
DEPARTMENT OF MEDICAID

Assistive personnel

- Grants certified assistive personnel who provide services to individuals enrolled in specified Medicaid programs administered by the Ohio Department of Aging (ODA) or the Ohio Department of Medicaid (ODM) the authority to administer prescribed medication, perform specified health-related activities, and perform tube feedings.
- Requires ODA and ODM to investigate complaints regarding the performance of those activities by assistive personnel.
- Requires ODA and ODM to develop courses that train the assistive personnel to engage in those activities and that train registered nurses to provide the training courses to the personnel.
- Requires ODA and ODM to certify personnel and registered nurses who successfully complete the applicable training and satisfy other requirements.
- Requires ODA and ODM to establish and maintain a registry of all personnel and registered nurses who have been certified by ODA or ODM, respectively.
- Permits ODA, ODM, the Department of Health, and the Department of Developmental Disabilities to enter into an interagency agreement to establish a unified system of training and certifying assistive personnel, MR/DD personnel, and registered nurses.

State agency collaboration for health transformation initiatives

- Extends to fiscal years 2016 and 2017 provisions that authorize the Office of Health Transformation Executive Director to facilitate collaboration between certain state agencies ("participating agencies") for health transformation purposes, authorize the exchange of personally identifiable information between participating agencies regarding a health transformation initiative, and require the use and disclosure of such information in accordance with operating protocols.

Medicaid third party liability

- Establishes a rebuttable presumption (rather than an automatic right) regarding the right to recover a portion of a medical assistance recipient's tort action or claim against a third party.

- Specifies that a third party's payment to ODM or a Medicaid managed care organization (MCO) regarding a medical assistance claim is final two years after the payment is made.
- Authorizes a third party to seek recovery of all or part of an overpayment by filing a notice with ODM or the MCO before that date.
- If ODM or the MCO agrees that an overpayment was made, requires ODM or the MCO to pay the amount to the third party or authorize the third party to offset the amount from a future payment.

Continuing issues regarding creation of ODM

- Extends through June 30, 2017, the authority of the ODM and ODJFS directors to establish, change, and abolish positions for their respective agencies and to assign, reassign, classify, reclassify, transfer, reduce, promote, or demote employees who are not subject to state law governing public employees' collective bargaining.
- Continues the authority of the ODJFS Director and boards of county commissioners to negotiate about amending or entering into a new grant agreement regarding the transfer of Medicaid, CHIP, and RMA to ODM.

ICDS performance payments

- For fiscal years 2016 and 2017, permits ODM to provide performance payments to Medicaid managed care organizations that provide care to Integrated Care Delivery System (ICDS) participants, and requires ODM to withhold a percentage of the premium payments made to the organizations for the purpose of providing the performance payments.

Termination of waiver programs

- Addresses administrative issues regarding termination of Medicaid waiver programs.

Money Follows the Person

- Requires that federal payments made to Ohio for the Money Follows the Person demonstration project be deposited into the Money Follows the Person Enhanced Reimbursement Fund.

Behavioral health

- During fiscal years 2016 and 2017, permits Medicaid to cover state plan home and community-based services for Medicaid recipients of any age who have behavioral health issues and countable incomes not exceeding 150% of the federal poverty line.

Medicaid School Program

- Makes a qualified Medicaid school provider solely responsible for timely repaying any overpayment that the provider receives under the Medicaid School Program and that is discovered by a federal or state audit.
- Prohibits ODM, with regard to an overpayment, from paying the federal government to meet or delay the provider's repayment obligation and from assuming or forgiving the provider's repayment obligation.
- Requires each qualified Medicaid school provider to indemnify and hold harmless ODM for any cost or penalty resulting from a federal or state audit.

Optional Medicaid eligibility groups

- Eliminates a requirement that the Medicaid program set the income eligibility threshold for pregnant women at 200% of the federal poverty level.
- Eliminates a requirement that the Medicaid program cover the group consisting of women in need of treatment for breast or cervical cancer.
- Eliminates a requirement that the Medicaid program cover the group consisting of nonpregnant individuals who may receive family planning services and supplies.

Transitional Medicaid

- Repeals a requirement that the ODM Director implement a federal option that permits individuals to receive transitional Medicaid for a single 12-month period (rather than an initial 6-month period followed by a second 6-month period).

Medicaid ineligibility for transfer of assets

- Permits an institutionalized individual to enroll in Medicaid despite a transfer of assets for less than fair market value under an additional circumstance.

Personal needs allowance

- Increases the monthly personal needs allowance for Medicaid recipients residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).



Independent providers' agreements

- Prohibits, effective July 1, 2016, ODM from entering into an initial Medicaid provider agreement with an independent provider to provide certain aide services, certain nursing services, home and community-based services (HCBS), or services covered by the Helping Ohioans Move, expanding (HOME) choice demonstration program.
- Permits independent providers' Medicaid provider agreements that are in effect on June 30, 2016, to continue in effect until they are phased out pursuant to a plan ODM is required to develop in consultation with other departments.
- Requires the last of the Medicaid provider agreements that are to be phased out to and not later than July 1, 2019.
- Exempts, from the prohibition against initial Medicaid provider agreements and the phase-out requirement for existing provider agreements, independent providers who provide services covered by Medicaid waiver programs that include participant-directed service delivery systems.

Suspension of provider agreements

- Makes an indictment of a provider, or provider's owner, officer, authorized agent, associate, manager, or employee, for a Medicaid-related criminal charge a reason to suspend a Medicaid provider agreement on the basis of being a source of a credible allegation of fraud rather than a separate cause for suspending a provider agreement.
- Subjects hospitals, nursing facilities, ICFs/IID to the requirement to suspend a Medicaid provider agreement because of an indictment for a Medicaid-related charge.
- Permits ODM to suspend a Medicaid provider agreement when an owner, officer, authorized agent, associate, manager, or employee of a provider has another provider agreement suspended due to a credible allegation of fraud.
- Requires ODM, when a Medicaid provider agreement is suspended due to a credible allegation of fraud, to suspend all Medicaid payments to the provider.
- Permits a provider to submit to ODM, as part of a request to reconsider a Medicaid provider agreement suspension, information about mistaken identity instead of information about a mistake of fact.

- Permits ODM to suspend a Medicaid provider agreement before conducting an adjudication if ODM determines that a credible allegation exists that the provider has negatively affected the health, safety, or welfare of Medicaid recipients.

Nursing facilities' Medicaid payment rates

- Repeals the laws establishing the formula for determining nursing facilities' regular Medicaid payment rates.
- Repeals most of the laws specifying circumstances under which a nursing facility is paid a Medicaid rate that is different from the regular rate.
- Repeals and revises many laws related to nursing facilities' Medicaid payment rates, including laws regarding cost reports and deadlines for calculating the rates.
- Requires ODM, beginning with fiscal year 2017, to (1) reduce all nursing facilities' Medicaid rates by an amount ODM determines and (2) use not more than the funds made available by the reductions to increase rates paid to nursing facilities that meet one or more quality indicators.

Care management system

- Repeals provisions that require ODM to take specified actions regarding Medicaid care management system participation.

HCAP

- Continues the Hospital Care Assurance Program (HCAP) for two additional years.
- Eliminates a requirement for a portion of the money generated by the HCAP assessments and intergovernmental transfers to be deposited into the Legislative Budget Services Fund.
- Abolishes the Legislative Budget Services Fund when all the remaining money in the fund has been spent.

Hospital franchise permit fees

- Continues the assessments (i.e., franchise permit fees) imposed on hospitals for two additional years.
- Requires ODM to establish a payment schedule for hospital franchise permit fees for each year and to include the payment schedule in the preliminary determination notice that ODM is required to mail hospitals.

Nursing home and hospital long-term care units

- Provides that a bed surrender does not occur for the purpose of the franchise permit fee charged nursing homes unless the bed is removed from a nursing home's licensed capacity in a manner that makes it impossible for the bed to ever be a part of any nursing home's licensed capacity.
- Provides that a bed surrender does not occur for the purpose of the franchise permit fee charged hospital long-term care units unless the bed is removed from registration as a skilled nursing facility bed or long-term care bed in a manner that makes it impossible for the bed to ever be registered as such a bed.
- Requires ODM to notify, electronically or by U.S. Postal Service, nursing homes and hospital long-term care units of (1) the amount of their franchise permit fees, (2) redeterminations of the fees triggered by bed surrenders, and (3) the date, time, and place of hearings to be held for appeals regarding the fees.

Home care services contracts

- Repeals a provision that requires, for contracts for home care services paid for with public funds, that the provider have a system for monitoring the delivery of services by the provider's employees.

Assistive personnel

Authority to provide specified health care services

(R.C. 173.57, 173.571(A), 5166.40, and 5166.41(A))

The bill authorizes assistive personnel to administer prescribed medications, perform health-related activities, and perform tube feedings when no other provisions of the Revised Code specifically authorize them to do so. It specifies that assistive personnel are persons, other than health care professionals, who are employed or under contract to provide home and community-based services. Included as assistive personnel are those who provide the services to individuals (1) receiving the services under Ohio Department of Aging (ODA) -administered Medicaid components (or, if those components are terminated, participating in the unified long-term services and support Medicaid waiver component) or (2) enrolled in a home and community-based services Medicaid waiver component administered by the Ohio Department of Medicaid (ODM).



Prescribed medication, health-related activities, and tube feedings

(R.C. 173.57 and 5166.40)

In establishing the authority of assistive personnel, the bill defines "prescribed medication" as a drug that is to be administered according to the instructions of a licensed health professional authorized to prescribe drugs. It defines "tube feeding" as the provision of nutrition to an individual through a gastrostomy tube or jejunostomy tube.

Regarding the authority to perform health-related activities, the bill lists specific types of activities. These activities are limited to the following:

- (1) Taking vital signs;
- (2) Application of clean dressings that do not require health assessment;
- (3) Basic measurement of bodily intake and output;
- (4) Oral suctioning;
- (5) Use of glucometers;
- (6) External urinary catheter care;
- (7) Emptying and replacing ostomy bags;
- (8) Collection of specimens by noninvasive means;
- (9) Use of continuous positive airway pressure machines;
- (10) Use of biphasic positive airway machines;
- (11) Use of pulse oximeters.

Nursing delegation requirements

(R.C. 173.57, 173.571(B), 5166.40, and 5166.41(B))

For each type of service being performed, the bill specifies whether nursing delegation is required. "Nursing delegation" is defined by the bill as the process established in rules adopted by the Board of Nursing under which a registered nurse, or a licensed practical nurse acting at the direction of a registered nurse, transfers the performance of a particular nursing activity or task to another individual who is not otherwise authorized to perform the activity or task.



Without nursing delegation, assistive personnel may perform health-related activities and administer oral and topical prescribed medications. Assistive personnel providing services to individuals receiving the services under ODA-administered Medicaid components (or, if those components are terminated, participating in the unified long-term services and support Medicaid waiver component) may also administer oxygen and meter-dose inhaled respiratory prescribed medications without nursing delegation.

With nursing delegation, assistive personnel may administer prescribed medications through gastrostomy and jejunostomy tubes, perform routine tube feedings, and administer routine doses of insulin through subcutaneous injections, insulin pumps, and inhalation methods. The gastrostomy and jejunostomy tubes being used for medication administration and tube feedings must be "stable and labeled."

Conditions on performance of services

(R.C. 173.571(C) and 5166.41(C))

To be authorized under the bill to administer prescribed medication, perform health-related activities, or perform tube feedings for individuals receiving those services under ODA-administered Medicaid components (or, if those components are terminated, participating in the unified long-term services and support Medicaid waiver component) assistive personnel must obtain the appropriate certificates issued either under the certification program the bill requires ODA to establish or a certification program established pursuant to an interagency agreement (see "**Interagency agreement**," below). To be authorized to perform the services for individuals enrolled in a home and community-based services Medicaid waiver component administered by ODM, assistive personnel must obtain the appropriate certificates issued either under the certification program the bill requires ODM to establish or the certification program established pursuant to the interagency agreement.

The bill provides that assistive personnel may act only as authorized by the certification held. If nursing delegation is required, the bill provides that the assistive personnel may not act without nursing delegation or in a manner that is inconsistent with the delegation.

The bill requires the employer of assistive personnel to ensure that they have been trained specifically with respect to each individual for whom they administer prescribed medications, perform health-related activities, or perform tube feedings. If the personnel have not received the training, they are prohibited from performing the services.

If an employer believes that assistive personnel have not or will not safely administer prescribed medications, perform health-related activities, or perform tube feedings, the employer is required by the bill to prohibit the action from continuing or commencing. Assistive personnel are prohibited from engaging in the action or actions subject to the employer's prohibition.

Implementation rules

(R.C. 173.571(D) and 5166.41(D))

Under the bill, ODA is required to adopt rules governing its implementation of the authority granted to assistive personnel to administer prescribed medications, perform health-related activities, and perform tube feedings for individuals receiving the services under ODA-administered Medicaid components or, if those components are terminated, participating in the unified long-term services and support Medicaid waiver component. Similarly, ODM is required to adopt rules governing its implementation of the authority granted to assistive personnel to provide the services for individuals enrolled in a home and community-based services Medicaid waiver component administered by ODM.

The bill requires the rules to include the following:

(1) Requirements for documentation of the administration of prescribed medications, performance of health-related activities, and performance of tube feedings by assistive personnel;

(2) Procedures for reporting errors that occur in the administration of prescribed medications, performance of health-related activities, and performance of tube feedings by assistive personnel;

(3) Other standards and procedures the departments consider necessary for implementation of the authority granted by the bill to assistive personnel.

Complaints

(R.C. 173.572 and 5166.42)

The bill requires ODA, or its designee, to accept complaints from any person or government entity regarding the administration of prescribed medications, performance of health-related activities, and performance of tube feedings by assistive personnel for individuals receiving the services under ODA-administered Medicaid components or, if those components are terminated, participating in the unified long-term services and support Medicaid waiver component. Similarly, ODM, or its designee, is required to accept complaints from any person or government entity

regarding the provision of the services for individuals enrolled in a home and community-based services Medicaid waiver component administered by ODM.

Each department is required to conduct investigations of the complaints it receives as it considers appropriate. Each department must adopt rules establishing procedures for accepting complaints and conducting investigations of the complaints.

Immunity from liability

(R.C. 173.573 and 5166.43)

The bill provides that assistive personnel are not liable for any injury caused by administering prescribed medications, performing health-related activities, or performing tube feedings, if both of the following apply:

(1) The assistive personnel acted in accordance with the methods taught in training completed in compliance with the bill's requirements;

(2) The assistive personnel did not act in a manner that constitutes wanton or reckless misconduct.

Training courses

(R.C. 173.574, 5123.43, 5166.44, and 5166.51)

The bill requires ODA and ODM each to develop courses for the training of assistive personnel in the administration of prescribed medications, performance of health-related activities, and performance of tube feedings. ODA is to provide training for assistive personnel who will provide services for individuals receiving the services under ODA-administered Medicaid components or, if those components are terminated, participating in the unified long-term services and support Medicaid waiver component. ODM is to provide training for assistive personnel who will provide the services to individuals enrolled in a home and community-based services Medicaid waiver component administered by ODM.

The bill specifies, however, that neither ODA nor ODM is required to develop the training courses if, pursuant to an interagency agreement, ODA, ODM, Ohio Department of Health (ODH), and Ohio Department of Developmental Disabilities (ODODD) develop training courses for assistive personnel and MR/DD personnel. If the departments develop the training courses pursuant to the interagency agreement, the bill also specifies that ODODD will no longer be required to provide courses for the training of MR/DD personnel in the administration of prescribed medications, performance of health-related activities, and performance of tube feedings.

The training courses developed by ODA and ODM or through the interagency agreement may be separate or combined training courses for the administration of prescribed medications, performance of health-related activities, and performance of tube feedings. Training in the administration of prescribed medications through gastrostomy and jejunostomy tubes may be included in a course providing training in tube feedings. Training in the administration of insulin may be developed as a separate course or included in a course providing training in the administration of other medications.

ODA and ODM are required by the bill to adopt rules, and any interagency agreement must include language, specifying the content and length of the training courses. The rules or agreement may include any other standards the departments consider necessary. The content of the training must include all of the following:

- (1) Infection control and universal precautions;
- (2) Correct and safe practices, procedures, and techniques for administering prescribed medication;
- (3) Assessment of drug reaction, including known side effects, interactions, and the proper course of action if a side effect occurs;
- (4) The requirements for documentation of medications administered to each individual;
- (5) The requirements for documentation and notification of medication errors;
- (6) Information regarding the proper storage and care of medications;
- (7) Course completion standards that require successful demonstration of proficiency in administering prescribed medications;
- (8) Any other material or standards for course completion standards that the department considers relevant to the administration of prescribed medications by assistive personnel.

Training provided by registered nurses

(R.C. 173.575, 173.576, 5123.44, 5166.45, 5166.46, and 5166.52)

Under the bill, each assistive personnel training course developed by ODA or ODM or through the interagency agreement must be provided by a registered nurse. To provide a training course, a registered nurse must complete the training required by the bill.



The bill requires ODA and ODM each to develop the courses that train registered nurses to provide assistive personnel training courses. The bill specifies, however, that neither ODA nor ODM is required to develop these training courses if training courses for the registered nurses are developed under an interagency agreement. If the departments develop the registered nurse training courses pursuant to the interagency agreement, the bill also specifies that ODODD will no longer be required to provide courses to train registered nurses to provide MR/DD personnel training courses.

The registered nurse training courses may be courses that train registered nurses to provide all of the personnel training courses or to provide any one or more of those courses. Rules are to be adopted by ODA and ODM, or language included in the interagency agreement, specifying the content and length of the training courses for registered nurses. The rules or interagency agreement may include any other standards the department or departments consider necessary.

The bill requires a registered nurse who provides the assistive personnel training developed by ODA to obtain a certificate or certificates issued either by ODA under its certification program or by ODM under a certification program established pursuant to the interagency agreement. A registered nurse who provides the assistive personnel training developed by ODM must obtain a certificate or certificates issued by ODM either under its certification program or under a certification program established pursuant to the interagency agreement. A registered nurse who provides the assistive personnel training developed pursuant to the interagency agreement must obtain a certificate or certificates issued by ODM under a certification program established pursuant to the interagency agreement.

Certification program

(R.C. 173.577, 5123.45, 5166.47, and 5166.54)

The bill requires ODA and ODM each to establish a program under which each department issues certificates to (1) assistive personnel to administer prescribed medications, perform health-related activities, and perform tube feedings and (2) registered nurses to provide the training courses for assistive personnel.

The bill specifies, however, that neither ODA nor ODM is required to develop the certification programs if a program that certifies assistive personnel, MR/DD personnel, and registered nurses is developed pursuant to an interagency agreement. Additionally, if the certification program is developed pursuant to the interagency agreement, ODODD will no longer be required to establish a certification program for MR/DD personnel or registered nurses.

To receive a certificate under a certification program established by ODA or ODM or under the interagency agreement, assistive personnel and registered nurses must successfully complete the applicable training courses and meet all other applicable requirements established in rules or in the interagency agreement. ODA and ODM must issue the appropriate certificates to assistive personnel and registered nurses who meet certification requirements. If a certification program is established pursuant to the interagency agreement, the bill specifies that ODM is to issue the appropriate certificates to assistive personnel, MR/DD personnel, and registered nurses who meet the applicable requirements for the certificates.

Certificates issued to assistive personnel are valid for one year and may be renewed. Certificates issued to registered nurses are valid for two years and may be renewed. To be eligible for renewal, assistive personnel and registered nurses must meet applicable continued competency requirements and continuing education requirements established in rules or the interagency agreement. The bill provides that continuing nursing education completed for renewal of a license to practice nursing as a registered nurse may be counted toward the continuing education requirements for renewal of a certificate to provide assistive personnel training courses.

The rules adopted by ODA and ODM for the certification program, or the interagency agreement, must establish all of the following:

- (1) Requirements that assistive personnel and registered nurses must meet to be eligible to take a training course;
- (2) Standards that must be met to receive a certificate, including requirements pertaining to an applicant's criminal background;
- (3) Procedures to be followed in applying for a certificate and issuing a certificate;
- (4) Standards and procedures for renewing a certificate, including requirements for continuing education and, in the case of assistive personnel who administer prescribed medications, standards that require successful demonstration of proficiency in administering prescribed medications;
- (5) Standards and procedures for suspending or revoking a certificate;
- (6) Standards and procedures for suspending a certificate without a hearing pending the outcome of an investigation;
- (7) Any other standards and procedures the respective department considers necessary.

Registry

(R.C. 173.578, 5123.451, 5166.48, and 5166.55)

The bill requires ODA and ODM to each establish and maintain a registry that lists the assistive personnel and registered nurses who hold valid certificates issued by the respective department. The bill specifies, however, that neither ODA nor ODM is required to develop a registry if a registry is established and maintained, pursuant to an interagency agreement. ODODD would no longer be required to establish and maintain a registry of MR/DD personnel authorized to administer prescribed medications, perform health-related activities, and perform tube feedings and registered nurses authorized to provide MR/DD personnel training.

The bill requires that a registry specify the type of certificate held by each individual and any limitations that apply to the individual. The information in a registry must be made available to the public in computerized form or any other manner that provides continued access to the information in the registry.

Adoption of rules

(R.C. 173.579 and 5166.49)

All rules required to be adopted under the bill by ODA and ODM must be adopted in accordance with the Administrative Procedure Act. ODA must adopt its rules in consultation with the Office of the State Long-Term Care Ombudsman Program, the Board of Nursing, and the Ohio Nurses Association. ODM must adopt its rules in consultation with ODA, ODH, ODODD, the Board of Nursing, and the Ohio Nurses Association.

Administration of medication in residential care facilities

(R.C. 3721.011)

The bill permits medication to be administered in residential care facilities by assistive personnel who are authorized to administer medication to individuals receiving services under ODA-administered Medicaid components or, if those components are terminated, participating in the unified long-term services and support Medicaid waiver component.

Interagency agreement

(R.C. 5166.50)

The bill permits ODM, ODA, ODH, and ODODD to enter into an interagency agreement to provide for a unified system regarding the authority of assistive personnel and MR/DD personnel to administer prescribed medications, perform health-related activities, and perform tube feedings. The agreement may provide for the following:

(1) The development of courses for training of personnel in the administration of prescribed medications, performance of health-related activities, and performance of tube feedings;

(2) The development of courses that train registered nurses to provide the personnel training developed pursuant to the agreement or the training courses developed by ODA or ODM for assistive personnel or ODODD for MR/DD personnel;

(3) The establishment of a certification program issuing certificates for the following:

(a) To authorize personnel to administer prescribed medications, perform health-related activities, and perform tube feedings;

(b) To authorize registered nurses to provide the personnel training developed pursuant to the agreement or the courses developed by ODA, ODM, or ODODD.

(4) The establishment and maintenance of a registry that lists all personnel holding certificates to administer medications, perform health-related activities, and perform tube feedings, and all registered nurses holding a certificate to provide personnel training.

State agency collaboration for health transformation initiatives

(R.C. 191.04 and 191.06; R.C. 191.01 and 191.02, not in the bill)

H.B. 487 of the 129th General Assembly authorized the Office of Health Transformation (OHT) Executive Director or the Executive Director's designee to facilitate the coordination of operations and exchange of information between certain state agencies ("participating agencies") during fiscal year 2013. H.B. 487 specified that the purpose of this authority was to support agency collaboration for health transformation purposes, including modernization of the Medicaid program, streamlining of health and human services programs in Ohio, and improving the quality, continuity, and efficiency of health care and health care support systems in Ohio. In furtherance of this authority, H.B. 487 required the OHT Executive Director or



the Executive Director's designee to identify each health transformation initiative in Ohio that involved the participation of two or more participating agencies and that permitted or required an interagency agreement. For each health transformation initiative identified, the OHT Executive Director or the Executive Director's designee had to, in consultation with each participating agency, adopt one or more operating protocols.

H.B. 487 also authorized a participating agency to exchange, during fiscal year 2013 only, personally identifiable information with another participating agency for purposes related to or in support of a health transformation initiative that had been identified as described above. If a participating agency used or disclosed personally identifiable information during fiscal year 2013, it was required to do so in accordance with all operating protocols adopted as described above that applied to the use or disclosure.

The main appropriations act of the 130th General Assembly, H.B. 59, extended the authorizations and requirements regarding the use and disclosure of personally identifiable information, described above, to fiscal years 2014 and 2015. The bill further extends these authorizations and requirements to fiscal years 2016 and 2017.

Medicaid third party liability

Portion of tort award subject to government right of recovery

(R.C. 5160.37)

An individual who receives medical assistance under Medicaid, the Children's Health Insurance Program (CHIP), or the Refugee Medical Assistance Program (RMA) gives an automatic right of recovery to ODM or a county department of job and family services (CDJFS) against the liability of a third party for the cost of medical assistance paid on the medical assistance recipient's behalf. If a recipient receives a tort recovery for injuries a third party caused the recipient, current law specifies that ODM or the appropriate CDJFS must receive no less than the lesser of (1) one-half of the amount remaining after attorneys' fees, costs, and other expenses are deducted from the recipient's total judgment, award, settlement, or compromise or (2) the actual amount of medical assistance paid on the recipient's behalf.

In 2013, the U.S. Supreme Court found that a North Carolina statute specifying that an irrebuttable presumption exists that one-third of a Medicaid recipient's tort recovery is attributable to medical expenses was pre-empted by the federal Medicaid anti-lien provision (42 U.S.C. 1396p(a)(1)).¹¹² The federal provision prohibits a state from

¹¹² *Wos v. E.M.A.*, 133 S.Ct. 1391 (2013).



making a claim to any part of a Medicaid recipient's tort recovery that is not designated for medical care.¹¹³

The bill responds to the Supreme Court decision by specifying that there is a rebuttable presumption (rather than a right) that ODM or a CDJFS is to receive (1) not less than one-half of a judgment, award, settlement, or compromise from a medical assistance recipient's tort action or claim against a third party, or (2) the actual amount of medical assistance paid on the recipient's behalf (whichever is less). The bill permits a party to rebut the presumption by a showing of clear and convincing evidence that a different allocation is warranted. The bill also specifies that the allocation of medical expenses pursuant to a settlement agreement between a medical assistance recipient and the third party may be considered by ODM or the CDJFS but it is not binding on either.

Recovery of overpayments

(R.C. 5160.401)

According to the federal Centers for Medicare & Medicaid Services (CMS), it is common for Medicaid recipients to have one or more additional sources of coverage for health care services. "Third party liability" refers to the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under Medicaid. Under federal law, all other available third party resources must meet their legal obligation to pay claims before Medicaid pays for a Medicaid recipient's care.¹¹⁴

Current Ohio law reflects federal policy by requiring a responsible third party to pay a claim for payment of a medical item or service provided to an individual who receives medical assistance from Medicaid, the Children's Health Insurance Program (CHIP), or the Refugee Medical Assistance Program.¹¹⁵ The bill specifies that a payment a third party makes is final on the date that is two years after the payment was made to ODM or the applicable Medicaid managed care organization (MCO). After a claim is final, the claim is subject to adjustment only if the third party commences an action for recovery of an overpayment before the date the claim became final and the recovery is agreed to by ODM or the MCO.

¹¹³ 42 U.S.C. 1396p(a)(1).

¹¹⁴ U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Medicaid Third Party Liability and Coordination of Benefits*, available at <http://medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/tpl-cob-page.html>.

¹¹⁵ R.C. 5160.40(A)(4).



The bill authorizes a third party that determines that it overpaid a claim for payment to seek recovery of all or part of the overpayment by filing a notice of its intent to seek recovery with ODM or the relevant MCO, as applicable. The notice of recovery must be filed in writing before the date the payment is final and specify all of the following:

--The full name of the medical assistance recipient who received the medical item or service that is the subject of the claim;

--The date or dates on which the medical item or service was provided;

--The amount allegedly overpaid and the amount the third party seeks to recover;

--The claim number and any other number that ODM or the MCO has assigned to the claim;

--The third party's rationale for seeking recovery;

--The date the third party made the payment and the method of payment used;

--If payment was made by check, the check number; and

--Whether the third party would prefer to receive the amount being sought by payment from ODM or the MCO, either by check or electronic means, or by offsetting the amount from a future payment owed to ODM or the MCO.

The bill specifies that if ODM or the appropriate MCO determines that a notice of recovery was filed before the claim for payment is final and agrees to the amount sought by the third party, ODM or the MCO, as applicable, must notify the third party in writing of its determination and agreement. Thereafter, the third party's recovery must proceed by the method specified by the third party.

Continuing issues regarding creation of ODM

(Sections 327.20 and 327.30)

Medicaid assistance programs (Medicaid, CHIP, and RMA) were administered by the Office of Medical Assistance in ODJFS before ODM was created. The biennial budget act enacted in 2013, H.B. 59 of the 130th General Assembly, created ODM.



Temporary authority regarding employees

H.B. 59 gave the ODM Director authority, during the period beginning July 1, 2013, and ending June 30, 2015, to establish, change, and abolish positions for ODM, and to assign, reassign, classify, reclassify, transfer, reduce, promote, or demote all employees of ODM who are not subject to the state's public employees collective bargaining law. H.B. 59 gave the ODJFS Director corresponding authority regarding ODJFS employees as part of the transfer of medical assistance programs to ODM.

The authority described above includes assigning or reassigning an exempt employee to a bargaining unit classification if the ODM Director or ODJFS Director determines that the bargaining unit classification is the proper classification for that employee.¹¹⁶ The actions of the ODM Director or ODJFS Director must comply with the requirements of a federal regulation establishing standards for a merit system of personnel administration. If an employee in the E-1 pay range is to be assigned, reassigned, classified, reclassified, transferred, reduced, or demoted to a position in a lower classification, the ODM Director or ODJFS Director, or in the case of a transfer outside ODM or ODJFS, the ODAS Director, must assign the employee to the appropriate classification and place the employee in Step X. The employee is not to receive any increase in compensation until the maximum rate of pay for that classification exceeds the employee's compensation. Actions the ODM Director, ODJFS Director, and ODAS Director take under this provision of the act are not subject to appeal to the State Personnel Board of Review.

Under the bill, the ODM Director and ODJFS Director continue to have this authority until June 30, 2018.

New and amended grant agreements with counties

H.B. 59 permitted the ODJFS Director and boards of county commissioners to enter into negotiations to amend an existing grant agreement or to enter into a new grant agreement regarding the transfer of medical assistance programs to ODM. Any such amended or new grant agreement had to be drafted in the name of ODJFS. The amended or new grant agreement had to be executed before July 1, 2013, if the amendment or agreement did not become effective sooner than that date.

Under the bill, the ODJFS Director and boards of county commissioners continue to have this authority. An amended or new grant agreement may be executed before

¹¹⁶ An exempt employee is a permanent full-time or permanent part-time employee paid directly by warrant of the OBM Director whose position is included in the job classification plan established by the ODAS Director but who is not considered a public employee for purposes of Ohio's collective bargaining law. (R.C. 124.152.)

July 1, 2015, if the amendment or agreement does not become effective sooner than that date.

ICDS performance payments

(Section 327.70)

ODM is authorized under continuing law to implement a demonstration project to test and evaluate the integration of care received by individuals dually eligible for Medicaid and Medicare. In statute the project is called the Integrated Care Delivery System (ICDS).¹¹⁷ It may be better known, however, as MyCare Ohio. For fiscal years 2016 and 2017, the bill requires ODM, if it implements ICDS in a way that provides participants with care through Medicaid managed care organizations, to do both of the following:

(1) Develop quality measures designed specifically to determine the effectiveness of the health care and other services provided to participants by Medicaid managed care organizations;

(2) Determine an amount to be withheld from the Medicaid premium payments paid to Medicaid managed care organization for participants.

For purposes of the amount to be withheld from premium payments, the bill requires ODM to establish a percentage amount and apply the same percentage to all Medicaid managed care organizations providing care to ICDS participants. Each organization must agree to the withholding as a condition of receiving or maintaining its Medicaid provider agreement. The bill authorizes the ODM Director to use these amounts to provide performance payments to Medicaid managed care organizations providing care to ICDS participants in accordance with rules that the Director may adopt. The bill provides that an organization providing care under ICDS is not subject to withholdings under the Medicaid Managed Care Performance Payment Program for premium payments attributed to ICDS participants during fiscal years 2016 and 2017.

Administrative issues related to termination of waiver programs

(Section 327.100)

If ODM and ODA terminate the PASSPORT, Assisted Living, Ohio Home Care, or Ohio Transitions II Aging Carve-Out program, the bill provides that all applicable statutes, and all applicable rules, standards, guidelines, or orders issued by ODM or ODA before the program is terminated, are to remain in full force and effect on and

¹¹⁷ R.C. 5164.91, not in the bill.



after that date, but solely for purposes of concluding the program's operations, including fulfilling ODM's and ODA's legal obligations for claims arising from the program relating to eligibility determinations, covered medical assistance provided to eligible persons, and recovering erroneous overpayments. The right of subrogation for the cost of medical assistance and an assignment of the right to medical assistance continue to apply with respect to the terminated program and remain in force to the full extent provided under law governing the right of subrogation and assignment. ODM and ODA are permitted to use appropriated funds to satisfy any claims or contingent claims for medical assistance provided under the terminated program before the program's termination. Neither ODM nor ODA has liability under the terminated program to reimburse any provider or other person for claims for medical assistance rendered under the program after it is terminated.

Money Follows the Person Enhanced Reimbursement Fund

(Section 327.110)

The bill provides for federal funds Ohio receives for the Money Follows the Person demonstration project to be deposited into the Money Follows the Person Enhanced Reimbursement Fund. The fund was created in 2008 by H.B. 562 of the 127th General Assembly after Ohio was first awarded a federal grant for the demonstration project. ODM is required to continue to use the money in the fund for system reform activities related to the demonstration project.

Home and community-based services regarding behavioral health

(Section 327.190)

During fiscal years 2016 and 2017, the bill permits Medicaid to cover state plan home and community-based services for Medicaid recipients of any age who have behavioral health issues and countable incomes not exceeding 150% of the federal poverty line. A Medicaid recipient is not required to undergo a level of care determination to be eligible for the services. The bill authorizes the ODM Director to adopt rules as necessary to implement this provision.

Medicaid School Program

(R.C. 5162.365 (primary), 5162.01, 5162.36, 5162.361, and 5162.363)

Under the Medicaid School Program, a qualified Medicaid school provider may submit a claim to ODM for federal Medicaid funds for providing, in schools, services covered by the Medicaid School Program to Medicaid recipients who are eligible for the services. Continuing law requires ODM to enter into an interagency agreement with



ODE that provides for ODE to administer the Medicaid School Program (other than aspects of the program that state law requires ODM to administer).

The following may obtain a Medicaid provider agreement to become a qualified Medicaid school provider: a board of education of a city, local, or exempted village school district; the governing authority of a community school; the State School for the Deaf; and the State School for the Blind. Generally, a qualified Medicaid school provider is subject to all conditions of participation in the Medicaid program that apply to other providers. Current law provides that the conditions expressly include conditions regarding audits and recovery of overpayments. The bill provides that the conditions also expressly include conditions regarding claims.

The bill makes a qualified Medicaid school provider solely responsible for timely repaying any overpayment that the provider receives under the Medicaid School Program and that is discovered by a federal or state audit. This is the case regardless of whether the audit's finding identifies the provider, ODM, or ODE as being responsible for the overpayment.

ODM is prohibited by the bill from doing any of the following regarding an overpayment that a qualified Medicaid school provider is responsible for repaying:

- (1) Making a payment to the federal government to meet or delay the provider's repayment obligation;
- (2) Assuming the provider's repayment obligation;
- (3) Forgiving the provider's repayment obligation.

The bill requires each qualified Medicaid school provider to indemnify and hold harmless ODM for any cost or penalty resulting from a federal or state audit finding that a claim submitted by the provider did not comply with a federal or state requirement applicable to the claim, including a requirement of a Medicaid waiver program.

Elimination of certain optional Medicaid eligibility groups

(R.C. 5163.06 and 5163.061 (repealed))

Federal law requires a state's Medicaid program to cover certain groups (mandatory eligibility groups). A state's Medicaid program is permitted to cover other groups (optional eligibility groups). The bill eliminates requirements in state law that the Medicaid program cover the following optional eligibility groups:

(1) The group consisting of the following individuals who are not in comparable mandatory eligibility groups: (a) women during pregnancy and the 60-day period beginning on the last day of pregnancy with incomes not exceeding 200% of the federal poverty line, (b) infants, and (c) children;

(2) The group consisting of women in need of treatment for breast or cervical cancer;

(3) The group consisting of nonpregnant individuals who may receive family planning services and supplies.

Transitional Medicaid

(R.C. 5163.08 (repealed))

Federal law includes a provision for transitional Medicaid. This provision requires a state's Medicaid program to continue to cover, for an additional six months and, if certain requirements are met, up to another additional six months certain low-income families with dependent children that would otherwise lose Medicaid eligibility because of changes to their incomes. The requirements for the second 6-month period of eligibility include reporting and income requirements. Federal law gives states the option to provide the low-income families transitional Medicaid for a single 12-month period rather than an initial 6-month period followed by a second 6-month period.¹¹⁸ The 12-month option enables the low-income families to receive transitional Medicaid for up to a year without having to meet the additional requirements for the second 6-month period.

The bill repeals a requirement that the ODM Director implement the option regarding the single 12-month eligibility period for transitional Medicaid.

Exception to Medicaid ineligibility for transfer of assets

(R.C. 5163.30)

Generally, an institutionalized individual is ineligible for nursing facility services, nursing facility equivalent services, and home and community-based services (HCBS) for a certain period of time if the individual or individual's spouse disposes of assets for less than fair market value on or after the look-back date. An institutionalized individual is (1) a nursing facility resident, (2) an inpatient in a medical institution for whom a payment is made based on a level of care provided in a nursing facility, or

¹¹⁸ 42 U.S.C. 1396r-6. This federal law is scheduled to expire March 31, 2015. Congress has extended the law when it was scheduled to expire on previous occasions.

(3) an individual who would be eligible for Medicaid if the individual was in a medical institution, would need hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) services if not for HCBS available under a Medicaid waiver program, and is to receive HCBS. The look-back date is the date that is a certain number of months before (1) the date an individual becomes an institutionalized individual if the Medicaid recipient is eligible for Medicaid on that date or (2) the date an individual applies for Medicaid while an institutionalized individual.

There are exceptions to this period of ineligibility. For example, an institutionalized individual may be granted a waiver of all or portion of the period of ineligibility if the ineligibility would cause an undue hardship for the individual.

The bill establishes a new exception. An institutionalized individual may be granted a waiver of all of the period of ineligibility if all of the assets that were disposed of for less than fair market value are returned to the individual or individual's spouse or if the individual or spouse receives cash or other personal or real property that equals the difference between what the individual or spouse received for the assets and the assets' fair market value. Unless the institutionalized individual is eligible for a waiver under another exception, no waiver of any part of the period of ineligibility is to be granted if the amount the individual or spouse receives is less than the difference between what the individual or spouse received for the assets and the assets' fair market value.

Monthly personal needs allowance for Medicaid recipients in ICFs/IID

(R.C. 5163.33)

The bill increases the monthly personal needs allowance for Medicaid recipients residing in ICFs/IID. Beginning January 1, 2016, the personal needs allowance is to be at least \$50 per month for an individual resident and at least \$100 for a married couple if both spouses are residents of an ICF/IID and their incomes are considered available to each other rather than \$40 or an amount determined by ODM. This personal needs allowance is the same that applies to residents of nursing facilities.

Independent providers' Medicaid provider agreements

(R.C. 5164.302 (primary), 5164.01, 5164.37, 5164.38, and 5166.30)

The bill restricts the Medicaid program's coverage of the following services when they are provided by independent providers:



(1) The following aide services: home health aide services available under the Medicaid program's home health services benefit, home care attendant services available under a Medicaid waiver program covering HCBS, and personal care aide services available under Medicaid waiver program covering HCBS;

(2) The following nursing services: nursing services available under the Medicaid program's home health services benefit, private duty nursing services, and nursing services available under a Medicaid waiver program covering HCBS;

(3) Services covered by a Medicaid waiver program covering HCBS;

(4) Services covered by the Helping Ohioans Move, Expanding (HOME) choice demonstration program.

The bill defines "independent provider" as an individual who personally provides one or more of the applicable services on a self-employed basis and does not employ, directly or through contract, another individual to provide any of those services.

Specifically, the bill prohibits, with one exception, ODM from entering into an initial Medicaid provider agreement on or after July 1, 2016, with an independent provider to provide any of the applicable services. If an independent provider has a provider agreement in effect on June 30, 2016, that authorizes the independent provider to provide any of the applicable services, the independent provider may continue to provide the services on and after July 1, 2016, and ODM may revalidate the provider agreement. However, the bill requires ODM, in consultation with ODA, ODODD, and ODH, to develop a plan to phase out the provider agreements. With one exception, the plan must provide for ODM to terminate or refuse to revalidate the provider agreements during the period beginning July 1, 2016, and ending June 30, 2019. The last of the provider agreements must cease to be in effect not later than July 1, 2019. A provider agreement may cease to be in effect sooner than its phase-out date if it is suspended or terminated pursuant to continuing law that authorizes ODM to take certain actions against Medicaid providers.

ODM is not required to issue an order pursuant to an adjudication conducted in accordance with the Administrative Procedure Act (R.C. Chapter 119.) when ODM, pursuant to this provision of the bill, denies an initial provider agreement to an independent provider or revokes or refuses to revalidate an independent provider's Medicaid provider agreement.

There is an exception to the prohibition against initial independent provider agreements and the requirement to phase-out independent provider agreements that

are in effect June 30, 2016. The prohibition and phase-out requirement do not apply to provider agreements that authorize independent providers to provide to Medicaid recipients enrolled in participant-directed Medicaid waiver programs any of the applicable services that are available through a participant-directed service delivery system. The following are participant-directed Medicaid waiver programs:

- (1) The Integrated Care Delivery System;
- (2) The Medicaid-funded component of the PASSPORT program administered by ODA;
- (3) The Self-Empowered Life Funding program administered by ODODD;
- (4) A Medicaid waiver program in operation on the effective date of this provision of the bill to which is added, on or after that date, a participant-directed service delivery system;
- (5) A Medicaid waiver program that begins operation on or after the effective date of this provision of the bill and includes a participant-directed service delivery system.

The Medicaid waiver programs known as Ohio Home Care and Ohio Transitions II Aging Carve-Out are authorized by current law to cover home care attendant services provided by independent providers. Because neither program is a participant-directed Medicaid waiver program, they are required to cease covering such services in accordance with the bill's prohibition and phase-out requirement regarding independent providers. However, either or both programs may continue to cover such services if they become a participant-directed Medicaid waiver program on or after the effective date of this provision of the bill.

The bill provides that an independent provider who provides any of the applicable services is not considered to be either of the following due to a provider agreement or the provision of the services:

- (1) An employee of the state or in the service of the state for the purpose of the state's civil service law;
- (2) A public employee for the purpose of the state's public employee collective bargaining law.



Suspension of Medicaid provider agreements

(R.C. 5164.36 (primary), 173.391, 5164.01, 5164.37 (repeal and new enact), 5164.38, and 5164.57)

Credible allegation of fraud and indictments

Current law includes a statute that generally requires ODM to suspend a Medicaid provider agreement on determining there is a credible allegation of fraud against the provider for which an investigation is pending under the Medicaid program. There is a separate statute in current law that requires ODM to suspend a Medicaid provider agreement on receiving notice and a copy of an indictment charging the provider (unless the provider is a hospital, nursing facility, or ICF/IID), or the provider's owner, officer, authorized agent, associate, manager, or employee, with committing an act that would be a felony or misdemeanor under Ohio's laws and relates to or results from (1) furnishing or billing for Medicaid services or (2) participating in the performance of management or administrative services relating to furnishing Medicaid services. The bill consolidates and revises these statutes.

Under the bill, an indictment of a person who is a provider or a provider's owner, officer, authorized agent, associate, manager, or employee constitutes a credible allegation of fraud for which ODM must suspend a Medicaid provider agreement if the indictment charges the person with a committing an act that would be a felony or misdemeanor under Ohio's laws or the laws in the jurisdiction in which the act is committed and relates to, or results from, one or more of the following:

- (1) Furnishing, ordering, prescribing, or certifying Medicaid services;
- (2) Billing for Medicaid services;
- (3) Referring a person to Medicaid services;

(4) Participating in the performance of management or administrative services related to furnishing Medicaid services.

In contrast to current law, the bill provides that such an indictment is grounds for suspending any Medicaid provider agreement, including hospitals, nursing facilities, and ICFs/IID. The bill maintains current law that prohibits ODM from suspending a provider agreement if the provider or provider's owner can demonstrate through the submission of written evidence that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee that resulted in the indictment.



The bill permits ODM, when it suspends a provider's (provider A's) Medicaid provider agreement because of a credible allegation of fraud, to suspend the provider agreement of any other provider (provider B) of which provider A is an owner, officer, authorized agent, associate, manager, or employee. However, this does not apply if provider B or provider B's owner can demonstrate through the submission of written evidence that provider B or the owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee (provider A) that resulted in the credible allegation of fraud.

Current law requires ODM, when it suspends a Medicaid provider agreement because of a credible allegation of fraud or indictment, to terminate Medicaid payments to the provider for services rendered subsequent to the date on which ODM sends the provider or owner notice of the suspension. Claims for payment of services rendered before the notice is issued may be subject to prepayment review procedures whereby ODM reviews claims to determine whether they are supported by sufficient documentation, are in compliance with state and federal statutes or rules, and are otherwise complete. The bill requires ODM, when it suspends a Medicaid provider agreement because of a credible allegation of fraud (including an indictment) to suspend all Medicaid payments to the provider for services the provider provided before, or provides after, the suspension of the provider agreement.

Under current law, a Medicaid provider agreement's suspension resulting from a credible allegation of fraud is to continue in effect until (1) ODM or a prosecuting authority determines that there is insufficient evidence of fraud by the provider or (2) the proceedings in any related criminal case are completed through dismissal of the indictment or through conviction, entry of a guilty plea, or finding of not guilty. The bill provides for the suspension also to cease if ODM or a prosecuting authority determines that there is insufficient evidence of fraud by a provider's owner, officer, authorized agent, associate, manager, or employee.

If ODM commences a process to terminate a Medicaid provider agreement that is suspended due to a credible allegation of fraud or indictment, the suspension must continue in effect until the termination process is concluded. The bill provides that the termination process includes any judicial appeal.

Current law prohibits a provider and the provider's owner, officer, authorized agent, associate, manager, or employee from doing any of the following while a Medicaid provider agreement is suspended: (1) owning, or providing services to, any other Medicaid provider or risk contractor or (2) arranging, rendering, or ordering services for any other Medicaid provider, a risk contractor, or a Medicaid recipient. Under the bill, these persons are also prohibited, during the suspension, from referring, prescribing, or certifying services to or for any other Medicaid provider, a risk



contractor, or Medicaid recipient. However, the bill provides that the prohibition applies to a provider's owner, officer, authorized agent, associate, manager, or employee only if such a person's actions resulted in the credible allegation of fraud.

Continuing law permits a provider or provider's owner to request reconsideration of a Medicaid provider agreement suspension. Written information and documents pertaining to certain matters must be submitted with the request. Current law specifies that the written information and documents may pertain to whether the determination to suspend the provider agreement was based on a mistake of fact, other than the validity of an indictment. The bill specifies instead that the written information and documents may pertain to whether the suspension determination was based on mistaken identity.

Health, safety, and welfare of Medicaid recipients

The bill permits ODM to suspend a Medicaid provider agreement before conducting an adjudication under the Administrative Procedure Act (R.C. Chapter 119.) if ODM determines that a credible allegation exists that the provider, by act or omission, has negatively affected the health, safety, or welfare of one or more Medicaid recipients. When ODM suspends a provider agreement for this reason, ODM (1) is required to also suspend all Medicaid payments to the provider for Medicaid services the provider provided before, or provides after, the provider agreement's suspension and (2) may also suspend the provider agreement of any other provider of which the provider is an owner, officer, authorized agent, associate, manager, or employee. "Owner" is defined as any person having at least 5% ownership in a Medicaid provider.

ODM is required by the bill to notify a provider not later than five days after suspending the provider's provider agreement. The notice must also inform the provider about the suspension of Medicaid payments.

Not later than ten days after suspending a provider's provider agreement, ODM must notify the provider of ODM's intent to terminate the provider's provider agreement. The notice must be provided as part of the adjudication continuing law requires ODM to conduct when terminating a provider agreement. It must state that the provider agreement is to be terminated because of the allegation that the provider negatively affected the health, safety, or welfare of one or more Medicaid recipients. The notice may state additional reasons for the termination.

A Medicaid provider agreement suspension and suspension of Medicaid payments is to continue in effect until the process to terminate the suspended provider agreement, including any judicial appeal, is concluded. However, if ODM fails to provide notice about the suspension or notice about ODM's intent to terminate the



provider agreement by the deadline, the suspension is to be lifted on the day immediately following the deadline.

The bill provides that this provision does not limit ODM's authority under any other statute to suspend or terminate a provider agreement or Medicaid payments to a provider.

Nursing facilities' Medicaid payment rates

(R.C. 5165.01 (primary), 173.47, 5165.10, 5165.106, 5165.109, 5165.155, 5165.158, 5165.193, 5165.40, 5165.41, 5165.99, and 5168.40; Repeals R.C. 5165.101, 5165.102, 5165.103, 5165.104, 5165.105, 5165.107, 5165.108, 5165.15, 5165.151, 5165.152, 5165.153, 5165.154, 5165.156, 5165.157, 5165.16, 5165.17, 5165.19, 5165.192, 5165.21, 5165.23, 5165.25, 5165.26, 5165.28, 5165.29, 5165.30, 5165.32, 5165.33, 5165.37, and 5165.516)

Repeal of statutory formula

The bill repeals the laws establishing the formula for determining nursing facilities' regular Medicaid payment rates. Under current law, a nursing facility's regular total rate is the sum of (1) each of its rates for the cost centers (ancillary and support costs, capital costs, direct care costs, and tax costs), (2) its critical access incentive payment (if applicable), and (3) its quality incentive payment. ODM is required by current law (also repealed by the bill) to pay a qualifying nursing facility a quality bonus in addition to its regular total rate.

The bill also repeals all but two of the laws specifying circumstances under which a nursing facility is paid a rate that is different from the regular rate. The circumstances specified in the laws being repealed are when a nursing facility (1) is new, (2) provides services to low resource utilization residents, (3) is designated an outlier or provides services to a resident who meets the criteria for admission to an outlier nursing facility, (4) provides services to a resident participating in the Centers of Excellence program, and (5) has a unit paid under an alternative purchasing model ODM is allowed to establish for residents with specialized health care needs.

The first of the two laws not repealed concerns the Medicaid payment rate for nursing facility services provided to a resident eligible for Medicaid and post-hospital extended care services under Medicare Part A (i.e., a dual eligible individual). Under that continuing law, ODM must pay the lesser of (1) the coinsurance for the services as provided under Medicare Part A and (2) the Medicaid maximum allowable, less the amount paid under Medicare Part A.

The other law not repealed concerns the Medicaid rate paid to a nursing facility to reserve a bed for a recipient during a temporary absence. The rate to be paid to a nursing facility for reserving a bed depends on its occupancy rate.

Repeal of and revisions to statutes related to the statutory formula

The bill repeals and revises a number of laws related to nursing facilities' Medicaid payment rates. The following are the repealed and revised laws:

Cost reports

Current law requires each nursing facility to file with ODM an annual cost report. The law specifies the period that a cost report is to cover and when it is due and authorizes ODM to grant extensions. The bill retains the requirement for nursing facilities to file with ODM a cost report but, instead of requiring an annual cost report, requires that the cost reports be filed at times ODM requires. The provisions concerning the coverage period, due dates, and extensions are repealed. Also repealed are provisions that (1) require franchise permit fees to be reported as nonreimbursable expenses, (2) prohibit certain fines from being reported in cost reports, (3) specify how cost reports are to be completed, (4) provide for an addendum for reporting costs that may be disputed, (5) concern amendments to cost reports, (6) concern ODM's reviews of cost reports, and (7) require that ODM's manual and program for field audits of cost reports mandate that an auditor provide a nursing facility certain information that is sufficient to permit the nursing facility to calculate with reasonable certainty the rate to which it is entitled. Whereas current law provides for a nursing facility's rate to be reduced by a certain amount while its Medicaid provider agreement is being terminated due to failure to file a cost report, the bill requires that the rate be reduced in accordance with rules.

Rate for added, replaced, and renovated beds

The bill repeals a requirement that the Medicaid payment rate for added, replaced, and renovated nursing facility beds be the same as the rate for existing beds.

Cost of operating rights for relocated beds not an allowable cost

The bill repeals a law that makes amortization of the cost of acquiring the operating rights for relocated beds an impermissible cost for the purpose of determining a nursing facility's Medicaid payment rate.

Goods, services, and facilities furnished by a related party

The bill repeals a law that generally makes the costs of goods, services, and facilities furnished to a nursing facility by a related party allowable costs at the



reasonable cost to the related party. Current law establishes exceptions in the case of capital costs. A related party of a nursing facility provider is an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider. A relative of a nursing facility owner also is a related party.

No reduced rate due to lower rates charged others

The bill repeals a prohibition against ODM reducing a nursing facility's Medicaid payment rate on the basis that the nursing facility charges a lower rate to a resident who is not eligible for Medicaid.

No payment for day of discharge

The bill repeals a prohibition against making a Medicaid payment to a nursing facility for the day a Medicaid recipient is discharged.

Deadline for determining rates

The bill repeals a requirement for ODM to make its best efforts to calculate nursing facilities' Medicaid payment rates in time to pay the rates by August 15th of each fiscal year. If ODM is unable to meet this deadline for a fiscal year, ODM is required by current law to pay each nursing facility the rate calculated at the end of the previous fiscal year. If ODM also is unable to calculate the rates in time to pay them by September 15 and October 15, ODM is required to pay the previous fiscal year's rate to make those payments. Current law permits ODM to increase the rate paid for these months by 5% if so requested by a nursing facility. Subsequent payment adjustments must be made if the actual rate is higher or lower than the rate paid before the actual rate is determined. ODM must use rates calculated for a fiscal year to make payments due by November 15th.

Adjustments to rate when there is a change of operator

Also repealed by the bill is a law that expressly permits the Medicaid Director to adopt rules governing adjustments to the Medicaid payment rate for a nursing facility that undergoes a change of operator. This law prohibits a rate adjustment resulting from a change of operator from taking effect before the effective date of the new operator's Medicaid provider agreement.

Rate reductions and increases regarding quality indicators

The bill requires ODM to reduce each nursing facility's total Medicaid payment rate for fiscal year 2017 and each fiscal year thereafter. ODM is to determine the amount of the reduction for each fiscal year.



Using not more than the funds made available for a fiscal year by the rate reduction, ODM is required to increase the total Medicaid payment rate to be paid for that fiscal year to each nursing facility that meets at least one certain quality indicators for the applicable measurement period. The largest increase available for a fiscal year is to be made to nursing facilities that meet all of the quality indicators for the applicable measurement period. For fiscal year 2017, the measurement period begins July 1, 2015, and ends December 31, 2015. For each subsequent fiscal year, the measurement period is the calendar year immediately preceding the fiscal year.

The following are the quality indicators:

(1) A nursing facility's residents must have received an average of at least 2.8 hours of direct care per inpatient day from nursing aides and an average of at least 1.3 hours of nursing care per inpatient day from registered nurses, other than the nursing facility's director of nursing, and from licensed practical nurses.

(2) At least 85% of a nursing facility's long-stay residents (residents who have resided in the nursing facility for at least 100 days) must have received direct care from not more than 12 different nurse aides during any 30-day period.

(3) Not more than a "target" percentage of a nursing facility's short-stay residents (residents who are not long-stay residents) must have had new or worsened pressure ulcers and not more than a "target" percentage of long-stay residents at high risk of pressure ulcers must have had pressure ulcers. ODM is required to specify the target percentages. The amount specified for short-stay residents may differ from the amount specified for long-stay residents.

(4) Not more than the "target" percentage of a nursing facility's short-stay residents may have newly received an antipsychotic medication and not more than the "target" percentage of the nursing facility's long-stay residents may have received such medication. ODM is required to specify the target percentages, and the amounts specified may differ for short-stay residents and long-stay residents.

(5) The number of a nursing facility's residents who had avoidable inpatient hospital admissions must not have exceeded the rate that ODM is required to specify.

The bill provides that if a nursing facility undergoes a change of operator during a fiscal year, the new operator is to be paid the same rate increase for the remainder of the fiscal year that the former operator was paid that fiscal year for meeting quality indicators. For the immediately following fiscal year, the amount of the increase is to be as follows:

(1) If the change of operator takes effect on or before the first day of October of the calendar year immediately preceding the fiscal year, the amount determined pursuant to the normal method discussed above;

(2) If the change of operator takes effect after the first day of October of the calendar year immediately preceding the fiscal year, the amount equal to the mean increase for all nursing facilities for the fiscal year.

In the case of a new nursing facility, the nursing facility's rate for its first year of operation is to be increased by the amount equal to the mean increase resulting from the quality indicators for all nursing facilities for the fiscal year.

Medicaid care management system

(R.C. 5167.03)

The bill repeals provisions that require ODM to take specified actions regarding Medicaid care management system participation, so that decisions regarding program designation and enrollment are left to ODM's discretion. Specifically, the bill repeals the following requirements:

(1) The requirement to designate for participation in the system those individuals who receive Medicaid on the basis of being included in either (a) the covered families and children group or (b) the aged, blind, or disabled group, subject to specified exceptions;

(2) The requirement to ensure the participants mentioned above are enrolled in Medicaid managed care organizations that are health insuring corporations;

(3) The prohibition from designating for participation individuals who receive Medicaid on the basis of being aged, blind, or disabled and satisfy other specified criteria;

(4) The prohibition from including Medicaid-covered alcohol, drug addiction, and mental health services in any component of the system when the nonfederal share of the cost of those services is provided by a board of alcohol, drug addiction, and mental health services or a state agency other than ODM.

HCAP

(R.C. 5168.01, 5168.06, 5168.07, 5168.10, 5168.11, and 5168.12 (repealed); Sections 610.10 and 610.11)

The bill continues the Hospital Care Assurance Program (HCAP) for two additional years. HCAP is scheduled to end October 16, 2015, but under the bill, is to continue until October 16, 2017. Under HCAP, hospitals are annually assessed an amount based on their total facility costs and government hospitals make annual intergovernmental transfers. ODM distributes to hospitals money generated by the assessments and intergovernmental transfers along with federal matching funds generated by the assessments and transfers. A hospital compensated under HCAP must provide, without charge, basic, medically necessary, hospital-level services to Ohio residents who are not recipients of Medicare or Medicaid and whose income does not exceed the federal poverty line.

The bill eliminates a requirement for a portion of the money generated by the HCAP assessments and intergovernmental transfers to be deposited into the Legislative Budget Services Fund and repeals the law creating the fund. Under current law, ODM is required to deposit into that fund an amount equal to the amount by which the biennial appropriation from the fund exceeds the amount of unexpended, unencumbered money in the fund. The money for the deposits is to come from the first installment of the HCAP assessments and intergovernmental transfers made during each year.

The bill requires that any money remaining in the Legislative Budget Services Fund on the date that the law creating the fund is repealed be used solely for the purpose stated in that law. The law states that the fund can be used solely to pay the expenses of LSC's Legislative Budget Office. The bill abolishes the fund when all the money in it has been spent.

Hospital franchise permit fees

(R.C. 5168.23 and 5168.26; Sections 610.10 and 610.11)

The bill continues the assessments imposed on hospitals for two additional years, ending October 1, 2017, rather than October 1, 2015. The assessments are in addition to HCAP, but like HCAP, they raise money to help pay for the Medicaid program. To distinguish the assessments from HCAP, the assessments are sometimes called hospital franchise permit fees.



Under current law and unless ODM adopts rules establishing a different payment schedule, each hospital is required to pay its assessment for a year in accordance with the following schedule:

- (1) 28% is due on the last business day of October;
- (2) 31% is due on the last business day of February;
- (3) 41% is due on the last business day of May.

The bill eliminates this payment schedule and instead requires ODM to establish a payment schedule for each year. ODM is required to consult with the Ohio Hospital Association before establishing the payment schedule for a year and to include the payment schedule in each preliminary determination notice of the assessment that continuing law requires ODM to mail to hospitals.

Nursing homes' and hospital long-term care units' franchise permit fees

(R.C. 5168.40, 5168.44, 5168.45, 5168.47, 5168.48, 5168.49, and 5168.53)

The bill revises the law governing the annual franchise permit fees that nursing homes and hospital long-term care units are assessed. The fees are a source of revenue for nursing facilities and HCBS covered by the Medicaid program and the Residential State Supplement program.

Bed surrenders

Under continuing law, ODM is required to redetermine each nursing home's and hospital long-term care unit's franchise permit fee for a year if one or more bed surrenders occur during the period beginning on the first day of May of the preceding calendar year and ending on the first day of January of the calendar year in which the redetermination is made. Current law defines "bed surrender" as the following:

(1) In the case of a nursing home, the removal of a bed from a nursing home's licensed capacity in a manner that reduces the total licensed capacity of all nursing homes;

(2) In the case of a hospital, the removal of a hospital bed from registration as a skilled nursing facility bed or long-term care bed in a manner that reduces the total number of hospital beds registered as skilled nursing facility beds or long-term care beds.

The bill revises what constitutes a bed surrender. In the case of a nursing home, a bed surrender does not occur unless a bed's removal from its licensed capacity is done



in a manner that, in addition to reducing the total licensed capacity of all nursing homes, makes it impossible for the bed to ever be a part of any nursing home's licensed capacity. In the case of a hospital long-term care unit, a bed surrender does not occur unless a bed's removal from registration as a skilled nursing facility bed or long-term care bed is done in a manner that, in addition to reducing the total number of hospital beds registered as such, makes it impossible for the bed to ever be registered as a skilled nursing facility bed or long-term care bed.

Notices of fees and redeterminations

Under current law, ODM is required to mail each nursing home and hospital long-term care unit notice of the amount of its franchise permit fee for a year not later than the first day of each October. ODM must mail each nursing home and hospital long-term care unit notice of its redetermined franchise permit fee due to bed surrenders not later than the first day of each March. If a nursing home or hospital long-term care unit requests an appeal regarding its franchise permit fee, ODM must mail a notice of the date, time, and place of the hearing to the nursing home or hospital.

The bill requires that these notices be provided electronically or by the U.S. Postal Service.

Home care services contracts

(R.C. 121.36)

For contracts for home care services paid for with public funds, the bill repeals a provision of current law that requires the provider to have a system for monitoring the delivery of the services by the provider's employees.