6. What will be the impact on economic development, if any, as the result of this rule?

This rule is expected to continue having a positive impact on economic development because it allows organizational providers such as local governments, school districts,

and local health department to become an Ohio Medicaid provider to be reimbursed for services provided.