CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid (ODM)

Regulation/Package Title: Provider screening and application fee

Rule Number(s): 5160-1-17.8 (Rescind and adopt as new)

Date: 7/17/2018

Rule Type:

- ✓ New
- Amended
- ✓ 5-Year Review
- ✓ Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   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). The new rule, which is being proposed to replace the emergency filed 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 new 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. The new 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 new 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The new rule, which is proposed to replace the rescinded one and has the same rule number, includes the same provisions as the rule to be rescinded but specifically identifies the exclusionary offenses and exclusionary time periods for different tiers of offenses as identified in the criminal background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. It also adds specific provider types to the appendix.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   Sections 5164.02 and 5164.31 of the Ohio Revised Code.

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   This new rule, which is proposed to replace the rescinded one, implements federal requirements. Provider screening and application fees as addressed in proposed rule 5160-1-17.8 are requirements applied to Medicaid providers by CMS under provisions set forth in 42 C.F.R. 455.410, 42 C.F.R. 455.452, and 42 C.F.R. 455.460.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   This new rule, which is proposed to replace the rescinded one, does not exceed federal requirements.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   This new rule, which is proposed to replace the rescinded one, is necessary to implement federal requirements concerning provider screening and application fees as described in 42 C.F.R. 455.410, 42 C.F.R. 455.452, and 42 C.F.R. 455.460. The implementation of this rule is important in ensuring patient safety and program integrity.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   This new rule, which is proposed to replace the rescinded one, will be determined successful as providers are screened in accordance with state and federal laws while appropriate exclusions or penalties are applied as necessary. The success of this new rule is also demonstrated by safe and qualified providers treating Medicaid patients.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

   A request for comments concerning the rule was posted on the internet during the first week of July 2018. The following provided comments:

   The Ohio Council of Behavioral Health and Family Services Providers (Ohio Council)

   Medical Association Coalition

   Ohio Counseling Association

8. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

   The Ohio Council recommended that the list of provider disqualifying offenses be reduced to those federally required and those including fraud, patent abuse or violations of controlled substances. ODM did not make the requested change and responded that Medicaid agencies have the authority to establish more stringent provider screening methods according to 42 CFR 455.452 and that more stringent requirements are also permitted in ORC 5164.34.

   The Ohio Council recommended that the rule be clearer regarding its application to providers. ODM did make changes to address this concern.

   The Ohio Council recommended that ODM reduce exclusionary offenses to avoid collateral sanctions and to prevent lawsuits under the ADA and EEOC. ODM did not make the requested change based on 42 CFR 455.452 and ORC 5164.34 as stated previously.

   The Ohio Council recommended that specified provider types be listed in the rule appendix to clarify their inclusion. ODM made the requested change.

   The Ohio Council is concerned that a conflict occurs between this rule and 5160-1-17.6 (G)(2). ODM responded that a conflict is not present as ODM does have authority to determine specific instances (stated in 5160-1-17.8) that would prevent provider enrollment to ensure program integrity.

The Ohio Council, the Medical Association Coalition, and the Ohio Counseling Association all expressed a concern that Ohio's professional licensing boards has the sole authority to determine the ability of an individual provider to become a Medicaid provider. ODM responded that licensing boards do not have the authority to determine how public funds (provider reimbursement) may be spent. ODM is responsible for protecting Medicaid recipients and ensuring program integrity which is, in part, accomplished by having its own eligible provider requirements.

The Medical Association Coalition also made a comment about 5160-1-17.6(I)(1) which is not the subject of this BIA or related rule filing. ODM's response is that 5160-1-17.6 is not being impacted by this rule filing, therefore any comments are unrelated to this filing.

9. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

   No scientific data was used to develop this Medicaid policy.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    No other alternative regulations were considered. ODM considers administrative rules the most appropriate method to codify these rules.

11. **Did the Agency specifically consider a performance-based regulation? Please explain.** ***Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

    ODM did not specifically consider a performance-based regulation because the regulations stated in the new rule do not lend themselves to being performance-based.

12. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    The new rule was thoroughly reviewed by ODM legal and legislative staff, and other policy areas to ensure it does not duplicate an existing Ohio regulation.

13. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

    While some of the requirements and regulations stated in the rule are new, the processes (Medicaid IT system, provider enrollment staff) are already in place to implement and apply the requirements and regulations. Medicaid provider enrollment staff will need to familiarize themselves with the rule requirements and regulations.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

The impacted business community includes any individual or organization who applies to become an Ohio Medicaid provider or currently holds an Ohio Medicaid provider agreement.

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

Proposed new rule 5160-1-17.8, to replace the rescinded 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 new rule. 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 (including, in some cases, proof of fee payment) to support the fact that it meets the criteria for an exemption. This new 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.

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.

If required, there could be a time cost for a provider to prepare for an on-site review.

Should a provider be excluded from participation as a Medicaid provider, either permanently or for a limited amount of time, there could be adverse impact resulting from the potential loss of income. Such financial loss would vary depending on the type of provider impacted and the quantity of potential services rendered.

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. If the provider

chooses to have representation at the hearing, it could result in additional fees but will be dependent on individual circumstances.

c. Quantify the expected adverse impact from the regulation.
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

Proposed rule 5160-1-17.8, to replace the rescinded rule, requires time for compliance and an application fee for certain provider types as indicated in the appendix to the new rule. This fee may be waived if certain circumstances stated in the rule apply. This new 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.

The costs associated with this regulation are mostly administrative in nature. For providers who are subject to an application fee, the cost will also be monetary in nature. For calendar year 2018, the provider application fee for an organizational provider is $569. If the provider paid an applicable application fee to another state Medicaid agency or paid an application fee to CMS for the participation in the Medicare program, the ODM application fee is waived. This rule requires the provider to submit documentation of fees paid that qualify them for an exemption.

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.

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 will be dependent on individual circumstances.

15. **Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?**

    The regulatory intent of this new rule is justified by the benefit to Medicaid covered individuals in protecting their safety, protecting the integrity of the Medicaid program by ensuring compliance with federal requirements related to provider screening, and application fees.

Regulatory Flexibility

16. **Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.**

    There are no alternate means of compliance because this regulation applies to all provider types enrolled in Medicaid. No exception can be made on the basis of the provider group or agency size.

17. **How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?**

    This new rule does not impose a fine or penalty for first-time paperwork violations.

18. **What resources are available to assist small businesses with compliance of the regulation?**

    The Ohio Department of Medicaid website, www.medicaid.ohio.gov, has several resources available for providers related to provider enrollment and revalidation.
    ODM's Bureau of Provider Services also renders technical assistance to providers through its provider hotline, (800) 686-1516.