Rule Summary and Fiscal Analysis (Part A)

Ohio Department of Medicaid
Agency Name

Division

Tommi Potter
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5160-1-17.8
Rule Number

NEW
TYPE of rule filing

Rule Title/Tag Line **Provider screening and application fee.**

RULE SUMMARY

1. Is the rule being filed for five year review (FYR)? **No**

2. Are you proposing this rule as a result of recent legislation? **No**

3. Statute prescribing the procedure in accordance with the agency is required to adopt the rule: **119.03**

4. Statute(s) authorizing agency to adopt the rule: **5164.02, 5164.31**

5. Statute(s) the rule, as filed, amplifies or implements: **5164.02, 5164.31, 5164.34**

6. State the reason(s) for proposing (i.e., why are you filing,) this rule:

This new rule is being proposed for adoption as new to replace existing rule 5160-1-17.8 of the same title which is being proposed for rescission. Existing rule 5160-1-17.8 was reviewed as part of the five year rule review process and is being proposed for rescission because more than 50% of the rule needs to be amended. This permanent filing is to replace the emergency filed rule which became effective July 1, 2018.

7. If the rule is an AMENDMENT, then summarize the changes and the content of the proposed rule; If the rule type is RESCISSION, NEW or NO CHANGE, then summarize the content of the rule:

Rule 5160-1-17.8, entitled "Provider screening and application fee" is a new rule replacing a rule of the same number and title that is being proposed for rescission. It 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). Language and provisions from the rule proposed for rescission have been incorporated in this new proposed rule.

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, 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.

This rule states that providers who have paid an application fee to Medicare or another state Medicaid agency may be exempt from the application fees set forth in the rule but are not exempt from the screening requirements set forth in the rule. It adds that the application fee will not be refunded if ODM or its designee identifies circumstances under which refunding the application fee is not warranted.

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 adds that each person with a five per cent or greater ownership or control interest must submit to a fingerprint-based background check in addition to the criminal background check.

This new rule includes the same provisions as the rule to be rescinded but instead of referencing Chapter 5160-45-11, 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. Additionally, this new rule adds an appendix identifying screening risk level by provider type and the provider types subject to an application fee. These provisions were added to the new rule to provide further clarity and for convenience.

8. If the rule incorporates a text or other material by reference and the agency claims the incorporation by reference is exempt from compliance with sections 121.71 to 121.74 of the Revised Code because the text or other material is **generally available** to persons who reasonably can be expected to be affected by the rule,

provide an explanation of how the text or other material is generally available to those persons:

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 121.76(A)(3).

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 121.76(A)(1).

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(D).

9. If the rule incorporates a text or other material by reference, and it was **infeasible** for the agency to file the text or other material electronically, provide an explanation of why filing the text or other material electronically was infeasible:

Not applicable.

10. If the rule is being **rescinded** and incorporates a text or other material by reference, and it was **infeasible** for the agency to file the text or other material, provide an explanation of why filing the text or other material was infeasible:

Not Applicable.

11. If **revising** or **refiling** this rule, identify changes made from the previously filed version of this rule; if none, please state so. If applicable, indicate each specific paragraph of the rule that has been modified:

In paragraph (F)(6) changing the word "July" to "October."

12. Five Year Review (FYR) Date:

(If the rule is not exempt and you answered NO to question No. 1, provide the scheduled review date. If you answered YES to No. 1, the review date for this rule is the filing date.)

NOTE: If the rule is not exempt at the time of final filing, two dates are required: the current review date plus a date not to exceed 5 years from the effective date for Amended rules or a date not to exceed 5 years from the review date for No Change rules.

FISCAL ANALYSIS

13. Estimate the total amount by which *this proposed rule* would **increase / decrease** either **revenues / expenditures** for the agency during the current biennium (in dollars): Explain the net impact of the proposed changes to the budget of your agency/department.

This will have no impact on revenues or expenditures.

0.00

This will have no impact on revenues or expenditures.

14. Identify the appropriation (by line item etc.) that authorizes each expenditure necessitated by the proposed rule:

N/A

15.
Provide a summary of the estimated cost of compliance with the rule to all directly affected persons. When appropriate, please include the source for your information/estimated costs, e.g. industry, CFR, internal/agency:

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 2018, the provider application fee for an organizational provider is $569.

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.

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 e-mail 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.

Should a provider, with a criminal offense, choose to secure a certificate for employment, the request, made to the appropriate court, may involve an application/ processing fee. The fee can vary by court and county and can range from no cost up to $450. Some counties offer an affidavit of hardship regarding the fee.

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.

16. Does this rule have a fiscal effect on school districts, counties, townships, or municipal corporations? **Yes**

You must complete Part B of the Rule Summary and Fiscal Analysis in order to comply with Am. Sub. S.B. 33 of the 120th General Assembly.

17. Does this rule deal with environmental protection or contain a component dealing with environmental protection as defined in R. C. 121.39? **No**

S.B. 2 (129th General Assembly) Questions

18. Has this rule been filed with the Common Sense Initiative Office pursuant to R.C. 121.82? **Yes**

19. Specific to this rule, answer the following:

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

> ODM requires that a provider hold a Medicaid provider agreement and provider number in order to participate in the Ohio Medicaid program.

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 who want to participate in the Ohio Medicaid program to complete an enrollment application and meet requirements set forth in the rule. Providers who fail to meet screening requirements or pay any associated application fee will not be enrolled as an Ohio Medicaid provider.

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.

Rule Summary and Fiscal Analysis (Part B)

1. Does the Proposed rule have a fiscal effect on any of the following?

(a) School Districts	(b) Counties	(c) Townships	(d) Municipal Corporations
Yes	**Yes**	**Yes**	**Yes**

2. Please provide an estimate in dollars of the cost of compliance with the proposed rule for school districts, counties, townships, or municipal corporations. If you are unable to provide an estimate in dollars, please provide a written explanation of why it is not possible to provide such an estimate.

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 2018, the provider application fee for an organizational provider is $569.

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.

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 e-mail 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.

3. If the proposed rule is the result of a federal requirement, does the proposed rule exceed the scope and intent of the federal requirement? **No**

4. If the proposed rule exceeds the minimum necessary federal requirement, please provide an estimate of, and justification for, the excess costs that exceed the cost of the federal requirement. In particular, please provide an estimate of the excess costs that exceed the cost of the federal requirement for (a) school districts, (b) counties, (c) townships, and (d) municipal corporations.

Not Applicable.

5. Please provide a comprehensive cost estimate for the proposed rule that includes the procedure and method used for calculating the cost of compliance. This

comprehensive cost estimate should identify all of the major cost categories including, but not limited to, (a) personnel costs, (b) new equipment or other capital costs, (c) operating costs, and (d) any indirect central service costs.

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(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.

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 e- mail 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.

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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 2018, the provider application fee for an organizational provider is $569. 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.

6. Please provide a written explanation of the agency's and the local government's ability to pay for the new requirements imposed by the proposed rule.

There are no new requirements in this rule.

7. Please provide a statement on the proposed rule's impact on economic development.

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.