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 Rules@Medicaid.Ohio.gov

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

Provider Credentialing

Rule Number(s): 5160-1-42

Date of Submission for CSI Review: 04/06/2021

Public Comment Period End Date:

Rule Type/Number of Rules:

New/1 rules **No Change/____ rules (FYR? ___)**

Amended/__ 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 __) **Rescinded/__ rules (FYR?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.

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.

   OAC rule 5160-1-42, entitled "Provider Credentialing," is being proposed for adoption

   This rule sets forth credentialing requirements for eligible, active providers who enroll with the Department. The credentialing process will now be completed by the Department or its credentialing designee, rather than the individual Managed Care Plans. This will lessen the burden on enrolled providers and facilities as they currently must credential with every managed care plan with whom they choose to contract.

   This rule provides the process and requirements ODM, and its credentialing designee, will follow for applicable providers that require credentialing for their specific provider type. This rule also identifies the required information needed to complete the credentialing process and details any additional actions necessary on behalf of the provider or facility to complete credentialing.

   Some provider groups are considered by the department to be a delegate. The definition and requirements of becoming a delegate are outlined in the rule. Those providers who meet the delegate requirements will complete the full credentialing process for their providers on behalf

of the Department. Practitioners within a delegated group will revalidate their information on a schedule as determined by the Department.

This rule outlines the process the Department will take to establish a credentialing committee which will review practitioner or facility appeals or negative findings after the initial credentialing process. In addition, the credentialing committee will also make decisions regarding participation status with Medicaid when providers are required to recredential. Active participation from the individuals on the credentialing committee is necessary and outlined in the rule. The credentialing committee will meet on a timeline as specified in the rule.

It is necessary for providers to re-credential, and the re-credentialing process is outlined and for all designated provider types. Re-credentialing is mandatory every thirty-six months. Failure to re-credential will result in termination of the provider agreement.

This new rule allows for the Department to uphold and carry out credentialing requirements set forth by the Center for Medicare and Medicaid Services (CMS) in 42 C.F.R.422.204

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 5164.32 and 3963.05 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.

   These rules implement federal requirements.

   Provider agreement revalidation as addressed in proposed rule 5160-1-42 is a requirement applied to Medicaid providers by CMS under provisions set forth in 42 C.F.R.422.204.

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, however a rule is necessary as we are implementing state-specific regulations which fall within the federal guidelines

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 proposed rule is necessary to implement federal requirements concerning provider selection and credentialing as described in 42 C.F.R 422.204. 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 will implement and streamline this federal requirement to ease the current burden on providers and facilities of credentialing with many Managed Care Plans.

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 credentialed and re-credentialed in accordance with state and federal laws.

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 rules are not being submitted pursuant to 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.

An email communication was sent to every provider currently enrolled in the Medicaid provider portal (MITS) who require credentialing on 8/31/2020. Any returned emails were then followed up with a postal mail communication.

On 8/28/2020 a homepage banner was established on the MITS webpage portal announcing credentialing.

Communication was made in January 2021 regarding the delay of the Provider Network Module, PNM, directly impacting the go-live date for provider credentialing. These updates were sent to all enrolled ODM providers as well as on the Department website and through the MITS provider portal.

Ohio Department of Health

Ohio Department of Aging

Ohio Department of Mental Health and Addiction Services

Ohio Boards of Nursing, Medicine, and Chiropractic

Ohio State Medical Association

Ohio Association of Advanced Practice Nurses

Ohio Optometric Association

Ohio State Chiropractic Association

Ohio Association of Physicians Assistants

Ohio Counseling Association

National Association of Social Workers Ohio Chapter

Ohio Association of Alcoholism and Drug Addiction Counselors

Ohio Academy of Nutrition and Dietetics

Ohio Physical Therapy Association

Ohio Occupational Therapy Association

Ohio Health Care Association

Ohio Council for Home Care & Hospice

Ohio Hospital Association

The Ohio Council of Behavioral Health & Family Services Providers

All hospital systems who will enter into a Delegation Agreement with the Department have had one-on-one meetings with the ODM's operations and policy departments. These meetings were conducted between June and August 2020. The following delegated groups were contacted:

Cardinal PHO

Children's Hospital Medical Center of Akron

Christ Hospital

Cincinnati Children's Hospital

Cooperative Care

Dayton Children's Hospital

Genesis Healthcare System

The Holzer Clinic

King's Daughters Medical Center

Kettering Health System

Lake PHO

Licking Memorial Hospital

MetroHealth System

Mt Carmel Health System

Ohio State Wexner Medical Center

OhioHealth

Partners for Kids/Nationwide Children's Hospital

St Elizabeth Physicians

Summa PHO

University of Cincinnati Physicians

University Hospitals and Health Systems

University of Toledo Physicians

Western Reserve Hospital

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

While the rule is upholding specific qualifications set forth in 42 C.F.R 422.204, (October, 2020) the Ohio stakeholder community has only had positive comments regarding the centralized initiative. Providers are anxiously awaiting the streamlined credentialing process as a time and financial burden of credentialing with many organizations will be reduced.

Centralized credentialing is part of the five pillars of the next generation of Managed Care in Ohio and will continue to be broadly communicated as the Department proceeds.

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 necessary to develop this Medicaid policy, however careful analysis of federal policy was conducted to ensure outcomes were met.

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?

Federal regulation requires credentialing for specific provider and facility types. The previous alternative to ODM managing the credentialing initiative within the department level was to have each individual managed care plan credential for the required providers and facilities contracting with the plan. This was not effective, however, as it resulted in an increased burden on the providers and facilities as they were credentialing many times. Therefore, the department decided it was in best interest of contracted providers to have the department take on the credentialing responsibilities, resulting in a streamlined, less burdensome process.

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 this rule implements federal requirements and is not performance-based.

14. 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.

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.

The aspects of this regulation are contained within the Ohio Medicaid Enterprise System (OMES) Provider Network Module (PNM). ODM has contracted with a National Committee for Quality Assurance (NCQA)-accredited Credentials Verification Organization (CVO) to complete certain credentialing-related tasks. The CVO will be responsible for collecting primary source verifications (licensure, board certification, Drug Enforcement Agency certificate, etc.), monitoring sanctions (the process of reviewing licensing board actions) and participating in the Medicaid credentialing committee to inform the agency of best practices and processes. Once the CVO authenticates all required documentation, records will be forwarded to ODM for final determinations. ODM will follow all NCQA rules and regulations, and complete periodic auditing of the CVO to determine compliance. This will include policy review, documentation review, and timeliness considerations.

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 and are included in the list of specific provider types who are required to be credentialed as detailed in the rule. This includes individual providers, facilities, and hospital systems and physician groups meeting the qualifications to serve as a delegate.

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

The nature of the adverse impact for this new rule are primarily administrative costs in employee time, as a provider is required to gather and submit information specified in the rule to complete the credentialing process. However, the department is streamlining the credentialing process, making it easier, less costly, and more time efficient for effected providers and facilities as now they will only be responsible for credentialing once, rather than with every Managed Care plan with which they choose to contract.

This rule also requires reporting of provider information to the Department to fulfill credentialing information gathering and reporting requirements. The provider is required to be fully licensed with their required boards and submit all required credentialing information to the Department or its credentialing designee.

Rule 5160-1-42 requires specific Ohio Medicaid providers to credential and re-credential with the Department every thirty-six months.

For providers who fail to timely or properly credential or re-credential, this rule indicates what actions ODM may take including denying the credentialing application and terminating the provider agreement.

There may also be an adverse impact for those systems who choose to enroll with the department as a delegate. Prerequisites for becoming a delegate must be met, however, these prerequisites are administrative in nature.

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.

Rule 5160-1-42 requires identified provider types enrolled with the Department to credential and re-credential with the Department or its Designee thirty-six months.

Credentialing by ODM is mandatory for the following practitioners:
(1) Physicians as defined in Chapter 4731. of the Revised Code;
(2) Psychologists as defined in Chapter 4732 of the Revised Code;
(3) Physician assistant as defined in Chapter 4730. of the Revised Code;
(4) Dentists as defined in Chapter 4715. of the Revised Code;
(5) Optometrists as defined in Chapter 4725. of the Revised Code;
(6) Pharmacists as defined in Chapter 4729. of the Revised Code;
(7) Chiropractors as defined in Chapter 4734. of the Revised Code;
(8) Acupuncturists as defined in Chapter 4762. of the Revised Code;
(9) Clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner as defined in Chapter 4723. of the Revised Code;
(10) Licensed independent social worker, licensed independent marriage and family therapist, or licensed professional clinical counselor as defined in Chapter 4757. of the Revised Code;
(11) Licensed independent chemical dependency counselor as defined in Chapter 4758. Of the Revised Code;
(12) Certified Ohio Behavior Analysts as defined in Chapter 4783. of the Revised Code;
(13) Audiologists as defined in Chapter 4753. of the Revised Code;
(14) Occupational therapist as defined in Chapter 4755. of the Revised Code;
(15) Physical therapist as defined in Chapter 4755. of the Revised Code;
(16) Speech-language pathologist as defined in Chapter 4753. of the Revised Code; and
(17) Dietitians as define in Chapter 4759. of the Revised Code.

Credentialing by ODM is mandatory for the following facilities:
(1) Nursing Facilities as defined in Chapter 3721. of the Revised Code;
(2) Intermediate Care Facilities for Individuals with Intellectual Disabilities as defined in Chapter 5124. of the Revised Code;
(3) Hospitals as defined in Chapter 3727. of the Revised Code ;
(4) Hospice as defined in Chapter 3721. of the Revised Code;
(5) Home Health Agencies as defined in Chapter 3701-60. of the Revised Code;
(6) Ambulatory Surgical Facilities as defined in Chapter 3702.30. of the Revised Code;
(7) Community Mental Health Centers as defined in Chapter 5119. of the Revised Code;
(8) Substance Use Disorder Clinics as defined in Chapter 5119. of the Revised Code;
(9) End Stage Renal Disease Treatment Centers as defined in 3701-83-23.1 of the Administrative Code;
(10) Radiology Centers as defined in 3701-83-51. of the Administrative Code;
(11) Residential Treatment Centers as defined in Chapter 5119. of the Revised Code; and
(12) Substance Abuse Rehabilitation Centers as defined in Chapter 5119. of the Revised Code.

The facilities listed in paragraph (C) of this rule will provide ODM or ODM's credentialing designee access to the following information for initial credentialing verification and may add to administrative time and costs. However, this information will only need to be provided to ODM once, rather than to all the Managed Care Plans as previously required. Facilities are required to complete certification by their applicable accreditation body, or a site visit by the state designated agency.

(1) The Ohio department of insurance (ODI) form INS5036, revision date August of 2020, found at https://insurance.ohio.gov/static/Forms/Documents/INS5036.pdf ;
(2) Active provider licensing information;
(3) Certification through an accrediting body or a site visit completed by a state designated agency.
(4) Eligibility for participation in medicare and medicaid, if applicable;
(5) Verification of good standing with applicable state and federal bodies; and
(6) Active malpractice insurance.

Prerequisites for becoming a delegate as defined in paragraph (A)(4) of this rule are the following and may also require administrative time. Many conditions for becoming a delegate are also required for obtaining enrollment with ODM.

(1) Maintain an active, valid delegation contract approved by the credentialing committee;
(2) The delegate has to complete a pre-delegation audit prior to their becoming an active delegate;
(3) The delegate has to adhere to the standards set forth in the delegated contract, including the time frames and content for reporting, duties assigned, necessary processes and procedures, and collaborating of a yearly audit;

(4) The delegate has to have their own credentialing committee, with decision making capabilities, and delegation contract monitoring;
(5) The delegate has to report any additions, changes, terminations in a timely manner including both credentialed and non-credentialed practitioners and facilities;
(6) Delegates will be audited by ODM every twelve months; and
(7) Practitioners with a delegated group are still expected to update their information in the provider data system, and to revalidate according to their ODM determined schedule.

According to the Bureau of Labor Statistics, the average salary (with fringe benefits) for a First-Line Supervisor of a Physician's Office is $57,240. Based on this figure, the estimated ninety (90) minutes it takes to complete the credentialing application, report information, or provide documentation would cost the provider approximately $41.28 to complete the required process. This cost would be incurred once during a period not to exceed every three (3) years.

For providers who fail to timely and properly re-credential, 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.

.

The provider may experience additional administrative costs in this case. These costs may include staff time required to prepare for a credentialing committee 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 but will include the time to gather and provide the information requested, the time to complete the review and the personnel required to assist.

17. 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 credentialing.

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 these regulations apply to the specified 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 monetary 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.