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TO BE RESCINDED

5160-1-17.8 Provider screening and application fee.

(A) In accordance with 42 C.F.R. 455.410 (as in effect July 1, 2018) and rule 5160-1-17 of the Administrative Code in order to ~~To~~ become an eligible provider~~ as described in rule 5101:3-1-17 of the Administrative Code~~, a provider must meet the screening requirements described in this rule and in 5164.34 of the Ohio Revised Code and pay an applicable application fee if required in the appendix to this rule. Provider screening and application fees are required at the time of enrollment and ~~re-enrollment~~ revalidation as defined in rule ~~5101:3-17.4~~ 5160-1-17.4 of the Administrative Code.

(1) Exemptions.~~ from this rule.~~

(a) If a provider is required to participate in the medicare program as a condition of enrollment in medicaid or elects to participate in the medicare program and has met the provider screening requirements and paid an applicable application fee to the centers for medicare and medicaid services (CMS) or its designee, the provider is exempt from the application fee requirements set forth in this rule.

(b) If a provider has met the provider screening requirements and paid an applicable application fee to another state medicaid agency or its designee, the provider is exempt from the application fee requirements set forth in this rule.

(c) A provider must provide documentation to support it meets the criteria for an exemption described in paragraphs (A)(1)(a) and (A)(1)(b) of this rule.

(2) The appendix to this rule sets forth:

(a) The screening risk level assigned to each provider type in accordance with paragraph (B) of this rule; and

(b) The provider types that must pay an application fee in accordance with paragraph (~~C~~G) of this rule.

(B) The appropriate screening based on screening risk level must be given to all service locations of an enrolled provider. Providers must disclose all service locations at time of enrollment and notify the department of changes or additional service locations within thirty days of the change in order to be reimbursed for services delivered at that location.

(C) In accordance with 42 C.F.R. 455.452 (as in effect July 1, 2018), the Ohio department of medicaid (ODM) reserves the right to conduct additional screenings and background checks as determined necessary by ODM or its designee.

(B)(D) Screening requirements differ by risk level. If more than one risk level could apply to a provider, the highest level of screening is required.

(1) Limited.

(a) Providers are subject to verification that they meet any applicable medicaid requirements as stated in division agency 5160 5101:3 of the Administrative Code for their provider type; and

(b) Providers are subject to license verifications, including state licensure verification in states other than Ohio; and

(c) Providers are subject to database checks on a pre- and post-enrollment basis to ensure that providers continue to meet the enrollment criteria for their provider type.

(i) Database checks must confirm the identity and exclusion status of providers and any person with a five per cent or greater ownership or control interest; or any person who is an agent or an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the provider entity.

(ii) Databases to be checked include, but are not limited to, the social security administration's death master file, the national plan and provider enumeration systems (NPPES), the list of excluded individuals/entities maintained by the office of the inspector general, health and human services, the medicare exclusion database (MED), or the system for awards management (SAM), (LEIE), and the excluded parties list system (EPLS).the list of providers terminated by another state's medicaid program, the nurse aid registry maintained by the Ohio department of health and the abuser registry maintained by the Ohio department of developmental disabilities.

(2) Moderate.

(a) Providers are subject to the requirements in paragraph (BD)(1) of this rule; and

(b) Providers are subject to on-site visits.

(i) Pre- and post-enrollment site visits by ~~the Ohio department of job and family serivces (ODJFS)~~ ODM or its designee will verify that information provided to ~~ODJFS~~ODM or its designee is accurate and to determine compliance with medicaid enrollment requirements.

(ii) Once enrolled, providers must allow CMS or its agents or contractors, or ~~ODJFS~~ODM or its agents or contractors to conduct unannounced on-site inspections of any and all provider locations.

(3) High.

(a) Providers are subject to the requirements in paragraphs (~~B~~D)(1) and (~~B~~D)(2)(b) of this rule; and

(b) Each person with a five per cent or greater ownership or control interest with the provider is subject to a criminal background check and is required to submit to a fingerprint-based background check ~~his or her fingerprints~~ within thirty days of submission of the application in a form and manner determined by ~~ODJFS~~ODM, or its designee.

(E) The following sets forth the exclusionary offenses and exclusion time periods from participation in the Medicaid program:

(1) Tier I: Permanent exclusion: Any individual who has been convicted of or pleaded guilty to any of the offenses listed in paragraph (C) of rule 5160-45-11 of the Administrative Code.

(2) Tier II: Ten-year exclusionary period: Any individual who has been convicted of or pleaded guilty to any of the offenses listed in paragraph (D) of rule 5160-45-11 of the Administrative Code.

(3) Tier III: Seven-year exclusionary period: Any individual who has been convicted of or pleaded guilty to any of the offenses listed in paragraph (E) of rule 5160-45-11 of the Administrative Code.

(4) Tier IV: Five-year exclusionary period: Any individual who has been convicted of or pleaded guilty to any of the offenses listed in paragraph (F) of rule 5160-45-11 of the Administrative Code.

(5) Tier V: No exclusionary period: Any individual who has been convicted of or pleaded guilty to any of the offenses listed in paragraph (G) of rule 5160-45-11 of the Administrative Code.

(F) Pardons and Certificates. A conviction of, or a plea of guilty to, an exclusionary offense as set forth in paragraph (E) of this rule shall not prevent a provider from enrollment if any of the following circumstances apply:

(1) The provider has been granted an unconditional pardon for the offense pursuant to Chapter 2967. of the Revised Code;

(2) The provider has been granted an unconditional pardon for the offense pursuant to an existing or former law of the state of Ohio, any other state, or the United States, if the law is substantially equivalent to Chapter 2967. of the Revised Code;

(3) The provider has been granted a conditional pardon for the offense pursuant to Chapter 2967. of the Revised Code, and the condition(s) under which the pardon was granted have been satisfied;

(4) The provider's conviction or guilty plea has been set aside pursuant to law; or

(5) A certificate of qualification for employment has been issued by a court of common pleas pursuant to section 2953.25 of the Revised Code.

~~(C)~~(G) Application fee.

(1) Provider types identified as subject to an application fee in the appendix to this rule must submit the fee in a form and manner determined by ~~ODJFS~~ODM at the time of application for enrollment or ~~re-enrollment~~revalidation as a medicaid provider. If proof of fee payment is not submitted with the provider's application, the application will be ~~denied~~rejected as incomplete.

(2) Individual physicians and non-physician practitioners are exempt from paying an application fee in accordance with 42 C.F.R. 455.460, ~~effective~~ (February 2, 2011).

(3) ~~ODJFS~~ ODM may waive an application fee if:

(a) ~~ODJFS~~ ODM determines that imposing the fee would have an adverse impact on beneficiary access to services; and

(b) ~~ODJFS~~ ODM has requested and CMS has approved a waiver of the fee.

(4) If ~~ODJFS~~ ODM receives approval from CMS to waive a medicaid application fee, providers are still subject to the screening requirements set forth in this rule.

(5) The application fee is equal to the amount established by CMS and includes an annual adjustment for inflation in accordance with 42 U.S.C. 1395cc(j)(2)(C)(i) (December, 2016). ~~paragraph (a)(2)(C)(i) of 42 U.S.C. 1395cc(j).~~

(6) The application fee will not be refunded if:

(a) Enrollment is denied as a result of failure to meet the provider screening requirements described in this rule; ~~or~~

(b) If enrollment is denied based on the results of the provider screening~~.~~;or

(c) If ODM or its designee identifies other circumstances under which refunding the application fee is not warranted.

~~(D)~~(H) If enrollment is denied as a result of failure to meet the provider screening requirements or failure to pay any associated application fee, the provider may request a hearing pursuant to Chapter 119. of the Revised Code.

(I) This rule shall become effective July 1, 2018.

Effective:

Five Year Review (FYR) Dates: 8/10/2018

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Certification

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Date

Promulgated Under:	119.03
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