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## DEPARTMENT OF MEDICAID

### 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 for health transformation purposes, authorize the exchange of personally identifiable information between those 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 the Department of Medicaid (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 the Ohio Department of Job and Family Services (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, the Children's Health Insurance Program, and the Refugee Medical Assistance Program to ODM.



## **Integrated Care Delivery System**

- Permits a medical transportation provider to submit a claim to Medicaid for a service provided to a participant of the Integrated Care Delivery System (ICDS) without Medicare first denying the claim if Medicaid is responsible for paying the claim.
- Requires ODM to ensure that each ICDS participant who is a Holocaust survivor receives, while enrolled in a Medicaid waiver program, home and community-based services (HCBS) that the participant would have received if enrolled in another HCBS Medicaid waiver program.
- For fiscal years 2016 and 2017, permits ODM to provide performance payments to Medicaid managed care organizations that provide care to 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 HCBS for Medicaid recipients of any age who have behavioral health issues and countable incomes not exceeding 150% of the federal poverty line.

## **Physician groups acting as outpatient hospital clinics**

- Requires that certain amounts be used in fiscal years 2016 and 2017 to make Medicaid payments for certain services provided by a physician group practice that meets criteria specified in an existing administrative rule for enhanced payments.

## **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**

- Prohibits Medicaid from covering optional eligibility groups that state statutes do not address whether Medicaid may cover.
- Permits Medicaid to continue covering an optional eligibility group that it covers on the effective date of this provision unless state statutes expressly prohibit Medicaid from covering the group.
- Specifies that, if the income eligibility threshold for an optional eligibility group is not specified in state statute, the threshold is to be a percentage of the federal poverty line not exceeding the percentage that is the group's threshold on the effective date of this provision.
- 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.

## **Medicaid for inmates pilot program**

- Requires ODM to operate a two-year pilot program under which the suspension of a person's Medicaid eligibility ends when the person is to be confined only for 30 more days in a local correctional facility owned and operated by Montgomery or Jackson county.
- Requires that state funds be used for the Medicaid services provided under the pilot program.

## **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 provider study**

- States that it is the General Assembly's intent to study the issue of independent providers' Medicaid provider agreements and to resolve it not later than December 31, 2015.

## **Medicaid expansion group report**

- Requires ODM to submit a report to the General Assembly evaluating the Medicaid program's effect on clinical care and outcomes for individuals included in the Medicaid expansion group (also referred to as Group 8).

## **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**

- Replaces, for the purpose of determining the regular Medicaid payment rate for nursing facility services beginning with fiscal year 2017, the quality incentive payment with a quality payment and eliminates the quality bonus.
- Provides for \$16.44 (the maximum quality incentive payment under current law) to be added to the sum of a nursing facility's rates for the cost centers and, if applicable, its critical access incentive payment when determining the nursing facility's regular Medicaid payment rate.
- Provides for the amount determined above to be reduced by \$1.79 and requires ODM to use all of the funds made available by this reduction to determine the amount of each nursing facility's quality payment.
- Requires ODM to add the quality payment to the regular payment rate of each nursing facility that meets at least one of five quality indicators and requires that the largest quality payment be paid to nursing facilities that meet all of the quality indicators.
- Provides for a new nursing facility to be paid a quality payment that is the mean quality payment rate determined for nursing facilities and that \$14.65 be added to a new nursing facility's initial total rate.
- Provides for the per Medicaid day rate for nursing facility services provided to low resource utilization residents be (1) \$115 per Medicaid day if ODM is satisfied that the nursing facility is cooperating with the Long-Term Care Ombudsman Program



to help such residents receive the most appropriate services or (2) \$91.70 if ODM is not so satisfied.

- Requires ODM, when determining nursing facilities' case-mix scores, to use the grouper methodology designated by the federal government as the resource utilization group (RUG)-IV, 48 group model.

### **Medicaid rate for home health aide services**

- Requires that the fiscal year 2016 and fiscal year 2017 Medicaid payment rates for home health aide services, other than such services provided by independent providers, be at least 10% higher than the rate in effect on June 30, 2015, for the services.

### **Medicaid care management system**

- Prohibits alcohol, drug addiction, and mental health services from being included in any component of the Medicaid care management system.

### **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 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.
- Sets the hospital franchise permit fee assessment rate at 4% for the two program years that begin during fiscal years 2016 and 2017.

### **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**

- Adds ODM to a provision of current law 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.

### **Healthy Ohio Program**

- Requires the Medicaid Director to establish the Healthy Ohio Program (HOP).
- Provides that, under HOP, certain Medicaid recipients, in lieu of Medicaid coverage through the Medicaid fee-for-service or managed care system, are required to enroll in a comprehensive health plan offered by a managed care organization under contract with the Ohio Department of Medicaid (ODM).
- Requires that an account, to be known as a Buckeye account, be established for each HOP participant and that the account consist of Medicaid funds and contributions made by and on behalf of the participant.
- Requires a health plan in which a HOP participant enrolls to (1) cover certain services, (2) pay the Medicare rate for a health professional service that is covered by the health plan and Medicare, (3) require copayments for services as long as there are funds in the core portion of the participant's Buckeye account (the portion of the account consisting of contributions made by or on behalf of the participant and amounts awarded to the account for achieving health care goals and satisfying health care benchmarks), (4) not begin to pay for services until the noncore portion of the participant's Buckeye account is zero, and (5) have a \$300,000 annual payout limit and \$1 million lifetime payment limit.
- Prohibits a Buckeye account from having more than \$10,000.



- Requires, with certain exceptions, that \$1,000 of Medicaid funds be deposited annually into an adult HOP participant's Buckeye account and \$500 of Medicaid funds be deposited annually into a minor HOP participant's Buckeye account.
- Requires, with certain exceptions, that a HOP participant annually contribute to the participant's Buckeye account the greater of \$1 or 2% of the participant's annual countable family income.
- Permits, with certain limitations, the following to make contributions to a HOP participant's Buckeye account on the participant's behalf: the participant's parent or caretaker relative (if the participant is a minor), the participant's employer, a not-for-profit organization, and the managed care organization that offers the health plan in which the participant enrolls.
- Prohibits an individual from beginning to participate in HOP until an initial contribution is made to the individual's Buckeye account unless the individual is exempt from the requirement to make contributions.
- Provides for all or part of the amount remaining in a HOP participant's Buckeye account at the end of a year to carry forward in the account for the next year and for the amount that the participant must contribute to the account that next year be reduced by the amount that carries forward.
- Specifies what a Buckeye account may be used for.
- Requires a managed care organization that offers the health plan in which a HOP participant enrolls to issue a debit swipe card to be used to pay only for (1) the costs of covered health care services provided to the participant as long as there are funds in the noncore portion of the participant's Buckeye account, (2) copayments, and (3) the costs of noncovered, medically necessary health care services.
- Requires that (1) the noncore portion of a HOP participant's Buckeye account be used to pay for covered health care services and (2) the core portion be used to pay for copayments and noncovered, medically necessary services.
- Requires the ODM Director to establish a system under which amounts are awarded to a HOP participant's Buckeye account if the participant (1) provides for the participant's contributions to the account to be made electronically, (2) achieves health care goals to be specified in rules, and (3) satisfies health care benchmarks set by one or more primary care physicians.
- Suspends a HOP participant's participation in HOP if the participant exhausts the annual payout limit and ends the suspension on the first day of the following year.



- Terminates a HOP participant's participation in HOP if (1) a monthly installment payment for the participant's contributions to his or her Buckeye account is 60 days late, (2) the participant, or if the participant is a minor, the participant's parent or caretaker relative, fails to submit documentation needed for a Medicaid eligibility redetermination before the 61st day after the documentation is requested, (3) the participant becomes eligible for Medicaid under a category not required to participate in HOP, (4) the participant becomes a ward of the state, (5) the participant ceases to be eligible for Medicaid, (6) the participant exhausts the lifetime payout limit, or (7) the participant, or if the participant is a minor, the participant's parent or caretaker relative requests that the participant's participation be terminated.
- Provides that a former HOP participant must wait at least 12 months before resuming participation in HOP if the former participant's participation was terminated because of a late installment payment or lack of eligibility redetermination documentation.
- Requires that a HOP participant's contributions to his or her Buckeye account be returned to the participant when the participant ceases to participate in HOP unless the amount in the account is transferred to a bridge account.
- Transfers to a bridge account the entire amount remaining in a HOP participant's Buckeye account if the participant ceases to qualify for Medicaid due to increased family countable income and the participant purchases a health insurance policy or obtains health care coverage under an eligible employer-sponsored health plan.
- Requires that a HOP participant be transferred to a catastrophic health care plan to be established in rules if the participant exhausts the annual or lifetime payout limits.
- Requires a county department of job and family services (CDJFS) to offer to refer to a workforce development agency each HOP participant who is an adult and either unemployed or employed for less than an average of 20 hours per week.
- Permits a HOP participant to refuse to accept the referral and to participate in workforce development activities without any effect on the participant's eligibility for, or participation in, HOP.

## **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 the Department of Medicaid (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)).<sup>133</sup> The federal provision prohibits a state from making a claim to any part of a Medicaid recipient's tort recovery that is not designated for medical care.<sup>134</sup>

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

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<sup>133</sup> *Wos v. E.M.A.*, 133 S.Ct. 1391 (2013).

<sup>134</sup> 42 U.S.C. 1396p(a)(1).



other available third party resources must meet their legal obligation to pay claims before Medicaid pays for a Medicaid recipient's care.<sup>135</sup>

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, or the Refugee Medical Assistance Program.<sup>136</sup> 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.

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. 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.

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<sup>135</sup> 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>.

<sup>136</sup> R.C. 5160.40(A)(4).



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 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 the Ohio Department of Job and Family Services (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.<sup>137</sup> 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.

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<sup>137</sup> 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.)

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

### **Integrated Care Delivery System**

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).<sup>138</sup> It may be better known, however, as MyCare Ohio.

### **Claims for medical transportation services**

(R.C. 5164.912)

The bill permits a medical transportation provider to submit a claim to the Medicaid program for a medical transportation service provided to an ICDS participant without the Medicare program first denying the claim if the Medicaid program is responsible for paying the claim.

### **Holocaust survivors in the ICDS Medicaid waiver program**

(R.C. 5166.161 (primary) and 5166.16)

The bill requires ODM to ensure that each ICDS participant who is a Holocaust survivor receives, while enrolled in the part of the ICDS that is a Medicaid waiver program, home and community-based services (HCBS) of the type and in at least the amount, duration, and scope that the participant is assessed to need and would have

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<sup>138</sup> R.C. 5164.91, not in the bill.



received if enrolled in another HCBS Medicaid waiver program operated by the Department of Aging (ODA) or ODM.

### **ICDS performance payments**

(Section 327.70)

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 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 HCBS 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 HCBS. The bill authorizes the ODM Director to adopt rules as necessary to implement this provision.

### **Physician groups acting as outpatient hospital clinics**

(Section 327.240)

An existing administrative rule<sup>139</sup> requires different Medicaid payment amounts (generally the regular Medicaid payment multiplied by 1.4) for physician group practices that meet both of the following criteria:

(1) The physician group practice is physically attached to a hospital that does not provide physician clinic outpatient services and the hospital and physician group practice have signed a letter of agreement indicating that the physician group practice provides the outpatient hospital clinic service for that hospital;

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<sup>139</sup> O.A.C. 5160-1-60.1.

(2) The state Medicaid provider utilization summary for calendar year 1990 establishes that the physician group practice, in that year, provided at least 40% of the total number of Medicaid physician visits provided in the county in which the physician group practice is located and an aggregate total of at least 10% of the physician visits provided in the contiguous counties.

The bill requires that \$500,000 of the main appropriation for the Medicaid program (appropriation item 651525, Medicaid/Health Care Services) in fiscal year 2016 and \$1 million of that appropriation in fiscal year 2017 be used to make Medicaid payments in accordance with the administrative rule for physician, pregnancy-related, evaluation, and management services provided by physician group practices that meet the rules' criteria for the enhanced rate.

### **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 the Department of Education (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, including a requirement of a Medicaid waiver program.

### **Optional Medicaid eligibility groups**

(R.C. 5163.03, 5163.04, 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).

Current state law requires Medicaid to cover all optional eligibility groups that state statutes require Medicaid to cover. Medicaid is permitted to cover an optional eligibility group if state statutes expressly permit Medicaid to cover the group or if state statutes do not address whether Medicaid may cover the group. Medicaid is prohibited from covering an optional eligibility group if state statutes prohibit Medicaid from covering the group.

Under the bill, Medicaid continues to be required to cover all optional eligibility groups that state statutes require Medicaid to cover. The bill permits Medicaid to cover other optional eligibility groups only if (1) state statutes expressly permit Medicaid to cover the group or (2) Medicaid covers the group on the effective date of this provision of the bill. The bill prohibits Medicaid from covering an optional eligibility group if (1) state statutes expressly prohibit Medicaid from covering the group or (2) state statutes do not address whether Medicaid may cover the group.

The bill requires that the income eligibility threshold for an optional eligibility group be the percentage of the federal poverty line specified in state statute for the group. If state statutes do not specify the income eligibility threshold for an optional eligibility group, the income eligibility threshold is to be a percentage of the federal poverty line that does not exceed the percentage that is the group's income eligibility threshold on the effective date of this provision of the bill.



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.<sup>140</sup> 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 HCBS for a certain period of time if the individual or individual's spouse disposes of assets for less than fair market value

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<sup>140</sup> 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.



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 (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.

## **Medicaid for inmates pilot program**

(Section 327.223)

Under federal law, states cannot receive federal Medicaid funds for medical assistance provided to inmates of a state or local correctional facility.<sup>141</sup> State law suspends the Medicaid eligibility of a person who is confined in a state or local correctional facility. No Medicaid payment is to be made for any care, services, or supplies provided to the person during the suspension. The suspension ends when the person is released.<sup>142</sup>

The bill requires ODM to operate a two-year pilot program with respect to local correctional facilities owned and operated by Montgomery or Jackson county. Under

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<sup>141</sup> 42 U.S.C. 1396d(a).

<sup>142</sup> R.C. 5163.45, not in the bill.



the pilot program, a person's Medicaid eligibility suspension that results from confinement in such a local correctional facility is to end when the remainder of the period for which the person is to be confined is 30 days or less.

The bill specifies that the pilot program is not subject to continuing law that prohibits a component of the Medicaid program from being implemented without (1) federal approval (when needed), (2) sufficient federal Medicaid funds for the component, and (3) sufficient nonfederal funds for the component that qualify as funds needed to obtain matching federal Medicaid funds. Instead, only state funds are to be used for the Medicaid payments made for Medicaid services provided under the pilot program.

### **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 provider study**

(Section 751.10)

The bill states that it is the intent of the General Assembly to study the issue of Medicaid provider agreements with independent providers and to resolve the issue not later than December 31, 2015. The bill defines "independent provider" as an individual who personally provides one or more of the following services on a self-employed basis and does not employ, directly or through contract, another individual to provide any of those services:

(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 U.S. Department of Labor (DOL) recently adopted a regulation extending federal minimum wage and overtime protection to most home care workers, including independent providers who provide certain services to Medicaid recipients.<sup>143</sup> DOL has stated that it will not bring enforcement actions against employers for violations before July 1, 2015. From July 1, 2015 to December 31, 2015, DOL will exercise prosecutorial discretion in determining whether to bring enforcement actions, with particular consideration given to good faith efforts to bring home care programs into compliance with the regulation;<sup>144</sup> however, a federal trial court recently found the regulation to be invalid and vacated it. That decision is currently on appeal.<sup>145</sup> If the regulation is determined to be valid, employers of home care workers, which could include states or state agencies overseeing Medicaid programs, will be responsible for ensuring the federal requirements are met.<sup>146</sup>

## Medicaid expansion group report

(Section 751.20)

The bill requires ODM to submit a report to the General Assembly evaluating the Medicaid program's effect on clinical care and outcomes for individuals included in the Medicaid expansion group (also referred to as Group 8). The report is to be submitted by January 1, 2017, and is to include information on the Medicaid program's effects on physical and mental health, health care utilization and access, and financial hardship.

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<sup>143</sup> 29 C.F.R. 552.6.

<sup>144</sup> Application of the Fair Labor Standards Act to Domestic Service; Announcement of Time-Limited Non-Enforcement Policy, 79 Fed. Reg. 60,974 (October 9, 2014).

<sup>145</sup> *Home Care Ass'n of Am. v. Weil*, Case No. 14-cv-967, 2014 WL 7272406 (December 22, 2014); *Home Care Ass'n of Am. v. Weil*, Case No. 14-cv-967, 2015 WL 1817120 (January 14, 2015).

<sup>146</sup> Joint letter from the U.S. Department of Justice and U.S. Department of Health and Human Services, December 15, 2014, available at: [www.hhs.gov/ocr/civilrights/resources/specialtopics/community/2014hhsdojdearcolleagueletter.pdf](http://www.hhs.gov/ocr/civilrights/resources/specialtopics/community/2014hhsdojdearcolleagueletter.pdf).



## **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. 5165.15 (primary), 173.47, 5165.151, 5165.152, 5165.192, 5165.23, and 5165.25 (new); R.C. 5165.25 and 5165.26 (repealed); Section 812.10)

#### **Quality payments**

A nursing facility's regular total Medicaid payment rate under current law 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 also required by current law to pay a qualifying nursing facility a quality bonus in addition to its regular total rate. The bill replaces the quality incentive payment with a quality payment and eliminates the quality bonus. The changes are to take effect July 1, 2016.

Current law sets the maximum quality incentive payment at \$16.44 per Medicaid day. A nursing facility can receive the maximum payment if it meets at least five accountability measures, including at least one accountability measure regarding moderate pain, pressure ulcers, physical restraints, urinary tract infections, hospital admissions, and vaccinations.

As part of the provision that replaces the quality incentive payment with a quality payment, the bill provides for the amount of the current maximum quality incentive payment (\$16.44) to be added to the sum of a nursing facility's rates for the cost centers and, if applicable, its critical access incentive payment when determining the nursing facility's regular total Medicaid payment rate. From that amount, \$1.79 is to be subtracted. ODM is required to use all of the funds made available by this reduction to determine the amount of each nursing facility's quality payment. These changes result in the following formula that is to be used to determine a nursing facility's regular total per Medicaid day payment rate:

(1) Determine the sum of the nursing facilities' rates for each cost center and, if applicable, its critical access incentive payment (see "**Critical access incentive payment**," below);

(2) Add \$16.44 to the amount determined under (1);



(3) Subtract \$1.79 from the amount determined under (2);

(4) Add the nursing facility's quality payment to the amount determined under (3).

To qualify for a quality payment under the bill, a nursing facility must meet at least one of five quality indicators. The largest quality payment is to be paid to nursing facilities that meet all of the quality indicators for the measurement period. The following is the measurement period:

(1) For fiscal year 2017, the period beginning July 1, 2015, and ending December 31, 2015;

(2) For each subsequent fiscal year, the calendar year immediately preceding the fiscal year.

The bill establishes the following quality indicators for the purpose of the quality payment:

(1) Not more than a target percentage of a nursing facility's short-stay residents (residents who have resided in the nursing facility for less than 100 days) had new or worsened pressure ulcers and not more than a target percentage of long-stay residents (residents who have resided in the nursing facility for at least 100 days) at high risk for pressure ulcers had pressure ulcers. ODM is required to specify the target percentages and the amount specified for short-stay residents may differ from the amount specified for long-stay residents.

(2) Not more than a target percentage of the nursing facility's short-stay residents newly received antipsychotic medication and not more than a target percentage of the nursing facility's long-stay residents received an antipsychotic medication. ODM is to specify the target percentages. The amount specified may differ for short-term residents and long-term residents. The amount specified also may be different from the target percentages specified for the quality indicator regarding pressure ulcers.

(3) The number of the nursing facility's residents who had avoidable inpatient hospital admissions did not exceed a target rate that ODM is to specify.

(4) The nursing facility's employee retention rate is at least a target rate that ODM is to specify.

(5) The nursing facility utilized the nursing home version of the Preferences for Everyday Living Inventory for all of its residents.



The bill provides that if a nursing facility undergoes a change of operator during a fiscal year, the amount of the quality payment rate to be paid to the new operator for the period beginning on the effective date of the change of operator and ending on the last day of the fiscal year is to be the same as the amount of the quality payment rate in effect on the day immediately preceding the effective date of the change of operator. For the immediately preceding fiscal year, the quality payment rate is to be the following:

(1) If the effective date of the change of operator is 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 effective date of the change of operator is after the first day of that October, the mean quality payment rate for all nursing facilities for the fiscal year.

### **Critical access incentive payment**

To qualify for a critical access incentive payment, a nursing facility must (1) be located in an area that, on December 31, 2011, was designated an empowerment zone under federal law, (2) have an occupancy rate of at least 85%, (3) have a Medicaid utilization rate of at least 65%, and (4) have met at least five accountability measures for the purpose of the quality incentive payment, including at least one of the accountability measures regarding moderate pain, pressure ulcers, physical restraints, urinary tract infections, and vaccinations. Under the bill, a nursing facility no longer has to meet the fourth requirement to qualify for a critical access incentive payment. The bill also revises how the amount of the critical access incentive payment is to be determined. Under current law, a nursing facility's critical access incentive payment is to equal 5% of the sum of its rates for each of the cost centers and quality incentive payment. With the elimination of the quality incentive payment, a nursing facility's critical access incentive payment is to equal 5% of the sum of its rates for each of the cost centers.

### **New nursing facilities**

A new nursing facility is not paid the regular Medicaid rate for the first fiscal year (or part thereof) that it participates in Medicaid. For example, a new nursing facility is paid the mean quality incentive payment for all nursing facilities instead of a quality incentive payment determined specifically for the new nursing facility. As part of the provision that replaces the quality incentive payment with a quality payment, the bill provides for a new nursing facility to be paid a quality payment that is the mean quality payment rate determined for nursing facilities and that \$14.65 be added to a new nursing facility's initial total rate.

## **Low resource utilization residents**

The regular Medicaid rate also is not paid for nursing facility services provided to low resource utilization residents. A low resource utilization resident is a Medicaid recipient residing in a nursing facility who, for purposes of calculating the nursing facility's Medicaid payment rate for direct care costs, is placed in either of the two lowest resource utilization groups, excluding any resource utilization group that is a default group used for residents with incomplete assessment data.<sup>147</sup>

Under current law, the total per Medicaid day payment rate for nursing facility services provided to low resource utilization residents is \$130. The bill provides that the per Medicaid day rate is to be the following:

(1) \$115 if ODM is satisfied that the nursing facility is cooperating with the Long-Term Care Ombudsman Program in efforts to help the nursing facility's low resource utilization residents receive the services that are most appropriate for such residents' level of care needs;

(2) \$91.70 if ODM is not so satisfied.

## **Case-mix scores**

ODM is required to determine case-mix scores for nursing facilities as part of the process of determining their Medicaid payment rates. When determining case-mix scores, ODM must use certain data and, except as provided in ODM's rules, the case-mix values established by the U.S. Department of Health and Human Services (USDHHS). Under current law, ODM also must use, except as modified in ODM's rules, the grouper methodology used on June 30, 1999, by the USDHHS for the prospective payment of skilled nursing facilities under the Medicare program. The bill requires that ODM instead use, except as modified in ODM's rules, the grouper methodology designated by the USDHHS as the resource utilization group (RUG)-IV, 48 group model.

## **Medicaid rate for home health aide services**

(Sections 327.250 and 327.260)

The bill requires that the fiscal year 2016 and fiscal year 2017 Medicaid payment rates for home health aide services, other than services provided by independent providers, be at least 10% higher than the rate in effect on June 30, 2015, for the services. An independent provider is a provider who personally provides home health aide

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<sup>147</sup> R.C. 5165.01, not in the bill.



services and is not employed by, under contract with, or affiliated with another entity that provides those services.

## **Behavioral health exclusion from care management system**

(R.C. 5167.03)

Continuing law requires ODM to establish a care management system as part of the Medicaid program. Medicaid managed care is part of the care management system.

Current law prohibits alcohol, drug addiction, and mental health services from being included in any component of the care management system *when the nonfederal share of the cost of the services is provided by a board of alcohol, drug addiction, and mental health services (ADAMHS board) or a state agency other than ODM*. The bill prohibits alcohol, drug addiction, and mental health services from being included in any component of the care management system regardless of who provides the nonfederal share of the cost of the services.

Before the enactment of the main operating budget act for fiscal years 2012 and 2013,<sup>148</sup> ADAMHS boards, the Ohio Department of Mental Health (ODMH), and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) were responsible for the nonfederal share of Medicaid payments for services provided under a component of the Medicaid program that ODMH or ODADAS administered. (ODMH and ODADAS have been combined into a single department called the Ohio Department of Mental Health and Addiction Services.) Under current law, ODM is responsible for the nonfederal share of such payments.<sup>149</sup>

## **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

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<sup>148</sup> H.B. 153 of the 129th General Assembly.

<sup>149</sup> R.C. 5162.371, not in the bill.



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**

(Sections 327.93, 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.

The bill requires that the assessment rate for the two program years that begin during the period beginning July 1, 2015, and ending June 30, 2017, be 4%. For the purpose of the hospital assessments, a program year runs from the period beginning October 1 and ending on September 30 of the immediately following year. Under current law, the amount of the assessment rate is set in rules adopted by the Medicaid Director.

### **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 adds ODM to 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. Current law requires the Departments of Developmental Disabilities, Aging, Job and Family Services, and Health to ensure that this requirement is met. ODM did not exist at the time the provision was originally enacted.<sup>150</sup>

## Healthy Ohio Program

(R.C. 5166.52 to 5166.5210)

### HOP established

The bill requires the ODM Director to establish a Medicaid waiver program to be known as the Healthy Ohio Program (HOP). An individual, unless a ward of the state, must participate in HOP if eligible for Medicaid on the basis of being included in the eligibility group identified by ODM as covered families with children or in the expansion eligibility group authorized by the Patient Protection and Affordable Care Act (i.e., Group VIII). A HOP participant is not to receive Medicaid services under the fee-for-service system or participate in Medicaid managed care.

### Comprehensive health plan

A HOP participant must enroll in a comprehensive health plan offered by a managed care organization under contract with ODM. All of the following apply to the health plan:

(1) It must cover physician, hospital inpatient, hospital outpatient, pregnancy-related, mental health, pharmaceutical, laboratory, and other health care services the ODM Director determines necessary.

(2) In the case of a health professional service also covered by the Medicare program, it must have the same payment rate as the Medicare payment rate for the health professional service.

(3) It must not begin to pay for any services it covers until the amount of the noncore portion of the participant's Buckeye account is zero. (See "**Buckeye accounts**" and "**Core and noncore portions of Buckeye accounts**" below.)

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<sup>150</sup> See H.B. 59 of the 130th General Assembly.



(4) It must require copayments for services covered by the health plan, except that a participant's copayments are to be waived whenever the amount of the core portion of the participant's Buckeye account is zero.

(5) It must have a \$300,000 annual payout limit and a \$1,000,000 lifetime payout limit.

### **Buckeye accounts**

The bill requires that a Buckeye account be established for each HOP participant. A participant's Buckeye account is to consist of (1) Medicaid funds deposited into the account each year (\$1,000 if the participant is an adult and \$500 if the participant is a minor) and (2) contributions made by and on behalf of the participant. (See "**Participants' contributions**" below.) However, a Buckeye account is not to have more than \$10,000 in it at one time. The initial deposit of Medicaid funds is not to be made until the initial contribution by or on behalf of the participant is made, unless the participant is not required to make contributions. (See "**Amounts in Buckeye account to carry forward to next year**" below.)

### **Participants' contributions**

With certain exceptions, a HOP participant must contribute each month to the participant's Buckeye account the greater of the following:

- (1) 2% of the participant's monthly countable family income;
- (2) \$1.<sup>151</sup>

The following are permitted to make contributions to a participant's Buckeye account on the participant's behalf:

- (1) If the participant is a minor, the participant's parent or caretaker relative;
- (2) The participant's employer, but only up to 50% of the contributions the participant is required to make;
- (3) A not-for-profit organization, but only up to 75% of the contributions the participant is required to make;
- (4) The managed care organization that offers the health plan in which the participant enrolls under HOP, but such contributions (a) are to be used only to pay for

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<sup>151</sup> An individual is not to begin participating in HOP until the initial contribution to the Buckeye account is made, unless the individual is not required to make a contribution.

the participant to participate in a health-related incentive available under the health plan (such as completion of a risk assessment or participation in a smoking cessation program and (b) cannot reduce the amount the participant is required to contribute.

Contributions made on behalf of a participant by an employer or not-for-profit organization must be coordinated in a manner so that the participant, or if the participant is a minor, the participant's parent or caretaker relative, makes at least 25% of the contributions the participant is required to make.

### **Core and noncore portions of Buckeye accounts**

The bill distinguishes between the core and noncore portions of a HOP participant's Buckeye account. The core portion consists of the contributions made by or on behalf of the participant and amounts awarded to the account when the participant satisfies certain health care goals and benchmarks. (See "**Amounts awarded to HOP debit swipe cards**" below.) The remaining portion of the Buckeye account is the noncore portion.

### **Amounts in Buckeye account to carry forward to next year**

The bill provides for a portion of the amount that remains in a participant's Buckeye account at the end of a year to carry forward in the account the next year. If the participant satisfies requirements regarding preventative health services the ODM Director is to establish in rules, the entire amount is to carry forward.<sup>152</sup> If the participant does not satisfy the requirements regarding preventative health services, only the amount representing the contributions made by or on behalf of the participant is to carry forward. The amount of contributions that must be made to the participant's Buckeye account for a year are to be reduced by the amount that is carried forward. If the amount carried forward is at least the amount of contributions that would otherwise have been required to be made by or on behalf of the participant for the year, no contributions are required to be made for the participant that year.

### **Use of Buckeye accounts**

The bill provides that a Buckeye account is to be used only for the following:

(1) To pay for the expenses for which a HOP debit swipe card may be used (see "**HOP debit swipe card**" below);

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<sup>152</sup> The rules may establish different requirements regarding preventative health services for HOP participants of different ages and genders.



(2) Other purposes the ODM Director is to specify in rules.<sup>153</sup>

### Monthly statements

ODM is required to provide for a HOP participant to receive monthly statements showing the current amount in the participant's Buckeye account and the previous month's expenditures from the account. The statement must specify how much of the amount in the account is the core portion and how much is the noncore portion. ODM is permitted to arrange for the statements to be provided in an electronic format.

### HOP debit swipe card

The bill requires a managed care organization that offers a health plan in which a HOP participant enrolls to issue a debit swipe card to be used to pay only for the following:

(1) Until the amount of the noncore portion of the participant's Buckeye account is zero, the costs of health care services that are covered by the health plan and provided to the participant by a provider participating in the health plan;

(2) The participant's copayments under the health plan;

(3) Subject to rules the ODM Director is to adopt, the costs of health care services that are medically necessary for the participant but not covered by the health plan.

A HOP participant's debit swipe card is to be credited one point for each of the following:

(1) Each dollar of Medicaid funds deposited into the participant's Buckeye account;

(2) Each dollar that is contributed to the account by or on behalf of the participant;

(3) Each point awarded to the participant for providing for the participant's contributions to the account to be made by electronic funds transfers and satisfying certain health care goals and benchmarks. (See "**Amounts awarded to HOP debit swipe cards**" below.)

Each time a HOP participant uses the debit swipe card, the amount for which the card is used must be deducted from the number of points on the card as follows:

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<sup>153</sup> The rules must also establish the means for using a Buckeye account for the additional purposes.



(1) If the card is used for the costs of health care services that are covered by the participant's health plan, the deduction is to come from the points representing the noncore portion of the participant's Buckeye account.

(2) If the card is used for the other allowable purposes, the deduction is to come from the points representing the core portion of the participant's account.

The bill requires that a HOP participant's debit swipe card do all of the following:

(1) Verify the participant's eligibility for HOP;

(2) Determine whether the service the participant seeks is covered by the participant's health plan;

(3) Determine whether the provider is a participating provider under the health plan;

(4) Be linked to the participant's Buckeye account in a manner that enables the participant to know at the point of service what will be deducted from the noncore portion and core portion of the account for the service and how much will remain in each portion after the deduction.

### **Amounts awarded to HOP debit swipe cards**

The bill requires the ODM Director to establish a system under which points are awarded to HOP participants' debit swipe cards. One dollar of Medicaid funds is to be deposited into a participant's Buckeye account for each point awarded.

The ODM Director must provide a one-time award of 20 points to a HOP participant who provides for the participant's contributions to his or her Buckeye account to be made by electronic funds transfers from the participant's checking or savings account. Twenty points are to be deducted if the participant terminates the electronic funds transfers.

The ODM Director is permitted to award up to 200 points annually to a HOP participant who achieves health care goals. The points must be awarded in accordance with rules the Director is to adopt. The rules must specify the goals that qualify for points and the number of points each goal is worth. The number of points may vary for different goals. A participant is not to be awarded more than 200 points per year regardless of the number of goals the participant achieves that year.

Up to 100 points may be awarded annually to a HOP participant by one or more primary care physicians who verify that the participant has satisfied health care



benchmarks set by the physicians. A participant is not to be awarded more than 100 points per year regardless of how many primary care physicians award points to the participant that year and the number of points the primary care physicians award the participant that year.

### **Suspension and termination of participation**

A participant's participation in HOP is to be suspended if the participant exhausts the annual \$300,000 payout limit. The suspension ends on the first day of the following year.

Participation is to cease if any of the following applies:

(1) A monthly installment payment to the participant's Buckeye account is 60 days late.

(2) The participant, or if the participant is a minor, the participant's parent or caretaker relative, fails to submit documentation needed for a Medicaid eligibility redetermination before the 61st day after the documentation is requested.

(3) The participant becomes eligible for Medicaid on a basis other than being included in the covered families and children eligibility group or Group VIII.

(4) The participant becomes a ward of the state.

(5) The participant ceases to be eligible for Medicaid.

(6) The participant exhausts the \$1,000,000 lifetime payout limit.

(7) The participant, or if the participant is a minor, the participant's parent or caretaker relative, requests that the participant's participation be terminated.

A participant who ceases to participate because of a late monthly installment payment or failure to timely submit documentation needed for an eligibility redetermination cannot resume participation in HOP earlier than 12 months after the participation ceases.

Except when a transfer to a bridge account is to be made, a participant is to be provided the contributions that are in the participant's Buckeye account when the participant ceases to participate in HOP. (See "**Buckeye account transferred to bridge account**" below.) If the participant is a minor, the contributions are to be provided to the participant's parent or caretaker relative.



### **Catastrophic health care plan**

If a HOP participant exhausts the \$300,000 annual or \$1,000,000 lifetime payout limits, the participant is to be transferred to a catastrophic health care plan established in rules the ODM Director is to adopt.

### **Buckeye account transferred to bridge account**

If a HOP participant ceases to qualify for Medicaid due to increased family countable income and purchases a health insurance policy or obtains health care coverage under an eligible employer-sponsored health plan, the amount remaining in the participant's Buckeye account is to be transferred to a bridge account. The amount transferred may be used only to pay for the following:

(1) If the participant has purchased a health insurance policy, the participant's costs in purchasing the policy and paying for the participant's out-of-pocket expenses under the policy for health care services and prescription drugs covered by the policy;

(2) If the participant obtained health care coverage under an eligible employer-sponsored health plan, the participant's out-of-pocket expenses under the plan for health care services and prescription drugs covered by the plan.

Only the amount remaining in a participant's Buckeye account at the time the participant ceases to participate in HOP is to be deposited into a bridge account. The bridge account must be closed once the amount transferred is exhausted.

The ODM Director is required to notify a participant when a bridge account is established for the participant.

### **Referrals to workforce development agencies**

The bill requires each CDJFS to offer to refer to a workforce development agency each HOP participant who resides in the county served by the CDJFS, is an adult, and is either unemployed or employed for less than an average of 20 hours per week. The referral must include information about the workforce development activities available from the workforce development agency. A participant is permitted to refuse to accept the referral and to participate in the workforce development activities without any effect on the participant's eligibility for, or participation in, HOP.