Rule Summary and Fiscal Analysis
Part A - General Questions

Rule Number: 5160-1-17.8

Rule Type: Amendment

Rule Title/Tagline: Provider screening and application fee.

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?** 11/15/2019

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, 5164.31

5. **What statute(s) does the rule implement or amplify?** 5164.02, 5164.31, 5164.34

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

   This rule is being proposed for amendment to update ODM's policy concerning provider screening for behavioral health practitioners.

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

   Rule 5160-1-17.8, entitled "Provider screening and application fee" sets forth the background screening requirements for potential Medicaid providers based on level of risk as determined by the Centers for Medicare and Medicaid Services (CMS). This rule sets forth exemptions and provides a description of the appendix identifying screening

risk level by provider type and provider types subject to an application fee. This rule describes the screening requirements by risk level, how application fees must be submitted to ODM, exemptions from fee payment, refunds, and circumstances under which ODM may or may not waive the application fee. This rule provides exclusionary offenses and exclusionary time periods from participation in the Medicaid program. It provides exceptions and circumstances for those who have a conviction of, or a plea of guilty to an exclusionary offense to enroll as an Ohio Medicaid provider.

Additionally, this rule allows ODM to conduct additional screenings as determined necessary and informs providers of their hearing rights pursuant to Chapter 119. of the Revised Code.

The rule states that enrolled providers with multiple service locations must notify ODM of changes to locations or any new locations within thirty days of the change in order for the appropriate screening to be conducted based on risk level.

For limited risk providers, this rule indicates databases ODM will check against when conducting provider screenings. This includes the Office of the Inspector General (OIG), Health and Human Services (HHS) or Medicare exclusion database (MED), System for Awards Management (SAM), list of providers terminated by other state Medicaid programs, nurse aid registry maintained by the Ohio Department of Health (ODH), and the abuser registry maintained by the Ohio Department of Developmental Disabilities (DODD). For high risk providers, this rule requires each person with a five per cent or greater ownership or control interest to submit to a fingerprint-based background check in addition to the criminal background check.

This rule specifically identifies the exclusionary offenses and exclusionary time periods for different tiers of offenses as identified in the criminal background check or fingerprint-based background check. The rule states that an applicant holding a certificate of qualification for employment or a pardon may obtain a Medicaid provider agreement even if the applicant has a disqualifying offense.

This rule is being revised to exempt specified behavioral health provider types from the impact of the exclusionary offenses' requirement stated in the rule. This is being done upon request from stakeholders as the application of the requirement could prevent several practitioners from being able to render services. The provider types are peer recovery supporters, practitioners licensed by the Ohio Chemical Dependency Professionals Board, and practitioners licensed by the Ohio Counselor, Social Worker, and Marriage and Family Therapist Board. In addition, language is being added to clarify the list of databases that, if an applicant is listed on a database, could prevent the applicant from receiving a Medicaid provider agreement. Language was added to reference section 2953.25 of the Revised Code to inform stakeholders that ODM

will use the discretion provided in this statute to review certificates of qualification for employment granted to individuals with permanent exclusionary disqualifying offenses on a case-by-case basis before deciding whether or not to approve a provider agreement. This added level of review for the highest category of disqualifying offense ensures Medicaid recipient safety. Lastly, the rule is being updated to remove discontinued provider types from the appendix.

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.

   This rule incorporates one or more references to the Ohio Revised Code. This question is not applicable to any incorporation by reference to the Ohio Revised Code because such reference is exempt from compliance with RC 121.71 to 121.74 pursuant to RC 121.75.

   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.

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

    Not Applicable

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 have no impact on revenues or expenditures.

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The rule change will not add any new providers or significantly change the process for screening, so no new costs will be incurred.

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

This rule requires time for compliance to meet screening requirements and submitting an application fee for certain provider types as indicated in the appendix to the rule. For calendar year 2019, the provider application fee for an organizational provider is $586. Under certain circumstances, the provider may be exempt from the application fee requirements set forth in the rule. If such circumstances apply, the provider must provide documentation to support it meets the criteria for an exemption. The application fee is used to offset the cost of the state employee time necessary to ensure that all applicable providers have been thoroughly vetted to safeguard against a provider with a disqualifying offense rendering services to a Medicaid beneficiary. Providers may submit documentation to ODM at no charge through electronic means therefore any costs incurred would be administrative in nature and are expected to be minimal. Providers who have paid an application fee to Medicare or other state Medicaid agency would have a receipt of payment to verify payment was made. Since healthcare providers maintain records as a normal part of business, this document should be easily obtained, requiring less than ten minutes of staff time. Submitting the actual documentation to ODM will require even less staff time as it can be submitted electronically.

This rule requires enrolled providers to disclose all service locations at the time of enrollment and notify ODM of changes or additional service locations within thirty days of the change in order to be reimbursed for services delivered at that location. ODM is unable to calculate the actual costs associated with this requirement because it will vary widely by provider and individual circumstances. For those who experience a change in service locations, they can notify ODM electronically at no cost or by contacting the provider support line. Submitting electronically will incur the least amount of administrative time, estimated at less than three minutes to construct an email to provide notification. If the provider chooses to call the ODM provider support line, this is estimated to incur roughly 10-15 minutes of administrative time to report the change over the phone.

If an on-site visit to a provider's location is required there could be a cost of time for the provider to prepare. The application fee paid by the provider encompasses any monetary costs related to an on-site visit, there is no separate fee for this aspect of the screening. For providers subject to an on-site visit, administrative costs will likely be incurred. ODM is unable to provide an estimate of actual figures because this will vary widely based on several factors including: the number and size of provider

sites, the purpose for the site-visit, concern or issue that is being addressed and the availability of appropriate staff to provide documentation or answer evaluator questions. Generally, on-site visits are completed in one day therefore significant provider resources are not needed for a period of time longer than this.

Persons with a five percent or greater ownership or control interest with the provider must submit to a fingerprint-based background check within thirty days of when the application was submitted. This cost is assumed by the provider and is not covered by ODM. According to the Ohio Attorney General website, the average cost is $60 per individual for both a Federal Bureau of Investigation (FBI) and Ohio Bureau of Criminal Investigation (BCI) background check. Individuals subject to this type of screening must present to an authorized location that performs the screenings. This may result in a minimal loss of income if the individual has to take time away from work. There are several locations throughout the state where such screenings are performed on a walk-in basis. Many have flexible or weekend hours therefore the individual may not be required to use personal time or experience a loss of income.

Providers whose enrollment is denied as a result of failure to meet the provider screening requirements or failure to pay any associated application fee may request a hearing pursuant to Chapter 119. of the Revised Code. There is no monetary cost required to request or participate in a hearing but it may result in additional time from the provider to comply and provide supporting documentation. Documentation can be provided electronically at no charge by uploading in ODM's secure provider enrollment portal or sending via secure e-mail. If the provider chooses to have representation at the hearing, it could result in additional fees but ODM cannot calculate a precise cost as this will be highly dependent on individual circumstances.

Should a provider be denied a Medicaid provider agreement on a permanent or temporary basis, a loss of potential income could result due to the inability to receive Medicaid reimbursement.

It is not expected that the proposed revisions to the rule will create any new cost of compliance.

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.**

An application fee is required and a completion of a background check and/or fingerprints for certain providers. If certain circumstances apply to the individual provider, additional documentation or information may be required as a condition of compliance. This includes providing documentation that the provider should be exempt from paying the application fee. The costs garnered from this fee are used of offset the costs of staff time to ensure proper vetting of practitioners as well as the cost to complete site visits to the facilities to ensure the safety of 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?** No

    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

    It creates a potential adverse impact on the provider if the rule requirements are not met.

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

    An application fee is required and a completion of a background check and/or fingerprints for certain providers. If certain circumstances apply to the individual provider, additional documentation or information may be required as a condition of compliance. This includes providing documentation that the provider should be exempt from paying the application fee.

    This rule requires providers to disclose all service locations at the time of enrollment and notify ODM of changes or additional service locations within thirty days of the change in order to be reimbursed for services delivered at that location.

    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

This rule requires time for compliance to meet screening requirements and to submit an application fee for certain provider types as indicated in the appendix to the rule. For calendar year 2019, the provider application fee for an organizational provider is $586. Under certain circumstances, the provider may be exempt from the application fee requirements set forth in the rule. If such circumstances apply, the provider must provide documentation to support it meets the criteria for an exemption. The application fee is used to offset the cost of the state employee time necessary to ensure that all applicable providers have been thoroughly vetted to safeguard against a provider with a disqualifying offense rendering services to a Medicaid beneficiary. The vetting process includes state staff time to review any relevant exclusionary databases, perform required on-site visits, and conduct any additional research into background information, exclusionary offenses, or licensure limitations. Providers may submit documentation supporting an exemption to ODM at no charge through electronic means therefore any provider costs incurred would be administrative in nature and are expected to be minimal. Providers who have paid an application fee to Medicare or other state Medicaid agency would have a receipt of payment to verify payment was made. Since healthcare providers maintain records as a normal part of business, this document should be easily obtained, requiring less than ten minutes of staff time. Submitting the actual documentation to ODM will require even less staff time as it can be submitted electronically.

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If an on-site visit to a provider's location is required there could be a cost of time for the provider to prepare. For providers subject to an on-site visit, administrative costs will likely be incurred. ODM is unable to provide an estimate of actual figures because this will vary widely based on several factors including: the number and size of provider sites, the purpose for the site-visit,

concern or issue that is being addressed and the availability of appropriate staff to provide documentation or answer evaluator questions. Generally, on-site visits are completed in one day therefore significant provider resources are not needed for a period of time longer than this.

Persons with a five percent or greater ownership or control interest with the provider must submit to a fingerprint-based background check within thirty days of when the application was submitted. This cost is assumed by the provider and is not covered by ODM. According to the Ohio Attorney General website, the average cost is $60 per individual for both a Federal Bureau of Investigation (FBI) and Ohio Bureau of Criminal Investigation (BCI) background check. Individuals subject to this type of screening must present to an authorized location that performs the screenings. This may result in a minimal loss of income if the individual has to take time away from work. There are several locations throughout the state where such screenings are performed on a walk-in basis. Many have flexible or weekend hours therefore the individual may not be required to use personal time or experience a loss of income.

Providers whose enrollment is denied as a result of failure to meet the provider screening requirements or failure to pay any associated application fee may request a hearing pursuant to Chapter 119. of the Revised Code. There is no monetary cost required to request or participate in a hearing but it may result in additional time from the provider to comply and provide supporting documentation. The hearing must be requested in writing to ODM as described in the hearing notice provided with the denial. If the provider chooses to have representation at the hearing, it could result in additional fees but ODM cannot calculate a precise cost as this will be highly dependent on individual circumstances.

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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.**

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   Under certain circumstances, the provider may be exempt from the application fee requirements set forth in the rule. If such circumstances apply, the provider must provide documentation to support it meets the criteria for an exemption. Providers may submit documentation to ODM at no charge through electronic means therefore any costs incurred would be administrative in nature and are expected to be minimal. Providers who have paid an application fee to Medicare or other state Medicaid agency would have a receipt of payment to verify payment was made. Since healthcare providers maintain records as a normal part of business, this document should be easily obtained, requiring less than ten minutes of staff time. Submitting the actual documentation to ODM will require even less staff time as it can be submitted electronically.

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It is not expected that the proposed revisions to the rule will create a cost of compliance.

3. **Is this rule the result of a federal government requirement?** No

   A. **If yes, does this rule do more than the federal government requires?** *Not Applicable*

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

      Not Applicable

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

   A. **Personnel Costs**

      Under certain circumstances, the provider may be exempt from the application fee requirements set forth in the rule. If such circumstances apply, the provider must provide documentation to support it meets the criteria for an exemption. Providers may submit documentation to ODM at no charge through electronic means therefore any costs incurred would be administrative in nature and are expected to be minimal. Providers who have paid an application fee to Medicare or other state Medicaid agency would have a receipt of payment to verify payment was made. Since healthcare providers maintain records as a normal part of business, this document should be easily obtained, requiring less than ten minutes of staff time. Submitting the actual documentation to ODM will require even less staff time as it can be submitted electronically.

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Providers whose enrollment is denied as a result of failure to meet the provider screening requirements or failure to pay any associated application fee may request a hearing pursuant to Chapter 119. of the Revised Code. Individuals may request a hearing on one of several ways including via phone, e-mail, fax, or mail. Each of these methods of submitting a request require minimal time, less than 15 minutes, on behalf of the individual to complete.

Participating in a hearing may require the individual take time away from their employment, potentially resulting in loss of income. Hearings typically last no more than an hour and are conducted via telephone. The actual time spent by the individual will vary based on individual circumstances including reason for the denied enrollment application and amount of evidence to be presented. As a result of the employee participating in their hearing, the employer may experience reduced productivity during this time or may be required to incur additional costs if another staff member is required to fill in for the regular employee's duties.

B. New Equipment or Other Capital Costs

No new equipment or other capital costs are anticipated as a result of this regulation.

C. Operating Costs

For calendar year 2019, the provider application fee for an organizational provider is $586. Once the individual is enrolled as an Ohio Medicaid provider, there are no additional operating costs required through this regulation.

D. Any Indirect Central Service Costs

No indirect central service costs are anticipated as a result of this regulation.

E. Other Costs

Persons with a five percent or greater ownership or control interest with the provider must submit to a fingerprint-based background check within thirty days of when the application was submitted. This cost is assumed by the provider and is not covered by ODM. According to the Ohio Attorney General website, the average cost is $60 per individual for both a Federal Bureau of Investigation (FBI) and Ohio Bureau of Criminal Investigation (BCI) background check.

Should a provider be denied a Medicaid provider agreement on a permanent or temporary basis, a loss of potential income could result due to the inability to receive Medicaid reimbursement.

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

There are no new requirements in this rule.

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.