DEPARTMENT OF MEDICAID

General provisions

Assistant director

- Adds an exception to the general requirement that state agencies have only one assistant director to permit the Medicaid Director to designate up to two assistant directors.

Medicaid coverage of services at outpatient health facilities

- Repeals law that requires Medicaid to cover comprehensive primary health services provided by outpatient health facilities that are operated by a city or general health district, another public agency, or certain types of nonprofit private agencies or organizations that receive at least 75% of their operating funds from public sources.

Joint Medicaid Oversight Commission (JMOC) report reduction

- Reduces the frequency of the Medicaid Director's required report to JMOC from quarterly to semi-annually.

Obsolete Medicaid waiver repeal

- Repeals the Unified Long-Term Services and Support Medicaid Waiver component that was never implemented.

Medicaid eligibility

Medicaid group coverage expansion

- Grants Medicaid coverage to the following in the optional eligibility group of individuals under age 65 with incomes up to 133% of the federal poverty line (FPL): (1) pregnant women, (2) children under age 19, and (3) a reasonable classification of children under age 19 adopted through private agencies.
- Establishes the income eligibility threshold for the populations in (1) and (2) above at 300% FPL and specifies that there is no income threshold for (3).
- Requires ODM to exercise the presumptive eligibility option for the newly expanded coverage groups.

Post-COVID Medicaid unwinding

- Requires the Department of Medicaid (ODM) to use third-party data to conduct an eligibility redetermination of all Ohio Medicaid recipients at the conclusion of the COVID-19 emergency period.
- Requires ODM to conduct an eligibility review of all recipients, based on the recipient's eligibility review date, and to disenroll those recipients who are no longer eligible.
- Requires ODM to complete a report containing its findings from the verification and submit it to JMOC.

- Repeals requirements ODM must follow if it receives federal Medicaid funding contingent on a temporary maintenance of effort restriction or otherwise limiting its ability to disenroll ineligible recipients.
- Excepts provider rate increases and the per member unwinding impact identified by the JMOC actuary from the Medicaid reforms required under continuing law.

Medicaid providers

Interest on payments to providers

- Limits the time frame when interest is assessed against a Medicaid provider on an overpayment to the time period determined by ODM, instead of from the payment date until the repayment date.

Provider penalties

- Clarifies that when a Medicaid provider agreement is terminated due to a provider engaging in prohibited activities, the provider may not provide Medicaid services on behalf of any other Medicaid provider.

Suspension of provider agreements and payments

- Revises the law governing the suspension of Medicaid provider agreements and payments in cases of credible allegations of fraud or disqualifying indictments against Medicaid providers or their officers, agents, or owners, including by prohibiting a suspension if the provider or owner can demonstrate good cause.

Criminal records checks

- Revises the law governing the availability of criminal records check reports for Medicaid providers, independent providers, and waiver agencies and their employees, including by authorizing reports to be introduced as evidence at certain administrative hearings and requiring them to be admitted only under seal.

Programs

Voluntary community engagement program

- Requires the Medicaid Director to establish a voluntary community engagement program for medical assistance recipients.
- Requires the program to encourage work among able-bodied medical assistance recipients of working age, including providing information about the benefits of work on physical and mental health.
- Provides that the program is in effect through FY 2025, or until Ohio is able to implement the waiver component establishing work requirements and community engagement as a condition of enrolling in the Medicaid expansion eligibility group.

Care Innovation and Community Improvement Program

- Requires the Medicaid Director to continue the Care Innovation and Community Improvement Program for the FY 2024-FY 2025 biennium.

Ohio Invests in Improvements for Priority Populations

- Continues the Ohio Invests in Improvements for Priority Populations Program as a directed payment program for inpatient and outpatient hospital services provided to Medicaid managed care recipients.
- Provides that, under the program, state university-owned hospitals with fewer than 300 beds can directly receive payment for program services.
- Requires participating hospitals to remit to ODM, through intergovernmental transfer, the nonfederal share of payment for those services.

Physician directed payment program

- Permits the Medicaid Director to seek federal approval to establish a physician directed payment program for nonpublic hospitals and related health systems.
- Provides that, under the program, participating hospitals receive payments directly for physician services provided to enrollees.
- Caps directed payments under the programs at the average commercial level paid to participating health systems for physician and other covered professional services that are provided to Medicaid MCO enrollees.
- Requires eligible public entities to transfer, through intergovernmental transfer, the nonfederal share of those services.

Medicaid payment rates

Payment rates for community behavioral services

- Permits ODM to establish Medicaid payment rates for community behavioral health services provided during FY 2024 and FY 2025 that exceed the Medicare rates for those services.

Competitive wages for direct care workforce

- Requires certain funds contained in the bill for provider rate increases to be used to increase wages and needed workforce supports to ensure workforce stability and greater access to care for Medicaid recipients.

Assisted Living program payment rates

- Permits ODM, in consultation with the Department of Aging, to establish both (1) an assisted living services base payment rate and (2) an assisted living memory care service payment, for assisted living facilities participating in the Medicaid-funded component of the Assisted Living program.

Medicaid MCO credentialing

- Repeals a requirement that ODM permit Medicaid MCOs to create a credentialing process for providers.

Nursing facilities

Special Focus Facility Program

- Aligns statutory language regarding the Special Focus Facility (SFF) Program with federal changes to the program and prohibits a nursing facility provider from appealing an order issued by ODM terminating a nursing facility's participation in Medicaid based on the facility's participation in the SFF program.

Nursing facility case-mix scores

- Updates the formula and terminology used to calculate nursing facility case-mix scores to correspond to the new federal Patient Driven Payment Model.

Debt summary reports; CMS debts related to exiting operators

- Regarding determining the actual amount of debt an exiting operator of a nursing facility owes ODM, requires ODM to issue a final debt summary report, instead of having an initial or revised debt summary report become the final debt summary report.
- Eliminates various provisions related to debts an exiting operator owes to CMS.

Nursing facility field audit manual and program

- Eliminates the requirement that ODM establish a program and manual for field audits of nursing facilities.
- Eliminates certain required procedures for auditors that must be included in the manual.
- Requires audits conducted by ODM to be conducted by an audit plan developed before audit begins, and that audits conducted by auditors contracted with ODM be conducted by procedures agreed upon by the auditor and ODM, subject to certain continuing requirements.

General provisions

Assistant director

(R.C. 121.05 and 5160.04)

The bill adds an exception to the general requirement that state agencies have only one assistant director, permitting the Medicaid Director to designate up to two assistant directors. It clarifies that if two assistant directors are appointed, the Medicaid Director may designate which assistant director acts as director in the Director's absence or disability or when the position is vacant.

Medicaid coverage of services at outpatient health facilities

(Repealed R.C. 5164.05)

The bill repeals law that requires the Medicaid program to cover comprehensive primary health services provided by "outpatient health facilities." An outpatient health facility, as defined by the repealed law, is a facility that (1) provides comprehensive primary health services by or under the direction of a physician at least five days per week on a 40-hour per week basis to outpatients, (2) is operated by the board of health of a city or general health district or another public agency or by a nonprofit private agency or organization under the direction and control of a governing board that has no health-related responsibilities other than the direction and control of outpatient health facilities, and (3) receives at least 75% of its operating funds from public sources.

Joint Medicaid Oversight Committee report reduction

(R.C. 5168.90)

Current law requires the Medicaid Director to report to the Joint Medicaid Oversight Committee (JMOC) quarterly regarding the fee rates and aggregate total of fees assessed for the hospital assessment, the nursing home and hospital long-term care unit franchise permit fee, the ICF/IID franchise permit fee, and the health insuring corporation franchise permit fee. The report also must include any rate increases for those fees pending before the U.S. Centers for Medicare and Medicaid Services (CMS). The bill reduces the frequency of this reporting to twice a year.

Obsolete Medicaid waiver repeal

(Repealed 5166.14 (primary) with conforming changes in various other R.C. sections)

The bill repeals the requirement that the Department of Medicaid (ODM) create a Long-Term Services and Support Medicaid waiver component and removes all references to the waiver component, as it was never implemented.

Medicaid eligibility

Medicaid group coverage expansion

(R.C. 5163.06, 5163.062, and 5163.102)

The bill grants Medicaid coverage to a portion of the optional eligibility group consisting of individuals under the age of 65 with incomes above 133% of the federal poverty line (FPL). It specifies that this covered portion of the group consists of (1) pregnant women, (2) children under age 19, and (3) a reasonable classification of children under 19 who were adopted through private agencies. The income threshold for pregnant women and children under 19 is 300% FPL. There is no income eligibility threshold for children under 19 who were adopted through private agencies. Continuing law unchanged by the bill grants Medicaid coverage to (1) pregnant women

with household incomes up to 200% of FPL and (2) insured children with household incomes up to 156% FPL and uninsured children up to 206% FPL.[58]

The bill requires ODM to exercise the presumptive eligibility option for the above-referenced populations. An entity may serve as a qualified entity to conduct those presumptive eligibility determinations if the entity meets requirements established under federal law, requests to act as a qualified entity, and is determined capable of making those determinations by ODM. Presumptive eligibility is a pathway whereby individuals receive immediate Medicaid benefits based on limited information, allowing them to receive services while applying for Medicaid.

Post-COVID Medicaid unwinding

(Section 333.210; repealed R.C. 5163.52)

After the expiration of the federal COVID-19 emergency period,[59] the bill requires ODM or its designee to use third-party data sources and systems to conduct eligibility redeterminations of all Ohio Medicaid recipients. To the full extent permitted by state and federal law, ODM or its designee must verify Medicaid recipients' enrollment records against third-party data sources and systems, including any other records ODM considers appropriate to strengthen program integrity, reduce costs, and reduce fraud, waste, and abuse in the Medicaid program. These provisions are similar to provisions enacted in the last main operating budget, which required ODM to conduct a redetermination of all Ohio Medicaid recipients within 90 days of the expiration of the federal COVID-19 emergency period, using enumerated sources of information.

Upon the conclusion of the federal COVID-19 emergency period, the bill requires ODM or its designee to conduct an eligibility review of Medicaid recipients based on the recipient's next eligibility review date. ODM must disenroll those Medicaid recipients who are determined to no longer be eligible based on this expedited review, and must oversee the county determinations and administration to ensure timely and accurate compliance with these requirements.

Additionally, 13 months after the federal COVID-19 emergency period expires, the bill requires ODM to complete a report containing its findings from the redetermination, including any findings of fraud, waste, or abuse in the Medicaid program. The last main operating budget required the report to be submitted within six months of the emergency's expiration, and specified additional agencies as recipients.

Additionally, the bill repeals law enacted in the last main operating budget that establish requirements ODM must follow if it receives federal Medicaid funding contingent on a temporary maintenance of effort restriction or otherwise limiting ODM's ability to disenroll ineligible recipients, such as the maintenance of effort requirements under the Families First Coronavirus Response Act (FFCRA).[60] First, ODM must conduct eligibility redeterminations for the Medicaid

[58] R.C. 5163.061 and 5161.10; O.A.C. 5160:1-4-04 and 5160:1-4-02(D).

[59] 42 U.S.C. 1320b-5(g)(1)(B).

[60] Section 6008, Pub. L. No. 116-127.

program and act on them to the fullest extent permitted by federal law. Second, within 60 days of the end of the restriction, ODM must conduct an audit where it:

- Completes and acts on eligibility redeterminations for all recipients who have not had a redetermination in the last 12 months;
- Requests approval from the U.S. Centers for Medicare and Medicaid Services (CMS) to conduct eligibility redeterminations for each recipient enrolled for at least three months during the restriction; and
- Submits a report summarizing the results to the Speaker of the House and Senate President.

Unwinding the federal maintenance of effort requirements

The FFCRA granted states a 6.2% point increase in federal matching funds during the federal COVID-19 public health emergency (referred to as the enhanced FMAP). As a condition of that increase, states were required to provide continuous Medicaid coverage to Medicaid beneficiaries enrolled at the beginning of the public health emergency. The Consolidated Appropriations Act, 2023,[61] signed by President Biden on December 29, 2022, decouples the continuous coverage requirement from the COVID-19 public health emergency. Under that act, the federal matching rate increases begin to phase out on April 1, 2023, and will be fully eliminated by December 31, 2023. The continuous coverage requirement also ends on April 1, 2023. States have up to one year to initiate all Medicaid renewals, and must conduct those renewals in accordance with federal requirements, which include some temporary flexibilities intended to smooth the unwinding process. The public health emergency is scheduled to end on May 11, 2023.

Restoration of Medicaid eligibility determinations

(Section 333.220)

The bill excepts provider rate increases and the per member unwinding impact identified by the JMOC actuary from the Medicaid reforms required under continuing law. According to the bill, this exception is due to unprecedented and extraordinary inflationary pressures within the economy that are adversely impacting Medicaid providers resulting from the federal COVID-19 emergency declaration, and due to expected increases in per member costs associated with restoring eligibility operations in the Medicaid program after the maintenance of effort requirements and the reduction in federal financial participation under the federal Consolidated Appropriations Act, 2023.

[61] Pub. L. No. 117-164.

Medicaid providers

Interest on payments to providers

(R.C. 5164.35 and 5164.60)

The bill limits the time frame when interest is assessed against a Medicaid provider (1) that willingly or by deception received overpayments or unearned payments or (2) that receives an overpayment without intent, to the time period determined by ODM, but not exceeding the time period from the payment date until the repayment date. Current law permits the imposition of interest for the time period from the payment date until the repayment date.

Provider penalties

(R.C. 5164.35)

The bill clarifies that when a Medicaid provider agreement is terminated due to the provider engaging in prohibited activities, the provider may not provide Medicaid services *on behalf of* any other Medicaid provider, instead of to any other Medicaid provider.

Suspension of Medicaid provider agreements and payments

(R.C. 5164.36)

The bill revises the law governing the suspension of Medicaid provider agreements when there are credible allegations of fraud or disqualifying indictments against Medicaid providers or their officers, agents, or owners in all of the following ways. First, the bill prohibits ODM from suspending a provider agreement or Medicaid payments if the provider or owner can demonstrate good cause. The bill directs ODM to specify by rule what constitutes good cause as well as the information, documents, or other evidence that must be submitted as part of a good cause demonstration.

Second, the bill maintains the law prohibiting ODM from suspending a provider agreement or Medicaid payments if the provider or owner can demonstrate, by written evidence, that the provider or owner did not sanction the action of an agent or employee resulting in a credible allegation of fraud or disqualifying indictment. Under the bill, ODM must grant the provider or owner – before suspension – an opportunity to submit the written evidence. The bill also eliminates law allowing a Medicaid provider or owner, when requesting ODM to reconsider its suspension, to submit documents pertaining to whether the provider or owner can demonstrate that it did not sanction the agent's or employee's action resulting in a credible allegation of fraud or disqualifying indictment.

Third, the bill adds two other circumstances to the existing two circumstances until which the suspension of a provider agreement may continue – the provider (1) pays in full fines and debts it owes ODM and (2) no longer has certain civil actions pending against it. The bill requires the suspension to continue until the latest of the four circumstances occurs.

Fourth, when, under current law, a provider or owner requests ODM to reconsider a suspension, the bill eliminates the requirement that ODM complete not later than 45 days after receiving documents in support of a reconsideration both of the following actions: (1) reviewing the documents and (2) notifying the provider or owner of the results of the review.

Criminal records checks

(R.C. 5164.34, 5164.341, and 5164.342)

The bill revises the law governing the availability of criminal records check reports for Medicaid providers, independent providers, and waiver agencies and their employees. Current law specifies that the reports are not public records and prohibits making them available to any person, with certain limited exceptions.

In the case of a waiver agency, the bill authorizes a report of an employee's criminal records check to be made available to a court, hearing officer, or other necessary individual involved in a case or administrative hearing dealing with a denial, suspension, or termination of a Medicaid provider agreement.

With respect to a Medicaid provider or independent provider, the bill authorizes a report of an employee's or provider's criminal records check to be made available to a court, hearing officer, or other necessary individual involved in a case or administrative hearing dealing with a provider agreement suspension. Current law already authorizes such a report to be made available to the court, hearing officer, or other necessary individual in a case involving a denial or termination of a provider agreement.

The bill further authorizes a criminal records check report to be introduced as evidence at an administrative hearing concerning a provider agreement denial, suspension, or termination. If admitted, the bill specifies that the report becomes part of the hearing record. It also requires such a report to be admitted only under seal and specifies that the report maintains its status as not a public record.

Programs

Voluntary community engagement program

(Section 333.190; R.C. 5166.37, not in the bill)

As a result of the COVID-19 public health emergency, H.B. 110 of the 134th General Assembly required the Medicaid Director to establish and implement a voluntary community engagement program by January 1, 2022, and operate the program for the FY 2022-FY 2023 biennium. The bill extends the program through the FY 2024-FY 2025 biennium.

The program is voluntary and available to all medical assistance recipients (individuals enrolled or enrolling in Medicaid, CHIP, the refugee medical assistance program, or other medical assistance program ODM administers). The program must:

- Encourage medical assistance recipients who are of working age and able-bodied to work;
- Promote the economic stability, financial independence, and improved health incomes from work; and
- Provide information about program services, including an explanation of the importance of work to overall physical and mental health.

As part of the program, the Director must explore partnerships with education and training providers to increase training opportunities for Medicaid recipients. The program is to

continue through the FY 2024-FY 2025 biennium, or until ODM is able to implement the Work Requirement and Community Engagement Section 1115 Demonstration waiver, whichever is sooner. Note that CMS withdrew its approval for this waiver in August 2021.[62]

Care Innovation and Community Improvement Program

(Section 333.60)

The bill requires the Medicaid Director to continue the Care Innovation and Community Improvement Program for the FY 2024-FY 2025 biennium. The Director was originally required to establish it for the FY 2018-FY 2019 biennium.[63]

Any nonprofit hospital agency affiliated with a state university and any public hospital agency may volunteer to participate in the program if the hospital has a Medicaid provider agreement. The agencies that participate are responsible for the state share of the program's costs and must make or request that appropriate government entity to make intergovernmental transfers to pay for the costs. The Director must establish a schedule for making the transfers.

The bill requires each participating hospital agency to jointly participate in quality improvement initiatives that align with and advance the goals of ODM's quality strategy.

Under the program, each participating hospital agency receives supplemental Medicaid payments for physician and other professional services that are covered by Medicaid and provided to Medicaid recipients. The payments must equal the difference between the Medicaid rate and the average commercial payment rates for the services. The Director may terminate, or adjust the amount of, the payments if funding for the program is inadequate.

The Director must maintain a process to evaluate the work done under the program by nonprofit and public hospital agencies and their progress in meeting the program's goals. The Director may terminate a hospital agency's participation if the Director determines that it is not participating in required quality improvement initiatives or making progress in meeting the program's goals.

The bill does not include the requirement that existed in the prior budget that, not later than December 31 of each year, the Director must submit a report to the Speaker of the House, the Senate President, and JMOC that details the efficacy, trends, outcomes, and number of hospital agencies enrolled in the program.

All intergovernmental transfers made under the program must be deposited into the existing Care Innovation and Community Improvement Program Fund. Money in the fund and the corresponding federal funds must continue to be used to make the supplemental payments to hospital agencies under the program.

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[62] CMS letter (PDF), August 10, 2021, also available by conducting a keyword search for that date on CMS' website: www.medicaid.gov.

[63] Section 333.320 of H.B. 49 of the 132nd General Assembly, Section 333.220 of H.B. 166 of the 133rd General Assembly, and Section 333.60 of H.B. 110 of the 134th General Assembly.

Ohio Invests in Improvements for Priority Populations

(Section 333.170)

The bill continues the Ohio Invests in Improvements for Priority Populations Program as a directed payment program for inpatient and outpatient hospital services provided to Medicaid managed care recipients receiving care at state university-owned hospitals with fewer than 300 inpatient beds.

Under the program, participating hospitals receive payments directly (instead of through the contracted Medicaid MCO) for inpatient and outpatient hospital services provided under the program and remit to ODM the nonfederal share of payment for those services. The hospital must pay ODM through intergovernmental transfer. Funds transferred under the program must be deposited into the Hospital Directed Payment Fund.

In general, under federal law, states are prohibited from (1) directing Medicaid MCO expenditures or (2) making payments directly to providers for Medicaid MCO services ("directed payments") unless permitted under federal law or subject to federal authorization.[64] Therefore, the bill requires the Medicaid Director to seek approval from CMS to operate the program.

Physician directed payment program

(Section 333.260)

The bill also permits the Medicaid Director to seek approval from CMS to establish one or more physician directed payment programs for directed payments for nonpublic hospitals and the related health systems. The programs must advance the maternal and child health goals of ODM's quality strategy.

Under the program, participating hospitals receive payment directly for physician services provided to enrollees and remit to ODM the nonfederal share of those services through intergovernmental transfer. The directed payments may equal up to the average commercial level for participating health systems for physician and other covered professional services provided to Medicaid MCO enrollees. Eligible public entities may transfer funds to be used for the directed payments through intergovernmental transfer into the Health Care/Medicaid Support and Recoveries Fund.

Under the programs, ODM may only make directed payments to the extent local funds are available for the nonfederal share of the cost for the services. If receipts credited to the program exceed the available amounts in the fund, the Director can adjust the directed payment amounts or terminate the program.

[64] Centers for Medicare and Medicaid Services, Letter Re: Additional Guidance on State Directed Payments in Medicaid Managed Care (PDF), January 8, 2021, available at medicaid.gov.

Medicaid payment rates

Payment rates for community behavioral health services

(Section 333.140)

The bill permits ODM to establish Medicaid payment rates for community behavioral health services provided during FY 2024 and FY 2025 that exceed the Medicare rates for those services. This authorization does not apply to those services provided by hospitals on an inpatient basis, nursing facilities, or ICFs/IID.

Competitive wages for direct care workforce

(Section 333.230)

The bill includes funding from ODM, in collaboration with the Departments of Developmental Disabilities and Aging, to be used for provider rate increases, in response to the adverse impact experienced by direct care providers as a result of the COVID-19 pandemic and inflationary pressures. The bill requires the provider rate increases be used to increase wages and workforce supports to ensure workforce stability and greater access to care for Medicaid recipients.

Assisted Living program payment rates

(Section 333.240)

The bill permits ODM, in consultation with the Department of Aging, to establish an assisted living services base payment rate for residential care facilities (commonly known as "assisted living" facilities) participating in the Medicaid-funded component of the Assisted Living program.

The bill also permits ODM, in consultation with the Department of Aging, to establish an assisted living memory care service payment rate for such facilities. That payment rate must be based on additional costs that a provider may incur from serving individuals with dementia, and any other additional factors determined by the departments. It is only available to providers with a direct care staff to resident ratio that is at least 20% higher for individuals with dementia than for individuals without. The departments may adopt rules to incorporate workforce, performance, training, and other quality indicators into the payment rate.

The bill permits the departments to adopt rules establishing additional requirements related to person-centered service planning and facility design.

Medicaid MCO credentialing

(Repealed R.C. 5167.102 and 5167.12)

The bill repeals law that requires ODM to permit Medicaid MCOs to create a credentialing process for providers, because ODM is now credentialing Medicaid providers instead of Medicaid MCOs. As a conforming change, the bill modifies language that prohibits a Medicaid MCO from imposing a prior authorization requirement on certain antidepressant or antipsychotic drugs that are prescribed by a physician credentialed by the Medicaid MCO to instead refer to a physician who has registered with ODM.

Nursing facilities

Special Focus Facility Program

(R.C. 5165.771)

The bill makes changes to the law regarding the federal Special Focus Facility (SFF) Program to align with federal changes to the program. First, the bill references standard health surveys, which, under the federal changes, are comprehensive on-site inspections conducted every six months by the state nursing facility licensing agency on behalf of CMS. The bill replaces references to the old SFF tables and instead requires ODM to terminate a nursing facility's participation in the Medicaid program if it has not graduated from the SFF program after two standard health surveys, instead of based on the time the facility is listed in SFF tables.

Second, the bill prohibits a nursing facility from appealing to ODM an ODM order terminating the facility's participation in the Medicaid program if the appeal challenges (1) standard health findings under the SFF program or (2) a CMS determination to terminate the nursing facility's participation in the Medicare or Medicaid program. Instead, the appeals must be brought to (1) the Department of Health or (2) CMS, respectively.

Nursing facility case-mix scores

(R.C. 5165.01, 5165.152, and 5165.192)

The bill updates the formula and terminology used to calculate nursing facility case-mix scores to correspond to a new federal model. Effective October 1, 2019, CMS implemented a new payment model for nursing homes under the Medicare and Medicaid programs. The model, referred to as the Patient Driven Payment Model, consists of case-mix adjusted components (relative resources needed to provide care and habilitation to residents).

The bill updates nursing facility terminology to accord with the new federal model. Specifically, the bill (1) removes from the case-mix calculation language adjusting case-mix values based on Ohio wage differentials, establishing a hierarchy for case-mix categories, and permitting the case-mix calculation to include an index maximizer element and (2) updates terminology relating to nursing facility case-mix scores from "low resource utilization resident" to "low case-mix resident."

Debt summary reports; CMS debts related to exiting operators

(R.C. 5165.52, 5165.521, 5165.525, 5165.526, and 5165.528)

The bill makes several changes related to exiting operators of nursing facilities and various related duties of ODM. Regarding a requirement that ODM determine the actual amount of debt an exiting operator owes ODM, the bill requires ODM to issue a final debt summary report. This is in place of existing law under which an initial or revised debt summary report may automatically become the final debt summary report.

Also regarding exiting operators, the bill eliminates the following provisions related to debts an operator owes to CMS:

- A requirement that ODM determine other actual and potential debts the exiting operator owes or may owe to CMS;
- Authorization for ODM to withhold from a payment due to an exiting operator the total amount the exiting operator owes or may owe to CMS;
- A requirement that ODM determine the actual amount of debt an exiting operator owes to CMS by completing all final fiscal audits not already completed and performing other appropriate actions;
- Regarding releasing amounts withheld from an exiting operator, authorization for ODM to deduct any amount an exiting operator owes CMS;
- Authorization for moneys in the Medicaid Payment Withholding Fund to be used to pay CMS amounts an exiting operator owes CMS under Medicaid.

All of the above-described provisions are retained as they relate to debt owed to ODM under current law, and eliminated only with regard to debt owed to CMS. The bill, however, eliminates law expressly requiring ODM's debt estimate methodology to address any final civil monetary and other penalties.

Nursing facility field audit manual and program

(R.C. 5165.109)

ODM may conduct audits for any cost reports filed as either an annual cost report by a nursing home or by an exiting operator of a nursing home. The bill removes the requirement that ODM establish a program and publish a manual for those audits conducted in the field. Instead, the bill specifies general parameters for field audit procedures. Specifically, ODM must develop an audit plan before the audit begins for any audits it conducts, but the scope of the audit may change during its course based on the observations and findings. Field audits conducted by an auditor under contract with ODM must be conducted by procedures agreed upon between ODM and the auditor.

The bill eliminates the requirements, as part of the eliminated field manual, that all auditors conducting field audits:

- Comply with federal Medicare and Medicaid law;
- Consider standards prescribed by the American Institute of Certified Public Accountants;
- Include a written summary with each audit about whether cost report that is the subject of the audit complied with state and federal laws and the reported allowable costs were documented, reported, and related to patient care;
- Completed each audit within a time period specified by ODM; and
- Provide to the nursing home provider written information about the audit's scope and ODM's policies, including examples of allowable cost calculation.