Ohio | Common Sense Initiative

Mike DeWine, Governor
Jon Husted, Lt. Governor

Carrie Kuruc, Director

Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Medicaid

Rule Contact Name and Contact Information:

Tommi Potter 614-752-3877

Regulation/Package Title (a general description of the rules' substantive content):

Medicaid Provider Screening

Rule Number(s): 5160-1-17.8 (Amend)

Date of Submission for CSI Review: 9/17/2019

Public Comment Period End Date: 9/24/2019

Rule Type/Number of Rules:

New/___ rules

Amended/__1_ rule (FYR? Yes)

No Change/____ rules (FYR? ___)

Rescinded/____ rules (FYR? ___)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

77 SOUTH HIGH STREET | 30TH FLOOR | COLUMBUS, OHIO 43215-6117

CSIPublicComments@governor.ohio.gov

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☐ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☒ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☒ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. **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). 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. The rule is also being updated to remove discontinued provider types from the appendix.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

   Sections 5164.02 and 5164.31 of the Ohio Revised Code.

4. **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 rule 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.

5. **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.

6. **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 rule 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.

7. **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 screened in accordance with state and federal laws while appropriate exclusions or penalties are applied as necessary. The success of this rule is also demonstrated by the enrollment of safe and qualified providers in the Medicaid program.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**
   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.
   The proposed rule is not being submitted pursuant to any of the listed ORC sections.

Development of the Regulation

9. **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.

   Ohio County Behavioral Health Authorities

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

Governmental Policy Group, Inc.

Ohio Poverty Law Center

All four stakeholders participated in a conference call in May 2019 and additional dialog occurred with The Ohio Council by email during June and July 2019.

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

    The Ohio Council is the only stakeholder that provided substantive comments. They requested that the group of providers exempted from the disqualifying conditions be expanded from the one original provider type, peer recovery supporters. After a second provider type was added to the exclusion list, they requested that additional provider types be added. ODM agreed to the request and added the additional requested provider types for exclusion as currently listed in the rule. The Ohio Council also requested that the list of disqualifying conditions categorized as permanent be the same as those listed in rule 5122-29-15.1. Because of the seriousness of the criminal conditions that would have to be removed from the rule, ODM made the decision not to remove the conditions from the disqualifying conditions list. The Ohio Council also asked that rule language be clarified regarding provider listing on databases that might prevent a provider from holding a Medicaid provider agreement. ODM agreed and revised the proposed language.

    The Governmental Policy Group submitted a comment stating that they supported the final draft of the rule with the above noted changes made.

11. **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.

12. **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.

13. **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.

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

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

15. **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.

    The revision in the amended rule will not require any additional implementation activities on the part of ODM.

Adverse Impact to Business

16. **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; and**

    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 all adverse impact (e.g., fees, fines, employer time for compliance,); and**

    The proposed amended rule 5160-1-17.8 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. 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 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.

It is not expected that the proposed revisions to the rule will create any new adverse impacts.

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.

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.

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. 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.

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.

17. 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, and by protecting the integrity of the Medicaid program by ensuring compliance with federal requirements related to provider screening.

Regulatory Flexibility

18. 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.

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

20. 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.

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 become an eligible provider, a provider must meet the screening requirements described in this rule and in section 5164.34 of the 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 revalidation as defined in rule 5160-1-17.4 of the Administrative Code.

(1) Exemptions.

(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.

(d) When employed by or independently contracted with an entity certified by the Ohio department of mental health and addiction services, the following are exempt from the provisions of paragraphs (E)(2) to (E)(4) of this rule when providing services for the entity.

(i) Certified peer recovery supporters as defined in rule 5122-29-15.1 of the Administrative Code;

(ii) Practitioners licensed or certified under Chapter 4757. of the Revised Code;

(iii) Practitioners licensed or certified under Chapter 4758. of the Revised Code.

(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 (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.

(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 agency 5160 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), 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.

(iii) A provider is disqualified from receiving a medicaid provider agreement during the time the provider is on one or more of the following registries or databases:

(a) the social security administration's death master file;

(b) the list of excluded individuals or entities maintained by the office of the inspector general, health and human services;

(c) the medicare exclusion database (MED;

(d) the list of providers terminated by another state's medicaid program;

(e) the abuser registry maintained by the Ohio department of developmental disabilities;

(f) the system for awards manaement (SAM) list of individuals or entities with an exclusion;

(g) the nurse aid registery abuse listing maintained by the Ohio department of health.

(2) Moderate.

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

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

(i) Pre- and post-enrollment site visits by ODM or its designee will verify that information provided to 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 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 (D)(1) and (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 within thirty days of submission of the application in a form and manner determined by 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.

(a) Individuals who have been convicted of or pleaded guilty to, an offense in any of the following sections of the Revised Code are permanently excluded from participation in the medicaid program:

(i) 2903.01 (aggravated murder);

(ii) 2903.02 (murder);

(iii) 2903.03 (voluntary manslaughter);

(iv) 2903.11 (felonious assault);

(v) 2903.15 (permitting child abuse);

(vi) 2903.16 (failing to provide for a functionally-impaired person);

(vii) 2903.34 (patient abuse or neglect);

(viii) 2903.341 (patient endangerment);

(ix) 2905.01 (kidnapping);

(x) 2905.02 (abduction);

(xi) 2905.32 (human trafficking);

(xii) 2905.33 (unlawful conduct with respect to documents);

(xiii) 2907.02 (rape);

(xiv) 2907.03 (sexual battery);

(xv) 2907.04 (unlawful sexual conduct with a minor, formerly corruption of a minor);

(xvi) 2907.05 (gross sexual imposition);

(xvii) 2907.06 (sexual imposition);

(xviii) 2907.07 (importuning);

(xix) 2907.08 (voyeurism);

(xx) 2907.12 (felonious sexual penetration, as that offense existed prior to September 3, 1996);

(xxi) 2907.31 (disseminating matter harmful to juveniles);

(xxii) 2907.32 (pandering obscenity);

(xxiii) 2907.321 (pandering obscenity involving a minor);

(xxiv) 2907.322 (pandering sexually-oriented matter involving a minor);

(xxv) 2907.323 (illegal use of a minor in nudity-oriented material or performance);

(xxvi) 2909.22 (soliciting or providing support for act of terrorism);

(xxvii) 2909.23 (making terroristic threats);

(xxviii) 2909.24 (terrorism);

(xxix) 2913.40 (medicaid fraud);

(xxx) If related to another offense under paragraph (E)(1)(a) of this rule, 2923.01 (conspiracy), 2923.02 (attempt), or 2923.03 (complicity); or

(b) A conviction related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct involving a federal or state-funded program, excluding the disqualifying offenses set forth in section 2913.46 of the Revised Code (illegal use of supplemental nutrition assistance program (SNAP) or women, infants, and children (WIC) program benefits) and paragraph (E)(2)(a)(xiii) of this rule; or

(c) A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations described in paragraph (E)(1)(a) or (E)(1)(b) of this rule.

(2) Tier II. Ten-year exclusionary period.

(a) Individuals who have been convicted of or pleaded guilty to, an offense in any of the following sections of the Revised Code are excluded from participation in the medicaid program for a period of ten years from the date the individual was fully discharged from all imprisonment, probation or parole:

(i) 2903.04 (involuntary manslaughter);

(ii) 2903.041 (reckless homicide);

(iii) 2905.04 (child stealing, as that offense existed prior to July 1, 1996);

(iv) 2905.05 (child enticement);

(v) 2905.11 (extortion);

(vi) 2907.21 (compelling prostitution);

(vii) 2907.22 (promoting prostitution);

(viii) 2907.23 (enticement or solicitation to patronize a prostitute; procurement of a prostitute for another);

(ix) 2909.02 (aggravated arson);

(x) 2909.03 (arson);

(xi) 2911.01 (aggravated robbery);

(xii) 2911.11 (aggravated burglary);

(xiii) 2913.46 (illegal use of SNAP or WIC program benefits);

(xiv) 2913.48 (worker's compensation fraud);

(xv) 2913.49 (identity fraud);

(xvi) 2917.02 (aggravated riot);

(xvii) 2923.12 (carrying concealed weapons);

(xviii) 2923.122 (illegal conveyance or possession of deadly weapon or dangerous ordnance in a school safety zone, illegal possession of an object indistinguishable from a firearm in a school safety zone);

(xix) 2923.123 (illegal conveyance, possession, or control of deadly weapon or ordnance into courthouse);

(xx) 2923.13 (having weapons while under a disability);

(xxi) 2923.161 (improperly discharging a firearm at or into a habitation or school);

(xxii) 2923.162 (discharge of firearm on or near prohibited premises);

(xxiii) 2923.21 (improperly furnishing firearms to minor);

(xxiv) 2923.32 (engaging in a pattern of corrupt activity);

(xxv) 2923.42 (participating in a criminal gang);

(xxvi) 2925.02 (corrupting another with drugs);

(xxvii) 2925.03 (trafficking in drugs);

(xxviii) 2925.04 (illegal manufacture of drugs or cultivation of marijuana);

(xxix) 2925.041 (illegal assembly or possession of chemicals for the manufacture of drugs);

(xxx) 3716.11 (placing harmful or hazardous objects in food or confection); or

(xxxi) If related to an offense under paragraph (E)(2)(a) of this rule, 2923.01 (conspiracy), 2923.02 (attempt), or 2923.03 (complicity); or

(b) A violation of an existing or former municipal ordinance or law of this state, any other state or the United States that is substantially equivalent to any of the offenses or violations described under paragraph (E)(2)(a) of this rule.

(c) If the individual has been convicted of multiple disqualifying offenses, including an offense listed in paragraph (E)(2)(a) or (E)(2)(b) of this rule, and another offense or offenses listed in paragraph (E)(2)(a), (E)(3)(a), (E)(3)(b), (E)(4)(a), or (E)(4)(b) of this rule, the individual is subject to a fifteen-year exclusionary period beginning on the date the individual was fully discharged from all imprisonment, probation or parole for the most recent offense.

(3) Tier III. Seven-year exclusionary period.

(a) Individuals who have been convicted of or pleaded guilty to, an offense in any of the following sections of the Revised Code are excluded from participation in the medicaid program for a period of seven years from the date the individual was fully discharged from all imprisonment, probation or parole:

(i) 959.13 (cruelty to animals);

(ii) 959.131 (prohibitions concerning companion animals);

(iii) 2903.12 (aggravated assault);

(iv) 2903.21 (aggravated menacing);

(v) 2903.211 (menacing by stalking);

(vi) 2905.12 (coercion);

(vii) 2909.04 (disrupting public services);

(viii) 2911.02 (robbery);

(ix) 2911.12 (burglary);

(x) 2913.47 (insurance fraud);

(xi) 2917.01 (inciting to violence);

(xii) 2917.03 (riot);

(xiii) 2917.31 (inducing panic);

(xiv) 2919.22 (endangering children):

(xv) 2919.25 (domestic violence);

(xvi) 2921.03 (intimidation);

(xvii) 2921.11 (perjury);

(xviii) 2921.13 (falsification, falsification in a theft offense, falsification to purchase a firearm, or falsification to obtain a concealed handgun license);

(xix) 2921.34 (escape);

(xx) 2921.35 (aiding escape or resistance to lawful authority);

(xxi) 2921.36 (illegal conveyance of weapons, drugs or other prohibited items onto the grounds of a detention facility or institution);

(xxii) 2925.05 (funding drug trafficking);

(xxiii) 2925.06 (illegal administration or distribution of anabolic steroids);

(xxiv) 2925.24 (tampering with drugs);

(xxv) 2927.12 (ethnic intimidation); or

(xxvi) If related to an offense under paragraph (E)(3)(a) of this rule, 2923.01 (conspiracy), 2923.02 (attempt), or 2923.03 (complicity); or

(b) A violation of an existing or former municipal ordinance or law of this state, any other state or the United States that is substantially equivalent to any of the offenses or violations described under paragraph (E)(3)(a) of this rule.

(c) If an individual has been convicted of multiple disqualifying offenses, including an offense listed in paragraph (E)(3)(a) or (E)(3)(b) of this rule, and another offense or offenses listed in paragraph (E)(3)(a), (E)(3)(b), (E)(4)(a), or (E)(4)(b) of this rule, the individual is subject to a ten-year exclusionary period beginning on the date the individual was fully discharged from all imprisonment, probation or parole for the most recent offense.

(4) Tier IV. Five-year exclusionary period.

(a) Individuals who have been convicted of or pleaded guilty to, an offense in any of the following sections of the Revised Code are excluded from participation in the medicaid program for a period of five years from the date the individual was fully discharged from all imprisonment, probation or parole:

(i) 2903.13 (assault);

(ii) 2903.22 (menacing);

(iii) 2907.09 (public indecency);

(iv) 2907.24 (soliciting);

(v) 2907.25 (prostitution);

(vi) 2907.33 (deception to obtain matter harmful to juveniles);

(vii) 2911.13 (breaking and entering);

(viii) 2913.02 (theft);

(ix) 2913.03 (unauthorized use of a vehicle);

(x) 2913.04 (unauthorized use of computer, cable or telecommunication property);

(xi) 2913.05 (telecommunication fraud);

(xii) 2913.11 (passing bad checks);

(xiii) 2913.21 (misuse of credit cards);

(xiv) 2913.31 (forgery - forging identification cards or selling or distributing forged identification cards);

(xv) 2913.32 (criminal simulation);

(xvi) 2913.41 (defrauding a rental agency or hostelry);

(xvii) 2913.42 (tampering with records);

(xviii) 2913.43 (securing writings by deception);

(xix) 2913.44 (personating an officer);

(xx) 2913.441 (unlawful display of law enforcement emblem);

(xxi) 2913.45 (defrauding creditors);

(xxii) 2913.51 (receiving stolen property);

(xxiii) 2919.12 (unlawful abortion);

(xxiv) 2919.121 (unlawful abortion upon minor);

(xxv) 2919.123 (unlawful distribution of an abortion-inducing drug);

(xxvi) 2919.23 (interference with custody);

(xxvii) 2919.24 (contributing to the unruliness or delinquency of a child);

(xxviii) 2921.12 (tampering with evidence);

(xxix) 2921.21 (compounding a crime);

(xxx) 2921.24 (disclosure of confidential information);

(xxxi) 2921.32 (obstructing justice);

(xxxii) 2921.321 (assaulting or harassing a police dog, horse, or service animal);

(xxxiii) 2921.51 (impersonation of peace officer);

(xxxiv) 2925.09 (illegal administration, dispensing, distribution, manufacture, possession, selling, or using of any dangerous

veterinary drug);

(xxxv) 2925.11 (drug possession, other than a minor drug possession offense);

(xxxvi) 2925.13 (permitting drug abuse);

(xxxvii) 2925.22 (deception to obtain a dangerous drug);

(xxxviii) 2925.23 (illegal processing of drug documents);

(xxxix) 2925.36 (illegal dispensing of drug samples);

(xl) 2925.55 (unlawful purchase of pseudoephedrine product);

(xli) 2925.56 (unlawful sale of pseudoephedrine product);

(xlii) If related to an offense under paragraph (E)(4)(a) of this rule, 2923.01 (conspiracy), 2923.02 (attempt), or 2923.03 (complicity); or

(b) A violation of an existing or former municipal ordinance or law of this state, any other state or the United States that is substantially equivalent to any of the offenses or violations described under paragraph (E)(4)(a) of this rule.

(c) If an individual has been convicted of multiple disqualifying offenses listed in paragraph (E)(4)(a) or (E)(4)(b) of this rule, the individual is subject to a seven-year exclusionary period beginning on the date the individual was fully discharged from all imprisonment, probation or parole for the most recent offense.

(5) Tier V. No exclusionary period.

(a) Individuals who have been convicted of or pleaded guilty to, an offense in any of the following sections of the Revised Code are not subject to an exclusionary period and may participate in the medicaid program:

(i) 2919.21 (non-support/contributing to non-support of dependents);

(ii) 2925.11 (drug possession that is a minor drug possession offense); or

(iii) 2925.14 (drug paraphernalia); or

(iv) 2925.141 (illegal use or possession of marijuana drug paraphernalia); or

(b) A violation of an existing or former municipal ordinance or law of this state, any other state or the United States that is substantially equivalent to any of the offenses or violations described under paragraph (E)(5)(a) of this rule.

(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 an Ohio court of common pleas pursuant to section 2953.25 of the Revised Code, or an equivalent certification has been issued by an out of state or federal jurisdiction.

~~(6) A provider who has been convicted of, or pleaded guilty to, an offense listed in paragraph (E) of this rule and who has applied to obtain a pardon or certificate as described in paragraphs (F)(1) to (F)(5) of this rule shall not be excluded from participation in the medicaid program until the earlier of the date of the pardon or certificate is denied, or October 1, 2019.~~

(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 ODM at the time of application for enrollment or revalidation as a medicaid provider. If proof of fee payment is not submitted with the provider's application, the application will be 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, (February 2, 2011).

(3) ODM may waive an application fee if:

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

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

(4) If 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).

(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;

(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.

(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.