CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: ODM-administered Waiver Provider Enrollment Process

Rule Number(s): 5160-45-04

Date: December 3, 2015

Rule Type:

X New
Amended
X 5-Year Review
X Rescinded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.

   OAC 5160-45-04

   OAC rule 5160-45-04 sets forth the enrollment process for Ohio Department of Medicaid (ODM) -administered waiver service providers. The current rule is being proposed for rescission as a result of five-year review and it is being replaced with a proposed new rule bearing the same number.

77 SOUTH HIGH STREET | 30TH FLOOR | COLUMBUS, OHIO 43215-6117
CSIOhio@governor.ohio.gov

Among other things, the proposed new establishes:

(A) ODM-administered waiver provider applicants must successfully complete the provider enrollment process and receive approval from ODM before furnishing services to an individual enrolled on an ODM-administered waiver. Services furnished before ODM approves and enrolls the provider applicant are not reimbursable.

(B) The provider applicant must complete and submit a waiver provider application to ODM through its Medicaid Information Technology System (MITS) web portal in accordance with rule 5160-1-17.2 of the Administrative Code.

(C) Upon receipt of the waiver provider application, ODM or its designee shall verify:

(1) The provider applicant submitted and meets all applicable ODM-administered waiver provider requirements;

(2) The provider applicant included a statement affirming he or she is aware of, understands and agrees to all of the Administrative Code rules governing the ODM-administered waiver program; and

(3) The non-agency provider applicant, agency provider applicant and/or the agency's primary officer, director or owner is not on any federal or state exclusionary lists ODM considers when determining Medicaid provider eligibility.

(D) ODM or its designee shall notify the provider applicant if the application does not contain all of the required documentation. The rule also specifies the time frame during which the provider applicant must submit the outstanding information or the application will be rejected.

(E) ODM shall enroll or deny enrollment based upon its review and the review and recommendation of its designee. ODM will also notify the provider applicant in writing of its decision and if it denies enrollment, will issue appeal rights in accordance with Chapter 119 of the Revised Code.

(F) When a current ODM-administered waiver service provider submits its Medicaid provider agreement revalidation application, and/or applies for an additional provider type, and/or specialty under their current provider type, ODM shall ensure that criminal record

check requirements are satisfied. ODM shall also review the provider's history, including but not limited to, Medicaid program compliance and performance. ODM may approve or deny revalidation based on its findings and in accordance with rule 5160-1-17.6 of the Administrative Code.

(G) When a former Medicaid provider applies for enrollment to become an ODM-administered waiver provider, in addition to the above referenced process, ODM will also review the provider applicant's history, including but not limited to, Medicaid program compliance and performance. ODM may approve or deny enrollment based on its findings and in accordance with rule 5160-1-17.6 of the Administrative Code.

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

Ohio Revised Code Sections 5166.02 and 5166.30.

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.

Yes. In order for CMS to approve a 1915(c) home and community-based services waiver, a state must meet certain assurances concerning the operation of the waiver. These assurances are spelled out in 42 C.F.R 441.302, and include:

(a) "Health and Welfare - Assurance that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the services. Those safeguards must include—
(1) Adequate standards for all types of providers that provide services under the waiver;
(2) Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver;…."

Providers of ODM-administered waiver services must be qualified, i.e., only those agencies and persons who comply with established provider enrollment process set forth in this rule, and meet the appropriate provider qualifications, will be enrolled as an ODM-administered waiver service provider.

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

   Not applicable. This rule establishes the specific process for meeting waiver program provider eligibility and enrollment requirements as required by CMS.

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)?**

   The public purpose of these regulations is to assure the health and welfare of waiver participants as required by 42 C.F.R 441.302(a) through the provision of services by qualified providers. The State is doing so by establishing the process provider applicants must follow in order to be enrolled as ODM-administered waiver service providers. Additionally, these requirements are intended to ensure Medicaid program integrity.

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

   Successful outcomes are measured through the enrollment of qualified ODM-administered waiver service providers.

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.

   Waiver program staff worked with ODM Provider Enrollment staff, and the stakeholders listed below to review and revise OAC 5160-45-04.

   The Ohio Council for Home Care and Hospice
   Midwest Care Alliance
   CareSource (case management contractor)

CareStar (case management contractor)
Council on Aging (case management contractor)
Public Consulting Group (PCG) (provider oversight contractor)
Ohio Olmstead Task Force
Disability Rights Ohio
Ohio Department of Aging
Ohio Department of Developmental Disabilities

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

   The rules being proposed for rescission were distributed to the stakeholders listed in the Department's response to Question 7 on September 11, 2015 for review and comment by September 23, 2015. Minimal comments were received. ODM made one change from the original draft. Language was clarified such that when a former Medicaid provider applies for enrollment to become an ODM-administered waiver provider, in addition to the enrollment process set forth in the rule, ODM will also review the provider applicant's past history, including but not limited to, Medicaid program compliance and performance. ODM will approve or deny enrollment based on its findings and in accordance with rule 5160-1-17.6 of the Administrative Code. This change was made to ensure the health and welfare of individuals enrolled on the ODM-administered waiver program, as well as Medicaid program integrity.

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

   No scientific data was used.

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?**

    Together with ODM Provider Enrollment staff and the ODM-administered Waiver Rules Workgroup, waiver program staff conducted a thorough review of provider enrollment policy and practice in determining the new rule language.

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.

Paragraphs (G) and (H) are performance based.

- When a current ODM-administered waiver service provider submits its Medicaid provider agreement revalidation application, and/or applies for an additional provider type, and/or specialty under their current provider type, ODM shall ensure that criminal record check requirements are satisfied. ODM shall also review the provider's history, including but not limited to, Medicaid program compliance and performance. ODM may approve or deny revalidation based on its findings and in accordance with rule 5160-1-17.6 of the Administrative Code.

- When a former Medicaid provider applies for enrollment to become an ODM-administered waiver provider, in addition to the enrollment process set forth in the rule, ODM will also review the provider applicant's past history, including but not limited to, Medicaid program compliance and performance. ODM will approve or deny enrollment based on its findings and in accordance with rule 5160-1-17.6 of the Administrative Code.

These changes were made to ensure the health and welfare of individuals enrolled on the ODM-administered waiver program, as well as Medicaid program integrity.

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

All regulations regarding ODM-administered waivers are promulgated by ODM and implemented by ODM, its designees and providers, as appropriate. While other state agencies participated in the rule-writing process, they do not impose any requirements that are specific to this program. The regulations were reviewed by Medicaid's legal and legislative staff to ensure that there is no duplication within the rules.

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.**

Initial notification of rule changes will occur via a variety of communication methods including, but not limited to ODM's issuance via remittance advice, emails to ODM-administered waiver stakeholder groups, electronic communication via the ODM-approved assessment and case management system and the provider oversight contractor's (PCG) website.

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

(a) Currently, there are more than 10,600 personal care aides, 2,600 registered nurses (RN)/licensed practical nurses (LPN), and 40 home care attendants enrolled as non-agency home care providers in the Ohio Medicaid Program. There are also more than 770 Medicare-certified home health agencies, 80 otherwise-accredited agencies and 2,800 ancillary service providers.

(b)/(c) ODM consulted with the Ohio Council for Home Care and Hospice (OCHCH) and LeadingAge Ohio/Midwest Care Alliance regarding the potential business impact on ODM-administered waiver service agencies associated with proposed OAC rule 5160-45-04. Their analyses are found below:

OCHCH and LeadingAge Ohio/Midwest Care Alliance:

"Agencies must execute provider agreements in order to provide Medicaid services in Ohio. Provider agreements may take anywhere from one to two hours.

OAC 5160-45-04(B) – Provider agreement application's process may take anywhere from one to two hours at a rate of $29 per hour.

OAC 5160-45-04(G) - Providers must revalidate (renew) a provider agreement every 5 years and this includes a $533 fee for the revalidation. There are a number of otherwise accredited agencies that are not Medicare certified that would pay the fee. However, there is an exemption if the provider is a Medicare Certified agency. In either case, the revalidation may take from one to two hours at a rate of $29 hour to complete the revalidation process.

OAC 5160-45-04(C)(3) & (G) - Not ONLY must the provider ensure that the agency's primary officer, director or owner is not on any federal or state exclusionary lists, but also all direct care staff must go through database checks and criminal records checks upon hire and every five years. *(Please see attached home health agency BIA Information for 5160-45-04 (G).)*"

ODM also solicited review by four independent providers in good standing. Of them, only one responded. That provider did not offer any information related to cost, however, the provider:

- Acknowledged that provider applicants cannot be paid for services rendered before they have been approved as providers, but suggested that this can impact some families who want to hire a provider right away, as well as providers who want to work right away. The provider did indicate they should be aware of the process, and providers should allow for the time when setting up their business.
- Inquired about the availability of technical assistance during the provider application process and ODM responded that the ODM Provider Application Hotline is available to answer questions.
- Indicated that figuring out how to submit an application in MITS should be easy.
- Indicated the language about having the State look at not only the fingerprint/BCI information but also the history of an established aide when up for review/revalidation, or a provider who wants to be reinstated, should not be a problem if the provider has complied with all the existing rules.

The provider is also the parent of an individual enrolled on the Ohio Home Care Waiver, and stated "As a parent, I hope that you adhere to this process and I don't

see anything negative about it unless the denial of someone's provider # is arbitrary, which is not the case. However, the built in appeals process should take care of that, if there are any issues."

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

    The assurance of waiver participants' health and welfare is integral to the ODM-administered waiver program – both at the state and federal levels. Provider participation in this program is optional and at the provider's discretion. Compliance with provider enrollment process is required for provider applicants who choose to particpate and may include administrative costs associated with the completing and submitting a Medicaid provider application.

Regulatory Flexibility

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

    No. Not applicable.

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?**

    Not applicable for this program.

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

    Both ODM and its designated provider oversight contractor are available to answer questions associated with the ODM-administered waiver provider enrollment process.

Home Health Agency (HHA)
BIA Information for 5160-45-04 (G)

Cost Analysis for 5 Year Required Background Check Rule-Effective January 1, 2013

Agreed Upon Costs

Number of direct care staff employed for 5+ years:		23,478
Average cost per direct care worker:	$	100
Total statewide cost of proposed rules in first year:	$	2,347,750
Average cost per certified agency in first year:	$	1,806
Average statewide cost in subsequent years:	$	469,550
Average cost per agency in subsequent years:	$	361

Notes and Assumptions:

Original background checks cost analysis was completed in August 2012. Only available update since 2012 is number of Medicare Certified HHAs.
This analysis represents a conservative estimate partially based on data provided by home health agencies.
25% of direct care staff in Ohio will be employed 5 years or more, and will therefore be subject to an additional background check.
Total number of direct care staff is 93,910 and is based on 2010 NAICS data.
Direct care staff does not include office personnel.
Average cost includes administrative, employee wage, employee overtime, travel, BCII fee, and FBI fee .
Average cost encompasses different payscales among aides, RNs, LPNs, and therapists.
Analysis assumes more than 1300 home health agencies, 793 of which are Medicare certified as of 10/15/15.
The analysis assumes no distinction between Medicare certified/ODA certified/DODD certified/accreditation/or private pay private duty home health agencies.

Prepared by OCHCH and LeadingAge Ohio/MCA 10/15/15

5160-45-04 **Ohio department of medicaid (ODM) -administered waiver program: provider enrollment process.**

(A) Ohio department of medicaid (ODM) -administered waiver provider applicants must successfully complete the provider enrollment process set forth in this rule and receive approval from ODM before furnishing services to an individual enrolled on an ODM-administered waiver. Services furnished before ODM approves and enrolls the provider applicant are not reimbursable.

(B) The provider applicant must complete and submit a waiver provider application to ODM through its medicaid information technology system (MITS) web portal in accordance with rule 5160-1-17.2 of the Administrative Code.

(C) Upon receipt of the waiver provider application, ODM or its designee shall verify all of the following:

(1) The provider applicant submits and meets all applicable ODM-administered waiver provider requirements set forth in Chapters 5160-1, 5160-45 and 5160-46 of the Administrative Code.

(2) The provider applicant has included a statement affirming the provider applicant is aware of, understands and agrees to all of the Administrative Code rules governing the ODM-administered waiver program.

(3) The non-agency provider applicant, agency provider applicant and/or the agency's primary officer, director or owner are not on any federal or state exclusionary lists ODM considers when determining medicaid provider eligibility.

(D) ODM or its designee shall notify the provider applicant if the application does not contain all of the required documentation. The provider applicant shall have thirty calendar days from the date of written notification to submit the requested documentation. If the provider applicant does not submit the documentation within the prescribed time frame, ODM or its designee will reject the provider application.

(E) ODM shall enroll or deny enrollment of the provider applicant based upon its own review and the review and recommendation of its designee.

(F) ODM shall notify the provider applicant in writing of its decision. If ODM denies enrollment, it shall issue the provider applicant appeal rights in accordance with Chapter 119. of the Revised Code.

(G) When a current ODM-administered waiver service provider submits its medicaid provider agreement revalidation application, and/or applies for an additional

provider type(s), and/or speciality(ies) under their current provider type, ODM shall ensure that criminal record check requirements set forth in Chapter 5160-45 of the Administrative Code are satisfied. ODM shall also review the provider's history, including but not limited to medicaid program compliance and performance. ODM may approve or deny revalidation based on its findings and in accordance with rule 5160-1-17.6 of the Administrative Code.

(H) When a former medicaid provider applies for enrollment to become an ODM-administered waiver provider, in addition to following the process outlined in paragraphs (A) through (F) of this rule, ODM shall also review the provider applicant's history including, but not limited to medicaid program compliance and performance. ODM may approve or deny enrollment based on its findings and in accordance with rule 5160-1-17.6 of the Administrative Code.

Replaces: 5160-45-04

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5164.02, 5166.02
Prior Effective Dates:	7/1/04, 9/19/09, 4/1/11

TO BE RESCINDED

5160-45-04 **ODJFS-administered waiver program: provider enrollment process.**

(A) Waiver provider applicants must complete the enrollment process set forth in this rule and receive approval from the Ohio department of job and family services (ODJFS) before providing services to an ODJFS-administered waiver consumer. Services provided before ODJFS issues such approval are not reimbursable.

(B) All applicants must complete and submit a waiver provider application to ODJFS or the entity designated by ODJFS to process such applications. The waiver provider application shall be completed and submitted in accordance with the requirements set forth in Chapter 5101:3-1 of the Administrative Code. Each applicant must submit with its application a signed statement affirming that the applicant received and read all of the Administrative Code rules governing the ODJFS-administered waiver program.

(C) Upon receipt of a waiver provider application, ODJFS shall verify all of the following:

(1) The applicant meets the requirements set forth in Chapter 5101:3-45 of the Administrative Code, and depending upon the provider type for which the applicant is requesting authorization to furnish services, Chapter 5101:3-46, 5101:3-47 or 5101:3-50 of the Administrative Code.

(2) The application contains all of the documentation required on the applicant's specific medicaid provider agreement provider type addendum.

(3) The individual, agency and/or agency's primary officer, director or owner is not listed on:

(a) The U.S. department of health and human services' exclusionary participant list;

(b) The Ohio department of mental retardation and developmental disabilities' abuser registry; and

(c) Any additional federal or state exclusionary lists ODJFS may consider when determining provider eligibility.

(4) If the applicant is a medicare-certified home health agency, evidence that the applicant's certification status is current.

(5) If the applicant is an otherwise-accredited agency, evidence that the applicant's accreditation status is current.

(6) If the applicant is a non-agency personal care aide service provider, evidence that:

(a) The applicant:

(i) Meets the training requirements set forth in rule 5101:3-46-04, 5101:3-47-04 or 5101:3-50-04 of the Administrative Code, as appropriate, and

(ii) Has successfully completed a criminal records check as set forth in rule 5101:3-45-08 of the Administrative Code; and

(b) The consumer has requested that the applicant provide the service for which application is being made.

(7) If the applicant is a non-agency nurse, evidence that the applicant:

(a) Possesses a current, valid and unrestricted license as a registered nurse (RN) or licensed practical nurse (LPN) with the Ohio board of nursing;

(b) Has no pending actions or sanctions against the non-agency nurse by the Ohio board of nursing; and

(c) Has successfully completed a criminal records check as set forth in rule 5101:3-45-08 of the Administrative Code.

(8) If the applicant is a non-agency LPN, additional evidence that the applicant works at the direction of an RN who possesses a current, valid and unrestricted license with the Ohio board of nursing.

(D) ODJFS shall review all documentation and make a determination regarding the applicant's eligibility for enrollment. If the application does not contain all of the documentation required by this rule, then ODJFS shall notify the applicant in writing of the missing documentation.

(E) The applicant shall have thirty calendar days from the date of written notification to provide the missing documentation ODJFS identifies pursuant to paragraph (D) of this rule. If the applicant does not submit the required documentation within the thirty calendar-day period, ODJFS shall terminate the application process.

(F) ODJFS shall notify the applicant in writing of its approval or denial as a waiver provider. If ODJFS determines the applicant is ineligible to provide waiver services, ODJFS shall inform the applicant of his or her appeal rights in accordance with rule 5101:3-1-17.6 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	5162.03, 5164.02, 5166.02
Prior Effective Dates:	7/1/04, 9/19/09, 4/1/11