CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid (ODM)

Regulation/Package Title: Conversion to time-limited provider agreements and re-enrollment; Revalidation of provider agreements

Rule Number(s): 5160-1-17.4 (Rescind) and 5160-1-17.4 (New)

Date: 11/13/2018

Rule Type:

X New	X 5-Year Review
Amended	X Rescinded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.

Existing Ohio Administrative Code (OAC) rule 5160-1-17.4 (rescind), entitled "Conversion to time-limited provider agreements and re-enrollment," defines time-limited and open-ended provider agreements and lists entities excluded from requirements of time-limited provider agreements under this rule. This rule identifies agreements that are time-limited or will be converted to time-limited agreements. It sets forth the responsibilities of the Ohio Department of Job and Family Services (ODJFS) in selecting provider agreements to be converted and the methods in which the provider will be notified. This rule describes the discretion in which ODJFS has to convert provider agreements and change the length of time-limited agreements for all providers within like provider types. If a provider files an application for re-enrollment in the time and manner required but the provider agreement expires before the Department acts on the re-enrollment application, this rule states the provider may continue operating under the terms of the expired agreement until the effective date of the Department's decision.

This rule defines re-enrollment and describes the actions ODJFS will take in notifying providers when the time-limited agreement is close to expiration, when re-enrollment is required, and what actions are needed. It describes the re-enrollment process, requires providers to meet all conditions of participation as an eligible provider and to submit all required information before the re-enrollment date specified. This rule prohibits providers from initiating re-enrollment prior to the receipt of a re-enrollment notification. For providers who fail to re-enroll, this rule indicates what actions ODJFS may take including denying the re-enrollment application, terminating the provider agreement, or denying claims for payment. This rule requires providers to notify ODJFS within thirty days of approval or rejection of an application for renewal of licensure, certification, accreditation, or registration when that decision was delayed by a government entity.

This rule indicates when the new provider agreement will take effect, when a provider agreement may be made retroactive, and the exceptions to approving a twelve month retroactive period. This rule provides information about provider hearing rights in accordance with Chapter 119. of the Revised Code. Additionally, this rule states that ODJFS may conduct on-site review of provider facilities and place of business as deemed necessary to ensure program integrity.

This rule has been reviewed as part of the five year rule review process and is being proposed for rescission because it includes outdated information and terminology, outdated references to the Ohio Revised Code (ORC), Ohio Administrative Code (OAC) rules, and to the Department. This rule will be replaced with new proposed rule 5160-1-17.4 which is described below and included in this rule filing.

New OAC rule 5160-1-17.4, entitled "Revalidation of provider agreements," is being proposed for adoption as a result of the five year rule review process. This new rule is proposed to replace existing rule, 5160-1-17.4, entitled "Conversion to time-limited provider agreements and re-enrollment" which is being rescinded as part of this rule filing.

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 proposed rule.

Specifically, this rule states that for providers whose professional license or certification 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. This rule requires provider agreements to be revalidated when the risk level of a provider changes, if a provider's license or certification expires less than five years from the effective date of the provider agreement, or no later than five years from the effective date of the most current provider agreement.

Additionally, this new rule removes outdated language from the previous rule, updates references to the OAC and Ohio Revised Code, updates terminology, clarifies fees and removes a provision regarding denial of claims when a provider fails to revalidate.

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

   Sections 5164.02 and 5164.32 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.

   These rules implement federal requirements.

   Provider agreement revalidation as addressed in proposed rule 5160-1-17.4 is a requirement applied to Medicaid providers by the Centers for Medicare and Medicaid Services (CMS) under provisions set forth in 42 C.F.R. 455.414.

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

   This rule 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)?**

   These proposed rules are necessary to implement federal requirements concerning revalidation of provider enrollment as described in 42 C.F.R. 455.414. The implementation of this rule is important in ensuring patient safety and program integrity. The public purpose of this rule is to communicate to providers and the public how ODM implements this federal requirement.

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

   This rule will be determined successful as providers are revalidated in accordance with state and federal laws.

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.

   This rule was posted for public comment on the ODM website from July 3, 2018 through July 10, 2018.

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

   No concerns were raised by stakeholders in response to this this proposed regulation.

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 necessary 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 of regulating the processes outlined in 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 this rule implements federal requirements and is not performance-based.

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

    This rule was thoroughly reviewed by ODM staff 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.**

    The aspects of this regulation are already in place and will continue to be implemented as they are today through ODM's provider enrollment department and in the Medicaid Information Technology System (MITS) where provider revalidation applications are processed. No system or document changes are needed for the implementation of this rule.

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

The nature of the adverse impact for both the existing and proposed rules is primarily administrative in employee time but may also be monetary in nature.

Existing rule 5160-1-17.4 that is being proposed for rescission requires providers with time-limited agreements to renew their provider agreements. This rule requires the provider to meet all conditions of participation as an eligible provider and to submit all required information before the re-enrollment date specified by ODJFS.

For providers who fail to re-enroll, this rule indicates what actions ODJFS may take including denying the re-enrollment application, terminating the provider agreement, or denying claims for payment. This rule requires providers to notify ODJFS within thirty days of approval or rejection of an application for renewal of licensure, certification, accreditation, or registration when that decision was delayed by a government entity.

This rule requires providers to disclose any changes to its existing provider agreement in accordance with Administrative Code rule 5101:3-1-17.3.

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

The language and requirements from this rule have been incorporated into new proposed rule 5160-1-17.4 therefore the rescission of this rule does not result in additional adverse impacts.

New proposed 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, if a provider's license or certification expires less

than five years from the effective date of the provider agreement, or no later than five years from the effective date of the most current provider agreement.

This rule requires the provider to meet all conditions for participation as an eligible provider and submit all required information and pay the application fee, if applicable, before the revalidation deadline specified in the notice.

For providers who fail to timely or properly revalidate, this rule indicates what actions ODM may take including denying the revalidation application and terminating the 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.

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.

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.

Existing rule 5160-1-17.4 that is being proposed for rescission requires providers with time-limited agreements to renew their provider agreements. This rule requires the provider to meet all conditions of participation as an eligible provider and to submit all required information before the re-enrollment date specified by ODJFS.

The information, documentation, and fees required in the re-enrollment 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 $569 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 yearly salary (with fringe benefits) for a healthcare administration position is $42,770. Based on this figure, the

estimated ten minutes it takes to complete the re-enrollment application, report information, or provide documentation would cost the provider approximately $3.43 to revalidate the provider agreement. This cost would be incurred once during a period not to exceed every five years unless the provider has changes to report before the next re-enrollment period.

For providers who fail to timely and properly re-enroll, this rule indicates what actions ODJFS may take including denying the re-enrollment application, terminating the provider agreement, or denying claims for payment. The cost of this sanction will vary by provider and sanction. If the sanction is denial of the re-enrollment application or termination of the provider agreement, the cost 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. If the sanction is denial of the claims for payment, the facility will lose the claims reimbursement unless, once the re-enrollment is properly completed, the claim may still be timely resubmitted for payment.

This rule requires providers to notify ODJFS within thirty days of approval or rejection of an application for renewal of licensure, certification, accreditation, or registration when that decision was delayed by a government entity. The cost of providing this notification will vary by affected provider and will be determined by the amount of time it takes to notify ODJFS and the notifying employee's hourly rate.

This rule requires providers to disclose any changes to its existing provider agreement in accordance with Administrative Code rule 5101:3-1-17.3. 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 re-enrollment process, providers may be subject to an on-site review at the provider's facility, place of business, or both, as ODJFS deems necessary to ensure program integrity. The provider may experience additional administrative costs in the process of the on-site review because staff must be available to answer the reviewer's questions and provide information needed for the review. The cost will vary by provider 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.

New proposed 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, if a provider's license or certification expires less than five years from the effective date of the provider agreement, or no later than five years from the effective date of the most current provider agreement.

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 $569 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 healthcare administration position is $42,770. 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 $3.43 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.

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

The regulatory intent of these rules is justified by the benefit to Medicaid covered individuals in protecting their safety, and protecting the integrity of the Medicaid program by ensuring compliance with federal requirements related to provider revalidation.

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 these regulations apply 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?

Per ORC 119.14 paragraph (E), this section shall not apply to any violation by a small business of a statutory or regulatory requirement mandating the collection of information by a state agency or regulatory body if that small business previously violated any such requirement mandating the collection of information.

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.

TO BE RESCINDED

5160-1-17.4 **Conversion to time-limited provider agreements and re-enrollment.**

(A) Definitions:

(1) Open-ended provider agreement. This type of provider agreement has no specific termination date and continues to be in effect as long as agreeable by both parties.

(2) Time-limited provider agreement. This type of provider agreement is for a specific period of time and will expire on a designated date unless renewed in accordance with the Ohio department of job and family services (ODJFS) re-enrollment process. A time-limited provider agreement will be limited to no longer than seven years from the effective date.

(B) The use of time-limited provider agreements pursuant to this rule does not apply to provider agreements issued to the following, including any provider agreements issued to the following that are otherwise time-limited under the medicaid program:

(1) Nursing facilities, as defined in section 5111.20 of the Revised Code;

(2) Intermediate care facilities for the mentally retarded, as defined in section 5111.20 of the Revised Code;

(3) Managed care organizations under contract with the department pursuant to section 5111.17 of the Revised Code; and

(4) Hospitals.

(C) The following agreements shall be time-limited agreements or will be converted to time-limited agreements pursuant to section 5111.028 of the Revised Code, unless the provider is one of the provider types listed in paragraphs (B)(1) to (B)(4) of this rule:

(1) Any new provider agreement shall be time-limited in accordance with this rule.

(2) Any existing open-ended provider agreement held by a provider that was enrolled before January 1, 2008, shall be converted to a time-limited agreement on or before January 1, 2015, in accordance with this rule.

(a) ODJFS shall select the provider agreements to be converted and automatically phase in time-limited agreements in a manner and for a time determined by ODJFS.

(b) ODJFS shall notify the provider by sending a conversion notice by regular mail to the address on file that the provider has been automatically converted to a time-limited-agreement in accordance with this rule. Providers are not required to respond to the ODJFS conversion notice.

(c) Providers that have been selected and converted to time-limited agreements may not request that the proposed expiration be altered, either to an earlier or later date.

(3) ODJFS may convert any existing open-ended provider agreement to a time-limited provider agreement whenever the conversion is in the best interest of the medicaid consumers or the state of Ohio.

(4) The conversion from an open-ended to a time-limited provider agreement does not affect the amount or scope of medicaid reimbursement.

(5) The length of time-limited agreements is decided by ODJFS and is determined by provider type. The length of time-limited agreements may vary by provider type but will be consistent for all providers within like provider types. ODJFS may change the length of time-limited agreements by provider type and the length of these agreements may change or vary upon the discretion of ODJFS.

(6) ODJFS will notify the provider when its time-limited provider agreement is close to expiration and when the re-enrollment process is required, as described in paragraph (D) of this rule.

(D) Re-enrollment is the process that a provider with a time-limited agreement is required to follow to renew its provider agreement. The re-enrollment process does not apply to MCPs or open-ended agreements. The re-enrollment process is as follows:

(1) ODJFS shall send a re-enrollment notice by regular mail ninety days prior to the expiration date of the provider's time-limited agreement to the provider's address on file notifying the provider that it is required to renew its agreement.

(2) The re-enrollment notice shall instruct the provider what is required to complete the re-enrollment process. Providers are expected to meet all conditions for participation as an eligible provider that are in effect in division 5101:3 of the Administrative Code at the time of re-enrollment.

(3) The provider shall submit all required information before the re-enrollment deadline date specified in the re-enrollment notice.

(4) A provider shall not initiate re-enrollment prior to the receipt of the re-enrollment notification sent by ODJFS as specified in paragraph (D) of this rule. This rule does not negate the requirement that a provider must disclose any changes to its provider agreement in accordance with rule 5101:3-1-17.3 of the Administrative Code. The reporting of changes in accordance with rule 5101:3-1-17.3 of the Administrative Code does not constitute the initiation of re-enrollment and remains the provider's responsibility.

(5) When a provider fails to re-enroll in the time and the manner required by ODJFS, as specified in this rule and in accordance with the re-enrollment notice referred to in paragraph (D)(2) of this rule, ODJFS may deny an application for re-enrollment or terminate a time-limited provider agreement. The denial or termination will take effect thirty days after ODJFS mails a written notice to the provider by regular mail to the address on file notifying the provider of the decision. ODJFS shall specify in the notice the date on which the provider is required to cease operating under a terminated provider agreement.

In lieu of denying an application for re-enrollment or terminating a time-limited agreement when a provider fails to re-enroll in the time and manner required and the agreement expires, ODJFS may deny claims submitted by the provider until the provider completes the re-enrollment process and the re-enrollment application is approved by ODJFS. Once the re-enrollment application is approved by ODJFS, ODJFS may allow the provider to re-submit any claims that were denied while its re-enrollment application pended ODJFS approval. ODJFS will not deny claims pursuant to this paragraph when a provider has re-enrolled in the time and the manner required by ODJFS.

(6) If a provider files an application for re-enrollment within the time and in the manner required, as specified in this rule, but the provider agreement expires before ODJFS acts on the application or before the effective date of the ODJFS decision on the application, the provider may continue operating under the terms of the expired agreement until the effective date of the ODJFS decision.

(7) If a provider files an application for re-enrollment in the time and manner required, as specified in this rule, but has not been able to obtain a renewal of its licensure, certification, accreditation, or registration due to a delay in processing by an official, board, commission, department, division, bureau or other agency of state or federal government:

(a) ODJFS shall not deny the application for re-enrollment or deny payment of services if the provider has included documentation with the re-enrollment application that the licensure, certification, accreditation, or registration has been delayed for processing by an official, board, commission, department, division, bureau or other agency of state or federal government; and

(b) When the decision is made by an official, board, commission, department, division, bureau or other agency of state or federal government to approve or reject an application for renewal of required licensure, certification, accreditation, or registration, the provider is obligated to notify ODJFS within thirty days of the date of approval or rejection in accordance with rule 5101:3-1-17.2 of the Administrative Code.

(E) The effective date of a new provider agreement is the date on which the provider signs the application and meets all of the federal and state requirements for participation in the medicaid program. The effective date of a new provider agreement may be made retroactive for up to twelve months prior to the date of application. A retroactive period will be counted when assigning a time-limit to a new provider agreement to encompass dates on which the provider furnished covered services to a medicaid consumer for which the provider has not been reimbursed. Upon ODJFS approval of the application and the effective date of the agreement, ODJFS will accept claims submitted timely for the retroactive period. Exceptions to the twelve month retroactive period include:

(1) When required licensure, certification, accreditation, or registration is obtained by the provider within the twelve months prior to the application date, the effective date will be that date on which the required license, certification, accreditation, or registration was obtained.

(2) Claims submitted within the twelve month retroactive period will be denied for any service provided if the provider did not meet all ODJFS program requirements for participation on the date the service was provided.

(3) ODJFS may deny retroactive eligibility to a provider for failure to meet re-enrollment requirements as specified in this rule.

(F) Pursuant to section 5111.06 of the Revised Code, ODJFS is not required to issue a notice of hearing rights, in accordance with Chapter 119. of the Revised Code, when converting a provider agreement to a time-limited agreement or when terminating a time-limited provider agreement due to the provider's failure to file an application for re-enrollment.

(G) In processing an application for re-enrollment, ODJFS may conduct an on-site review at the provider's facility, place of business, or both, as ODJFS deems necessary to ensure program integrity.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under: 119.03
Statutory Authority:
Rule Amplifies:

5160-1-17.4 **Revalidation of provider agreements.**

(A) Revalidation is the process that a provider is required to follow to renew and revalidate its provider agreement. Provider agreements must be revalidated no later than five years from the effective date of the original or the last revalidated provider agreement, whichever is applicable. 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. Provider agreements must also be revalidated whenever there is a change in risk pursuant to 42 C.F.R. 455.450 (as in effect May 29, 2018) The revalidation process is as follows:

(1) The Ohio department of medicaid (ODM) shall send a revalidation notice by regular mail ninety days prior to the expiration date of the provider's time-limited agreement to the provider's address on file notifying the provider that it is required to revalidate its agreement.

(2) The revalidation notice shall instruct the provider what is required to complete the revalidation process. Providers are expected to meet all conditions for participation as an eligible provider that are in effect in Chapter 5160-1 of the Administrative Code at the time of revalidation.

(3) The provider shall submit all required information before the revalidation deadline date specified in the revalidation notice including the required fee as specified in rule 5160-1-17.8 of the Administrative Code.

(4) A provider shall not initiate revalidation prior to the receipt of the revalidation notification sent by ODM. This rule does not negate the requirement that a provider must properly disclose any changes to its provider agreement in accordance with rule 5160-1-17.3 of the Administrative Code. The reporting of changes does not constitute the initiation of revalidation and remains the provider's responsibility.

(5) When a provider fails to revalidate in the time and the manner required by ODM, as specified in this rule and in accordance with the revalidation notice referred to in paragraph (A)(1) of this rule, ODM shall deny an application for revalidation and terminate the time-limited provider agreement. The denial and termination will take effect thirty days after ODM mails a written notice to the provider by regular mail to the address on file notifying the provider of the decision. ODM shall specify in the notice the date on which the provider is required to cease operating under a terminated provider agreement.

(6) If a provider files an application for revalidation within the time and in the manner required, as specified in this rule, but the provider agreement expires before ODM acts on the application or before the effective date of the ODM decision on the application, the provider may continue operating under the

terms of the expired agreement until the effective date of the ODM decision.

(7) If a provider files an application for revalidation within the time and in the manner required, as specified in this rule, but has not been able to obtain a renewal of its licensure, certification, accreditation, or registration the application may be accepted and processed by ODM as long as the granting official, board, commission, department, division, bureau, or other agency of state or federal government considers the provider in good standing and that its licensure, certification, accreditation, or registration is still active.

(B) The effective date of a new provider agreement is the date on which the provider signs the application and meets all of the federal and state requirements for participation in the medicaid program. The effective date of a new provider agreement may be made retroactive for up to twelve months prior to the date of application if the provider was properly licensed or certified.

(C) Pursuant to section 5164.38 of the Revised Code, ODM is not required to afford hearing rights, in accordance with Chapter 119. of the Revised Code when terminating a time-limited provider agreement due to the provider's failure to properly file an application for revalidation.

(D) In processing an application for revalidation, ODM reserves the right to conduct an on-site review at the provider's facility, place of business, or both, as ODM deems necessary to ensure program integrity.