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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.
- Establishes processes whereby a party may rebut the presumption and specifies that one process is retroactive to the extent it may be used by a party who repaid money, on or after September 29, 2007, to the Department of Medicaid (ODM) or a county department of job and family services (CDJFS).
- 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 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.

### **Contracts for the management of Medicaid data requests**

- Requires, instead of permits as under current law, the Medicaid Director to enter into contracts with persons to receive and process requests for certain Medicaid-related data that will be used for commercial or academic purposes.
- Requires a person with such a contract to charge a person seeking the data a fee in an amount equal to 102% of the cost ODM incurs in making the data available.

### **Integrated Care Delivery System**

- Requires ODM to ensure that each Integrated Care Delivery System (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 year 2016 and fiscal year 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 rates (known as the Holzer rule).

- Requires ODM to adjust the amount by which the Holzer rule increases the Medicaid rates for the services provided by the physician group practices as necessary to reflect the amounts required to be so used.

### **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 cover the group consisting of nonpregnant individuals who may receive family planning services and supplies.

### **209(b) option**

- Prohibits ODM from terminating, before July 1, 2016, the federal 209(b) option under which the Medicaid program's eligibility requirements for aged, blind, and disabled individuals are more restrictive than the eligibility requirements for the Supplemental Security Income program.



- Requires ODM, if it terminates the 209(b) option, to establish a Medicaid waiver program under which an individual who has cystic fibrosis and is enrolled in the Program for Medically Handicapped Children or a program for adults with cystic fibrosis may qualify for Medicaid under a spenddown process.
- Requires the Program for Medically Handicapped Children and the program for adults with cystic fibrosis to continue to assist recipients in qualifying for Medicaid under the spenddown process.

### **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 eligibility determinations – revocable self-settled trusts**

- Enacts a federal provision prohibiting the home of a Medicaid applicant or recipient held in a revocable self-settled trust from being (1) considered for purposes of determining Medicaid eligibility and (2) included in the computation of spousal share determined under federal law.
- Excludes the transfer of a Medicaid applicant's or recipient's home from a revocable self-settled trust to the applicant or recipient or that individual's spouse from being considered an improper disposition of assets with respect to Medicaid eligibility.

### **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).

## **Pre-enrollment provider screenings and reviews**

- States the General Assembly's recommendation that ODM, during fiscal years 2016 and 2017, perform pre-enrollment screenings and reviews of Medicaid providers designated as moderate or high categorical risks to the Medicaid program.

## **Medicaid rate for medical transportation providers' fuel costs**

- Requires that the Medicaid payment rate for medical transportation services include a component paying for providers' fuel costs and that the rate for the fuel component be at least 5% higher than the national average for fuel prices.

## **Nursing facilities' Medicaid payment rates**

- Requires ODM, with the first rebasing of Medicaid rates for nursing facilities, to place nursing facilities in Allen County or Trumbull County in the peer groups used to determine the Medicaid rates for nursing facilities in Mahoning County or Stark County.
- 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.
- Requires ODM, when determining nursing facilities' case-mix scores on and after July 1, 2016, to use the grouper methodology designated by the federal government as the resource utilization group (RUG)-IV, 48 group model.
- Provides for the per Medicaid day rate for nursing facility services provided to low resource utilization residents on and after July 1, 2016, to 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, rather than permits as under current law, ODM to establish an alternative purchasing model for nursing facility services provided to Medicaid recipients with specialized health care needs by designated discrete units of nursing facilities.

### **Nursing facility demonstration project**

- Requires ODM to seek a federal Medicaid waiver to operate a two-year demonstration project under which Medicaid recipients are admitted to participating nursing facilities in lieu of freestanding long-term care hospitals.
- Requires ODM to select four nursing facilities meeting certain requirements and located in Cuyahoga, Franklin, Hamilton, and Lucas counties (or other counties if necessary to find four qualifying nursing facilities) to participate in the demonstration project.
- Requires each participating nursing facility to develop admission criteria and to give the criteria to hospitals located within 50 miles that routinely refer Medicaid recipients to freestanding long-term care hospitals.
- Requires hospitals that receive the criteria to consider the criteria when determining where to refer Medicaid recipients who need the type of services freestanding long-term care hospitals provide.
- Permits Medicaid recipients to refuse referrals to participating nursing facilities.
- Requires that the Medicaid payment rate for nursing facility services provided under the demonstration project not exceed the Medicaid payment rate for comparable freestanding long-term care hospital services.



## **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 5% higher than the rate in effect on June 30, 2015, for the services.

## **Medicaid care management system**

### **Elimination of mandatory participation**

- Repeals a requirement that ODM designate for participation in the Medicaid care management system Medicaid recipients identified as part of the covered families and children group and, with certain exceptions, aged, blind, and disabled recipients.

### **Behavioral health services**

- Repeals a prohibition against including certain alcohol, drug addiction, and mental health services in the care management system.
- Requires ODM to begin to include alcohol, drug addiction, and mental health services in care management system not later than January 1, 2018.
- Provides that alcohol, drug addiction, and mental health services cannot be included in the care management system before January 1, 2018, without the approval of the Joint Medicaid Oversight Committee (JMOC).
- Requires JMOC to monitor ODM's actions in preparing to implement and implementing inclusion of alcohol, drug addiction, and mental health services in the care management system.

### **Integrity strategies**

- Requires ODM to implement strategies to improve the integrity of the care management system.

### **Value-based provider payments**

- Requires Medicaid MCOs to implement strategies that base payments to providers on the value received from their services and their success in reducing waste in the provision of services.



- Requires Medicaid MCOs to ensure, not later than July 1, 2020, that at least 50% of the aggregate net payments it makes to providers is based on the value of the providers' services.
- Requires ODM to conduct a study about the feasibility and potential savings of delaying an individual's Medicaid coverage until the individual self-selects a Medicaid managed care organization if the individual is required to participate in the care management system.

### **Community health worker services**

- Requires Medicaid MCOs to provide (or arrange for the provision of) community health worker and similar services to enrollees who are pregnant or capable of becoming pregnant, who live in a community that the Ohio Department of Health (ODH) has identified as having high infant mortality, and who meet other criteria.
- Specifies that if an enrollee who is to receive community health worker services or similar services covered by the bill resides in a region served by a community hub that is nationally certified or has shown substantial progress toward certification, the enrollee must receive the services from that community hub.

### **Enhanced care management**

- Requires a Medicaid MCO to provide enhanced care management services to pregnant women and women capable of becoming pregnant in ODH-identified communities with high infant mortality.

### **Annual report on Medicaid effectiveness**

- Requires additional information to be included in an ODM annual report on the effectiveness of the Medicaid program in meeting the health care needs of low-income pregnant women, infants, and children.

### **Help Me Grow home visits**

- Requires a Medicaid MCO to provide (or arrange for the provision of) home visits (including depression screenings) and cognitive behavioral therapy to an enrollee who is a Help Me Grow participant and is either pregnant or the birth mother of a child under age three.
- Requires the cognitive behavioral therapy to be provided in the enrollee's home at her request.

## **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.
- 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.



## **Alternative health coverage for Medicaid recipients**

- Requires ODM to establish a Medicaid waiver program under which certain Medicaid recipients, instead of participating in Medicaid's fee-for-service component or Medicaid managed care, must enroll in innovative and value-based health coverage.
- Requires a Medicaid recipient to participate in the waiver program if the recipient (1) has income exceeding 100% of the federal poverty line, (2) is at least 21 years of age, and (3) is not aged, blind, disabled, or pregnant.

## **Medicaid rates for ambulette services**

- Requires that the Medicaid rates for ambulette services provided during fiscal years 2016 and 2017 be at least 10% higher than the rates in effect on June 30, 2015.

## **Graduate Medical Education Study Committee**

- Creates the Graduate Medical Education Study Committee.
- Requires the Committee to study the issue of Medicaid payments to hospitals for the costs of graduate medical education, including the feasibility of targeting the payments in a manner that rewards medical school graduates who practice in Ohio for at least five years after graduation.
- Requires the Committee to complete a report about its study not later than December 31, 2015.

## **Pilot Program for newborns with neonatal abstinence syndrome (Brigid's Path)**

- Requires ODM to implement a two-year pilot program under which newborns who have neonatal abstinence syndrome are, after being medically stabilized at a hospital, transferred to a nonhospital, community facility in Montgomery County that provides medical, pharmacological, and therapeutic services.
- Requires ODM to develop and implement the pilot program with ODJFS and the Ohio Department of Health (ODH).
- Requires ODM, ODJFS, and ODH jointly to complete a report about the pilot program that includes recommendations for making the pilot program statewide and part of the Medicaid program.



## **Medicaid waiver for married couple to retain eligibility**

- Requires ODM to establish a Medicaid waiver program under which Medicaid recipients who are married to each other retain, under certain circumstances, Medicaid eligibility despite employment earnings that exceed the applicable threshold.

## **Medicaid Recipients' ID and Benefits Cards Workgroup**

- Creates the 11-member Workgroup to Study the Feasibility of Medicaid Recipients' ID and Benefits Cards.
- Requires the Workgroup to evaluate the feasibility of using state-issued licenses and identification cards to establish an individual's eligibility for all state public assistance programs (e.g., Medicaid) and benefits under them.
- Requires the Workgroup, not later than July 1, 2018, to submit to the General Assembly a report that contains its findings and recommendations, at which time the Workgroup ceases to exist.
- Creates the Health and Human Services Fund in the state treasury to pay costs associated with state-provided programs or services to enhance public health and overall health care quality of citizens of this state.

## **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>143</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>144</sup>

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<sup>143</sup> *Wos v. E.M.A.*, 133 S.Ct. 1391 (2013).

<sup>144</sup> 42 U.S.C. 1396p(a)(1).



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 using one of two processes, depending on whether the party has already paid an amount to ODM or the CDJFS.

#### **Process for rebutting the presumption – payment not yet made**

If a party has not yet made a payment to ODM or the CDJFS, the party may submit to ODM or the CDJFS a request for a hearing in accordance with a procedure the bill requires ODM to establish in rules for this purpose. The bill specifies that the amount sought by ODM or the CDJFS must be held in escrow or in an Interest on Lawyers' Trust Account (IOLTA) until the hearing examiner renders a decision or the case is otherwise concluded. A party successfully rebuts the presumption by a showing of clear and convincing evidence that a different allocation is warranted.

#### **Process for rebutting the presumption – payment already made**

If a party has made a payment on or after September 29, 2007,<sup>145</sup> to ODM or the CDJFS pursuant to that agency's right of recovery, the bill permits the party to request a hearing in accordance with a procedure the bill requires ODM to establish in rules for this purpose. The bill requires the request to be made not later than 180 days after the bill's effective date or 90 days after the payment is made, whichever is later. A party successfully rebuts the presumption by a showing of clear and convincing evidence that a different allocation is warranted.

#### **Hearings**

A hearing that is requested pursuant to either of the two processes is subject to all of the following:

(1) The hearing examiner may consider, but is not bound by the allocation of, medical expenses specified in a settlement agreement between the medical assistance recipient and the relevant third party.

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<sup>145</sup> September 29, 2007, is the date that current law governing the amount of a tort judgment or settlement subject to ODM's or a CDJFS's right of recovery became effective.



(2) ODM or the CDJFS may raise affirmative defenses during the hearing, including the existence of a prior settlement with the medical assistance recipient, the doctrine of accord and satisfaction, or the common law principle of *res judicata*.<sup>146</sup>

(3) If the parties agree, live testimony is not to be presented at the hearing.

(4) The hearing may be governed by rules that ODM is authorized to adopt; if adopted, the Administrative Procedure Act (R.C. Chapter 119.) applies to the hearing only to the extent specified in those rules.

(5) The hearing examiner's decision is binding on ODM or the CDJFS and the medical assistance recipient unless the decision is reversed or modified by the Medicaid Director on appeal.

### **Administrative appeals**

If a medical assistance recipient disagrees with a hearing examiner's decision, the recipient may file an administrative appeal with the Medicaid Director in accordance with the procedure the bill requires ODM to establish in rules for this purpose. A hearing is not required during the administrative appeal, but the Medicaid Director or the Director's designee must review the hearing examiner's decision and any prior relevant administrative action. After the review, the Medicaid Director or the Director's designee must affirm, modify, remand, or reverse the hearing decision. The decision of the Medicaid Director or the Director's designee is final and binding on ODM or the CDJFS and the medical assistance recipient unless it is reversed or modified on appeal by a court of common pleas.

The administrative appeal may be governed by rules that ODM is authorized to adopt; if adopted, the Administrative Procedure Act (R.C. Chapter 119.) applies to the appeal only to the extent specified in those rules.

### **Common pleas court appeals**

A party may appeal a decision made by the Medicaid Director or the Director's designee through the administrative appeal process. A party may file the appeal in accordance with the Administrative Procedure Act (R.C. 119.12).

### **Sole remedy**

The bill specifies that the hearing and appeals processes are remedial in nature and must be liberally construed by the courts of this state in accordance with existing

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<sup>146</sup> *Res judicata* is the principle that a decision by a competent court in a case fully and fairly litigated is final and conclusive as to the claims and issues of the parties and cannot be re-litigated.

law (R.C. 1.11). In addition, the bill specifies that the hearing and appeals processes are the sole remedy available to a party who claims that ODM or a CDJFS has received or is to receive more money than that to which it is entitled pursuant to its right of recovery.

### **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.<sup>147</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>148</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;

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<sup>147</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>148</sup> R.C. 5160.40(A)(4).



--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 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>149</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.

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.

### **Contracts for the management of Medicaid data requests**

(R.C. 5162.12)

Current law permits the Medicaid Director to contract with persons to receive and process requests for Medicaid recipient or claims payment data, data from nursing facility audit reports, or extracts or analyses of such data made by persons who intend to use the data for commercial or academic purposes. The bill requires the Director to enter into such contracts.

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<sup>149</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 current law, such a contract must specify the schedule of fees the contracting person is to charge for the data. The bill requires instead that the contract require the contracting person to charge for an item prepared pursuant to a request for the data a fee in an amount equal to 102% of the cost ODM incurs in making the data used to prepare the item available to the contracting person.

## **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>150</sup> It may be better known, however, as MyCare Ohio.

### **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 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

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<sup>150</sup> R.C. 5164.91, not in the bill.



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 327.243)

An existing administrative rule,<sup>151</sup> known as the Holzer rule, 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;

(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 \$666,844 of the main appropriation for the Medicaid program (appropriation item 651525, Medicaid/Health Care Services) in fiscal year 2016 and \$332,270 of that appropriation in fiscal year 2017 be used to make Medicaid payments in accordance with the Holzer rule for physician, pregnancy-related, evaluation, and management services provided by physician group practices that meet the rule's criteria for the enhanced rate. However, ODM is required, as necessary to reflect the amount of these earmarks, to adjust the amount by which the Holzer rule increases the Medicaid rates for such services provided by such physician group practices. The adjustment is to take effect July 1, 2015, and the Medicaid Director must amend the Holzer rule as soon as possible thereafter to reflect the adjustment.

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<sup>151</sup> O.A.C. 5160-1-60.1.



## 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 a requirement that the Medicaid program cover the optional eligibility group consisting of nonpregnant individuals who may receive family planning services and supplies.

### **209(b) option**

(R.C. 5166.33 (primary), 3701.023, and 5166.01; Section 327.310)

One of the eligibility groups for the Medicaid program consists of aged, blind, or disabled individuals who are eligible for the Supplemental Security Income (SSI) program. However, federal law permits states to establish Medicaid eligibility requirements for aged, blind, or disabled individuals that are more restrictive than the



eligibility requirements for the SSI program. This option is known as the 209(b) option. Ohio's Medicaid program currently implements the 209(b) option.

### **Restriction on termination**

The bill prohibits ODM from terminating the implementation of the 209(b) option before July 1, 2016.

### **Continued spenddown process for individuals with cystic fibrosis**

A state that implements the 209(b) option is required by federal law to permit aged, blind, and disabled individuals who have incomes exceeding the Medicaid eligibility limit to qualify for Medicaid through a spenddown process under which medical expenses are subtracted from their incomes.

The bill requires ODM, if it terminates implementation of the 209(b) option, to establish a Medicaid waiver program under which an individual who has cystic fibrosis and is enrolled in the Ohio Department of Health's (ODH's) Program for Medically Handicapped Children or an ODH program for adults with cystic fibrosis may qualify for Medicaid under the same type of spenddown process that is part of the 209(b) option. The ODH programs are required by the bill to continue to assist enrollees with cystic fibrosis in qualifying for Medicaid under the spenddown process in the same manner the programs assist such enrollees on the effective date of this provision of the bill. This requirement applies regardless of whether ODM terminates the 209(b) option or establishes the Medicaid waiver program for individuals with cystic fibrosis.

### **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>152</sup> The 12-month option enables the low-income families to receive transitional Medicaid

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<sup>152</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.



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 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 eligibility determinations – revocable self-settled trusts

(R.C. 5163.21)

When a Medicaid applicant or recipient is a trust beneficiary, the county department of job and family services (CDJFS) of the county in which the applicant or recipient resides must determine what type of trust it is and, for purposes of determining Medicaid eligibility, whether the trust or a portion of it (1) is a resource available to the applicant or recipient, (2) contains income available to the applicant or recipient, (3) constitutes both an available resource and contains available income, or (4) is neither an available resource nor contains available income.

A self-settled trust is a trust not established by will. Under current Ohio law, a CDJFS must treat a revocable self-settled trust as follows:

- (a) The corpus of the trust<sup>153</sup> must be considered an available resource;
- (b) Payments from the trust to or for the benefit of the applicant or recipient must be considered unearned income of the applicant or recipient; and
- (c) Any other payments from the trust must be considered an improper disposition of assets and makes the applicant or recipient ineligible for Medicaid for a certain period of time.<sup>154</sup>

The bill specifies that an applicant's or recipient's home (including the land that appertains the home) is not subject to the provisions described in (a) – (c), above, is not a resource available to the applicant or recipient, and must be excluded from the computation of spousal share determined under federal Medicaid provisions. (Under those federal provisions, a certain amount of a couple's combined resources is counted when determining the institutionalized spouse's Medicaid eligibility; however, depending on how much of his or her own income the community spouse actually has, a certain amount of income belonging to the institutionalized spouse can be set aside for

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<sup>153</sup> The "corpus" is all property and other interests held by the trust, including accumulated earnings and any other addition to the trust after its establishment (except that it excludes any earnings or addition in the month in which the earnings or addition is credited or otherwise transferred to the trust). 42 U.S.C. 1382b(e)(6)(B).

<sup>154</sup> See R.C. 5163.30.



the community spouse's use so that the community spouse is not impoverished.<sup>155</sup>) Federal law already specifies that the home is not to be counted as a resource.<sup>156</sup>

The bill also prohibits the transfer of a Medicaid applicant's or recipient's home from a revocable self-settled trust to the applicant or recipient or that individual's spouse from being considered an improper disposition of assets or a disposal of assets for less than fair market value for which a period of Medicaid ineligibility may be imposed.

### **Monthly personal needs allowance**

(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;

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<sup>155</sup> U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Spousal Impoverishment*, available at <http://medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/spousal-impoverishment-page.html>.

<sup>156</sup> 42 U.S.C. 1382b(a)(1).



(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>157</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>158</sup> however, a federal trial court recently found the regulation to be invalid and vacated it. That decision is currently on appeal.<sup>159</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>160</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>157</sup> 29 C.F.R. 552.6.

<sup>158</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>159</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>160</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).



## **Pre-enrollment provider screenings and reviews**

(Section 327.280)

The bill states the General Assembly's recommendation that ODM, during fiscal years 2016 and 2017, perform pre-enrollment screenings and reviews of Medicaid providers designated as moderate or high risks to the Medicaid program under the categorical risk levels established pursuant to federal Medicaid regulations.

## **Medicaid rate for medical transportation fuel costs**

(R.C. 5164.78)

The bill requires that the Medicaid payment rate for medical transportation services include a component that pays for providers' fuel costs. ODM is required by the bill to revise the rate for the fuel component each month. The rate for the fuel component for a month must be at least 5% higher than the national average for fuel prices for the immediately preceding month as reported by the U.S. Energy Information Administration.

## **Nursing facilities' Medicaid payment rates**

(R.C. 5165.15 (primary), 173.47, 5165.151, 5165.152, 5165.157, 5165.16, 5165.17, 5165.19, 5165.192, 5165.23, and 5165.25 (new); R.C. 5165.25 and 5165.26 (repealed); Section 812.10)

### **Nursing facilities' peer groups**

Nursing facilities are placed into various peer groups for the purposes of determining their Medicaid rates for ancillary and support costs, capital costs, and direct care costs. Continuing law requires ODM to revise the peer groups by placing nursing facilities located in Mahoning County or Stark County in different peer groups beginning with the first rebasing of nursing facilities' Medicaid rates. This will affect the Medicaid payment rates for all nursing facilities in the peer groups affected by the changes. A rebasing is a redetermination of nursing facilities' Medicaid rates for certain costs using information from Medicaid cost reports for a calendar year that is more recent than the calendar year used for the previous determination of the costs.

The bill requires ODM to further revise the peer groups by also placing nursing facilities located in Allen County or Trumbull County in the peer groups in which the nursing facilities located in Mahoning County or Stark County are to be placed with the first rebasing.



For the purpose of determining nursing facilities' Medicaid rates for ancillary and support costs and capital costs, a nursing facility located in Allen County or Trumbull County is currently placed in either peer group five or six, depending on how many beds it has. This also applies to a nursing facility located in Mahoning County or Stark County. If the nursing facility has fewer than 100 beds, it is placed in peer group five. If it has 100 or more beds, it is placed in peer group six. Nursing facilities located in any of the following counties are also placed in peer group five or six, depending on their number of beds: Adams, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot.

Beginning with the first rebasing, nursing facilities located in Allen County or Trumbull County are to be placed in peer group three or four. These are the peer groups that current law requires ODM to place nursing facilities located in Mahoning County or Stark County when the first rebasing occurs. Peer group three is for nursing facilities with fewer than 100 beds. Peer group four is for nursing facilities with 100 or more beds. Under continuing law, peer groups three and four consist of nursing facilities located in any of the following counties: Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union, and Wood.

For the purpose of determining nursing facilities' Medicaid rates for direct care costs, a nursing facility located in Allen County or Trumbull County is currently placed in peer group three under current law. This is the same peer group that a nursing facility located in Mahoning County or Stark County is in before the first rebasing. Peer group three also consists of nursing facilities located in any of the following counties: Adams, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot.

Beginning with the first rebasing, nursing facilities located in Allen County or Trumbull County are to be placed in peer group two for the purpose of direct care costs. This is the same peer group that nursing facilities located in Mahoning County or Stark County are to be placed with the first rebasing. Before the first rebasing, peer group two



consists of nursing facilities located in any of the following counties: Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union, and Wood.

### **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;
- (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.

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.

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.

### **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, beginning July 1, 2016, 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.

### **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>161</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, beginning July 1, 2016, 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.

### **Alternative purchasing model for nursing facility services**

Current law permits the Medicaid Director to establish an alternative purchasing model for nursing facility services provided to Medicaid recipients with specialized health care needs by designated discrete units of nursing facilities. The Medicaid rates paid under the alternative purchasing model are in lieu of the regular Medicaid rates for nursing facility services.

The bill requires the Director to establish the alternative purchasing model.

### **Nursing facility demonstration project**

(Section 327.270)

The bill requires ODM to submit to the U.S. Secretary of Health and Human Services a request for a federal Medicaid waiver to operate a two-year demonstration

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<sup>161</sup> R.C. 5165.01, not in the bill.

project under which Medicaid recipients receive nursing facility services in participating nursing facilities in lieu of hospital inpatient services in freestanding long-term care hospitals.<sup>162</sup> The request must be submitted not later than 30 days after the effective date of this provision of the bill. The request is to specify a January 1, 2016, starting date for the project.

ODM is to select four nursing facilities to participate in the project. To be selected, a nursing facility must (1) be held out to the public as providing short-term rehabilitation services, (2) have a hydrotherapy pool, (3) have a Medicaid-certified capacity that includes at least ten single-occupancy sleeping rooms that will be used for Medicaid recipients admitted to the nursing facility under the project, and (4) have been initially constructed, licensed for operation, and certified for participation in Medicaid on or after January 1, 2010. In selecting four nursing facilities, ODM must select one nursing facility located in Cuyahoga County, one located in Franklin County, one located in Hamilton County, and one located in Lucas County. However, ODM may select a nursing facility located in another county if necessary to find four nursing facilities that meet the selection requirements.

Each nursing facility selected for participation in the project is required to develop admission criteria that Medicaid recipients must meet to be admitted to the nursing facility under the project. A nursing facility is to give the criteria to each hospital that is located within 50 miles and routinely refers Medicaid recipients to freestanding long-term care hospitals. A hospital that receives the criteria must consider it when determining where to refer a Medicaid recipient who needs the types of services freestanding long-term care hospitals provide.

The bill permits a Medicaid recipient to refuse a referral to a nursing facility participating in the project and instead seek admission to a freestanding long-term care hospital. If a Medicaid recipient seeks admission to a nursing facility participating in the project, the nursing facility's staff must ensure that the recipient meets the nursing facility's admission criteria before admitting the recipient.

A nursing facility is required to notify ODM each time it admits a Medicaid recipient under the project. A recipient's admission is not subject to prior authorization from ODM or ODM's designee.

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<sup>162</sup> A hospital is a freestanding long-term care hospital if (1) it meets the definition of that term in federal regulations, (2) it has a Medicaid provider agreement to provide inpatient hospital services, and (3) pursuant to ODM rules, it is exempt from the patient refined diagnosis related groups (APR-DRG) and prospective payment methodology ODM uses to determine Medicaid payment rates for inpatient services provided by other types of hospitals not also excluded from the methodology.

The bill requires that the Medicaid payment rate for nursing facility services that a Medicaid recipient receives from a nursing facility participating in the project not exceed the Medicaid payment rate for comparable hospital inpatient services provided by freestanding long-term care hospitals in effect at the time the services are provided.

Each nursing facility participating in the project is required to report to ODM certain information not later than 30 days after the end of each quarter of the project. Specifically, a nursing facility must report all of the following information about each Medicaid recipient residing in the nursing facility under the project during the quarter:

- (1) The cost of the nursing facility services provided to the recipient that quarter;
- (2) The number of days the recipient resided in the nursing facility that quarter;
- (3) The recipient's health outcomes;
- (4) The recipient's satisfaction with the nursing facility as reported to the nursing facility's staff;
- (5) All other information ODM requires the nursing facilities to include in the reports.

ODM is required by the bill to complete a report about the project not later than three months after the project ends. The report must include an analysis of the information nursing facilities submit to ODM under the project. It also must include recommendations about resuming the project's operation and selecting nursing facilities from additional counties to participate. The report is to be submitted to the Governor, General Assembly, and the Joint Medicaid Oversight Committee.

### **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 5% 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 services and is not employed by, under contract with, or affiliated with another entity that provides those services.

### **Medicaid care management system**

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.



## **Elimination of requirements regarding groups that must participate**

(R.C. 5167.03)

The bill repeals a requirement that ODM designate for participation in the care management system individuals who receive Medicaid on the basis of being included in the eligibility category identified as covered families and children and, with certain exceptions, individuals who receive Medicaid on the basis of being aged, blind, or disabled. The bill also repeals a requirement to ensure the individuals mentioned above are enrolled in Medicaid managed care organizations that are health insuring corporations.

## **Adding behavioral health services to the care management system**

(R.C. 5167.04 (primary), 103.42, and 5167.03)

The bill repeals a prohibition against ODM including in the care management system alcohol, drug addiction, and mental health services for which a board of alcohol, drug addiction, and mental health services or a state agency other than ODM pays the nonfederal share.

ODM is required by the bill to begin to include alcohol, drug addiction, and mental health services in the care management system not later than January 1, 2018.

During the period beginning July 1, 2015, and ending June 30, 2018, the Joint Medicaid Oversight Committee (JMOC) must monitor on a quarterly basis ODM's actions in preparing to implement and implementing inclusion of the services in the system. Any ODM proposal to include all or part of the services in the system before January 1, 2018, is subject to JMOC's review. JMOC must vote on whether to approve or disapprove such a proposal. If a majority of JMOC's members approve the proposal, JMOC is to notify ODM. ODM may implement the proposal only if JMOC approves it.

On and after January 1, 2018, any ODM proposal to include all or part of the services in the system is subject to JMOC's monitoring but is not subject to JMOC's approval. Beginning on that date, JMOC on a periodic basis must monitor ODM's inclusion of the services in the system.

## **Strategies to improve care management system's integrity**

(R.C. 5167.32)

The bill requires ODM to implement, not later than July 1, 2016, strategies to improve the integrity of the care management system, including strategies to do both of the following:



(1) Increase ODM's oversight of Medicaid MCOs;

(2) Provide incentives for identifying fraud, waste, and abuse in the care management system.

### **Medicaid managed care organizations' payments to providers**

(R.C. 5167.33)

The bill requires Medicaid MCOs to implement, not later than July 1, 2018, strategies that base payments to providers on the value received from the providers' services, including their success in reducing waste in the provision of services. Not later than July 1, 2020, each Medicaid MCO is to ensure that at least 50% of the aggregate net payments it makes to providers is based on the value received from the providers' services.

ODM is permitted by the bill to measure a Medicaid MCO's compliance with these requirements based on the actions of the MCO, the providers in the MCO's provider panel, the MCO's subcontractors, or any combination of the MCO, providers, and subcontractors.

The Medicaid Director is required to adopt rules as necessary to implement this provision of the bill, including rules that specify all of the following:

(1) The value received from a provider's services;

(2) A provider's success in reducing waste in the provision of services;

(3) The percentage of a Medicaid MCO's aggregate net payments to providers that is based on the value received from the providers' services.

### **Study about self-selection of managed care organizations**

(Section 327.330)

The bill requires ODM to complete, not later than 180 days after the effective date of this provision of the bill, a study of the feasibility and potential savings to the state of delaying an individual's coverage under the Medicaid program until the individual self-selects a Medicaid managed care organization in which to enroll (if the individual is required to participate in the care management system). As part of the study, ODM must do both of the following:

(1) Examine the feasibility of obtaining any necessary federal waivers, including a waiver of the default enrollment process that federal law requires states to use when a Medicaid recipient fails to timely select a Medicaid managed care organization;

(2) Contract with an actuary to determine the effect that the delay on coverage would have on the amount of premiums to be paid Medicaid managed care organizations under the care management system.

ODM is required to prepare a report about the study and submit it to the Governor, General Assembly, and Joint Medicaid Oversight Committee.

## **New Medicaid managed care services**

### **Community health worker services**

(R.C. 3701.142 and 5167.15)

The bill requires Medicaid MCOs to provide certain Medicaid recipients, or arrange for those recipients to receive, services provided by community health workers certified by the Board of Nursing. A Medicaid recipient is eligible to receive the services if she (1) is pregnant or capable of becoming pregnant, (2) resides in a community with high infant mortality specified in rules required by the bill, (3) was recommended to receive the services by a physician or another licensed health professional specified in rules required by the bill, and (4) is enrolled in the Medicaid MCO.

The services that must be provided or arranged for under the bill are (1) community health worker services and (2) other services performed to ensure that the Medicaid recipient is linked to employment services, housing, educational services, social services, or medically necessary physician and behavioral health services. "Community health worker services" includes assisting in accessing community health and supportive resources through the provision of such services as education, role modeling, outreach, home visits, and referrals.<sup>163</sup>

The bill specifies that the services must promote and facilitate healthy behaviors across the preconception, prenatal, postpartum, and interconception (between pregnancies) stages of life. These behaviors are to be established in rules adopted by the Director of Health (ODH Director).

The bill specifies that if a Medicaid recipient who is to receive community health worker or similar services covered under the bill resides in a region served by a qualified community hub, the recipient must receive the services from that community

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<sup>163</sup> R.C. 4723.81, not in the bill.

hub. The bill defines a "qualified community hub" as a community-based agency that (1) uses the Pathways Community HUB model developed by the Community Health Access Project in Ohio for the purpose of coordinating two or more care coordination agencies and ensuring that the agencies use pathways to connect at-risk individuals to physical health, behavioral health, social, and employment services, and (2) demonstrates to the Medicaid Director that it fully or substantially complies with the Pathway Community HUB Certification Standards developed by the Rockville Institute by submitting to the Director a copy of a document from that institute stating that the community hub satisfies the standards or has shown substantial progress toward satisfying the standards. The Pathways Community HUB model was developed by the Community Health Access Project to ensure that at-risk individuals are served in a timely, coordinated manner.<sup>164</sup>

### **Enhanced care management services**

(R.C. 5167.17)

The bill requires ODM, when it contracts with a Medicaid MCO, to require the MCO to provide enhanced care management services for pregnant women and women capable of becoming pregnant who reside in a community with high infant mortality specified in rules required by the bill. The contract must specify that the services are to be provided in a manner intended to decrease the incidence of prematurity, low birth weight, and infant mortality, as well as improve the overall health status of women capable of becoming pregnant for the purpose of ensuring optimal future birth outcomes.

### **Rules**

(R.C. 3701.142(B) to (D))

The bill requires the ODH Director to adopt rules specifying healthy behaviors to be promoted and facilitated by certified community health workers who provide community health worker services and other services the bill requires. Before adopting the rules, the ODH Director must consult with members of the Ohio Perinatal Quality Collaborative or a successor organization. The ODH Director may consult with other health care organizations as the ODH Director determines to be appropriate.

In addition, the bill requires the ODH Director, in consultation with the Medicaid Director, to adopt rules specifying both of the following:

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<sup>164</sup> Community Care Coordination Learning Network. *Connecting Those at Risk to Care*, 1 (2010) available at <http://chap-ohio.net/press/wp-content/uploads/2010/09/CommunityHUBManual3.pdf>.



--The urban and rural communities, identified by zip code or portions of zip codes that are contiguous, that have the highest infant mortality rates in Ohio; and

--The licensed health professionals, in addition to physicians, who may recommend that a Medicaid recipient receive community health worker services.

All rules must be adopted in accordance with Ohio's Administrative Procedure Act (R.C. Chapter 119.).

### **Annual report on Medicaid effectiveness**

(R.C. 5162.13)

The bill requires additional information to be included in an annual report that ODM must complete under existing law on Medicaid's effectiveness in meeting the needs of low-income pregnant women, infants, and children. The additional information to be included is:

--The actual number of enrolled pregnant women categorized by estimated gestational age at time of enrollment; and

--The rates at which enrolled pregnant women receive addiction or mental health services, progesterone therapy, and any other service ODM specifies.

### **Help Me Grow home visits**

(R.C. 5167.03 and 5167.16)

The bill requires Medicaid managed care organizations (MCOs) to provide to certain Medicaid recipients (or arrange for those recipients to receive) home visits, including depression screenings, and cognitive behavioral therapy. The Medicaid recipients who are to receive those services are recipients who are (1) enrolled in the Help Me Grow program and the Medicaid MCO and (2) pregnant or the birth mother of a child under three years of age. Help Me Grow is a program established by the Department of Health to encourage early prenatal and well-baby care, provide parenting education to promote the comprehensive health and development of children, and provide early intervention services for individuals with disabilities.<sup>165</sup>

A Medicaid MCO is to provide or arrange for the provision of home visits for which federal financial participation is available under the federal targeted case management benefit. ("Federal financial participation" is that portion of the cost of a

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<sup>165</sup> R.C. 3701.61, not in the bill.



Medicaid service that is paid for from federal funds.) Cognitive behavioral therapy is to be provided or arranged for if it is determined to be medically necessary through a depression screening conducted as part of a home visit. The cognitive behavioral therapy must be provided by a community mental health services provider. When designating which Medicaid recipients are permitted versus required to participate in Medicaid managed care, the bill requires ODM to designate those who receive the cognitive behavioral therapy as among those required to participate in Medicaid managed care.

If requested, a Medicaid recipient who is eligible for the cognitive behavioral therapy is entitled to have that therapy provided at her home. The bill requires the Medicaid MCO to inform the recipient of the right to make such a request and how to make it.

## **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**

(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.

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 (repealed))

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.



## **Alternative health coverage for Medicaid recipients**

(R.C. 5166.51 and 5167.03)

The bill requires ODM to establish a Medicaid waiver program under which certain Medicaid recipients must, as a condition of Medicaid eligibility, enroll in innovative and value-based health coverage that is modeled on health savings accounts and uses premiums, copayments, or both. A Medicaid recipient must participate in the program if the recipient (1) has countable family income exceeding 100% of the federal poverty line, (2) is at least age 21, and (3) is not aged, blind, disabled, or pregnant. A Medicaid recipient required to participate in the program is not to receive Medicaid services under the fee-for-service system or participate in the care management system.

## **Medicaid rates for ambulette services**

(Section 327.300)

The bill requires that the Medicaid payment rates for ambulette services provided during fiscal years 2016 and 2017 be at least 10% higher than the amount of the rates for the services in effect on June 30, 2015.

## **Graduate Medical Education Study Committee**

(Section 327.320)

The bill creates the Graduate Medical Education Study Committee for the purpose of studying the issue of Medicaid payments to hospitals for the costs of graduate medical education. The Committee must include in its study the feasibility of targeting the payments in a manner that rewards graduates of medical schools of colleges and universities located in Ohio who practice medicine and surgery or osteopathic medicine and surgery in this state for at least five years after graduation.

The Committee is to consist of all of the following:

- (1) The Executive Director of the Office of Health Transformation;
- (2) The Medicaid Director;
- (3) The Chancellor of Higher Education;
- (4) Four deans of medical schools of Ohio colleges and universities, appointed by the President of the Senate;



(5) Four presidents of Ohio colleges and universities that have medical schools, appointed by the Speaker of the House;

(6) The chief executive officers of the Ohio State Medical Association, the Ohio Osteopathic Association, the Ohio Hospital Association, and the Ohio Children's Hospital Association.

The appointments must be made not later than 15 days after the effective date of this provision. A member of the Committee may designate an individual to serve in the member's place for one or more meetings. Members are to serve without compensation or reimbursement, except to the extent that serving on the Committee is part of their usual job duties.

The Executive Director of the Office of Health Transformation is to serve as the Committee's chairperson. ODM must provide the Committee all support services it needs.

The Committee must complete a report about its study not later than December 31, 2015. Copies of the report must be submitted to the Governor, General Assembly, and Joint Medicaid Oversight Committee. The Committee ceases to exist on submission of the report.

### **Pilot program for newborns with neonatal abstinence syndrome**

(Section 327.290)

The bill requires that ODM, in consultation with ODJFS and ODH, develop a pilot program (referred to as the Brigid's Path pilot program) under which newborns who have neonatal abstinence syndrome are, after being medically stabilized at a hospital, transferred to a nonhospital, community facility that is located in Montgomery County and provides the newborns medical, pharmacological, and therapeutic services ODM, ODJFS, and ODH are to specify. ODM, ODJFS, and ODH must begin operation of the pilot program not later than 90 days after the effective date of this provision of the bill. The pilot program is to be operated for two years.

Not later than 90 days after the pilot program ends, ODM, ODJFS, and ODH are required to jointly complete a report about the pilot program. The report must include recommendations for making the pilot program statewide and part of the Medicaid program. The report is to be submitted to the General Assembly.



## **Medicaid waiver for married couple to retain eligibility**

(R.C. 5166.33 (primary) and 5166.01)

The bill requires ODM to establish a Medicaid waiver program under which Medicaid recipients who are married to each other retain eligibility for Medicaid despite one of the recipients having earnings from employment that cause the recipients to have countable family income exceeding the income eligibility threshold for the eligibility group, or groups, under which the recipients qualify for Medicaid. To retain Medicaid eligibility, both of the following must apply:

(1) One of the recipients would qualify to participate in the Medicaid Buy-In for Workers with Disabilities Program (Buy-In Program) if not for a disability that, according to a physician's written evaluation, is too severe for the recipient to have earnings from employment or to be an employed individual with a medically improved disability.

(2) The other recipient's earnings from employment do not cause the recipients to have countable family income, determined in the same manner as income is determined for the Buy-In Program, exceeding 250% of the federal poverty line.

The Buy-In Program is the component of Ohio's Medicaid program under which Medicaid covers (1) individuals who are at least 16 but not more than 65 years of age and would be considered to be receiving Supplemental Security Income benefits if not for earnings that exceed a certain amount and (2) employed individuals with a medically improved disability.<sup>166</sup>

## **Medicaid Recipients' ID and Benefits Cards Workgroup**

(Section 751.30)

The bill creates the Workgroup to Study the Feasibility of Medicaid Recipients' ID and Benefits Cards, consisting of the following 11 members:

- (1) The Director of Public Safety or the Director's designee;
- (2) The Medicaid Director or the Director's designee;
- (3) The Director of Aging or the Director's designee;
- (4) The Director of Development Services or the Director's designee;

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<sup>166</sup> 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and (XVI).



- (5) The Director of Developmental Disabilities or the Director's designee;
- (6) The Superintendent of Public Instruction or the Superintendent's designee;
- (7) The Director of Health or the Director's designee;
- (8) The Director of Insurance or the Director's designee;
- (9) The Director of Job and Family Services or the Director's designee;
- (10) The Director of Mental Health and Addiction Services or the Director's designee; and
- (11) The Executive Director of Opportunities for Ohioans with Disabilities or the Executive Director's designee.

The Director of Public Safety or the Director's designee must serve as chairperson of the Workgroup, and the Department of Public Safety is required to provide staff and all other support functions for the Workgroup.

In order to reduce enrollee and provider fraud and abuse, the Workgroup is required to evaluate the feasibility of using state-issued licenses and identification cards to establish an individual's eligibility for all state public assistance programs and benefits under them, such as Medicaid, the Home Energy Assistance Program, the Supplemental Nutrition Assistance Program, the Temporary Assistance for Needy Families program, and child care. Upon conclusion of the evaluation, the Workgroup must develop findings and formulate recommendations.

Not later than July 1, 2018, the Workgroup is required to submit to the General Assembly a report that contains its findings and recommendations. The Workgroup must submit the report in accordance with the provisions of current law that govern the submission of reports to the General Assembly. Upon submission of the report, the Workgroup ceases to exist.

## **Health and Human Services Fund**

(Section 751.40)

The bill creates the Health and Human Services Fund in the state treasury, consisting of money appropriated and transferred to it. The Fund is to be used to pay any costs associated with programs or services provided by the state to enhance the public health and overall health care quality of citizens of this state. The bill requires the Director of Budget and Management to transfer any unexpended, unobligated cash that remains in the Fund as of June 30, 2017, to the Budget Stabilization Fund.

