DEPARTMENT OF MEDICAID

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.

Report on projected program trends

- Requires the Department of Medicaid (ODM) to submit a report to the Joint Medicaid Oversight Committee (JMOC), by October 1 of each even-numbered year, detailing historical and projected expenditure and utilization trend rates and interventions to curb the per member per month cost of the Medicaid program.

Report on Medicaid reforms

- Requires ODM, not later than October 1 of each even-numbered year, to submit a report to JMOC detailing Medicaid reforms during the two previous fiscal years.

Coverage of obesity treatment

- Requires the Medicaid program to cover obesity treatment and prohibits ODM from establishing certain limits or requirements concerning this coverage.

Coverage of donor breast milk and milk fortifiers

- Requires the Medicaid program to cover medically necessary pasteurized donor human milk and human milk fortifiers for inpatient and home use.
- Permits ODM to make rules as needed to implement donor human milk and human milk fortifier coverage.

Lockable and tamper-evident containers

- Requires ODM, during FY 2024 and FY 2025, to reimburse pharmacists and physicians for expenses related to dispensing or personally furnishing, respectively, drugs used in medication-assisted treatment in lockable or tamper-evident containers.

Obsolete Medicaid waiver repeal

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

Medicaid eligibility

Medicaid optional 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 described above.

Neonatal Abstinence Syndrome

- Grants Medicaid coverage to infants with Neonatal Abstinence Syndrome who receive services at a pediatric recovery center.

Medicaid coverage for workers with a disability

- Requires the Medicaid program to cover the optional eligibility group consisting of certain workers with a disability.
- Declares that the General Assembly's intent in requiring the coverage described above is to provide coverage consistent with Ohio's existing Medicaid Buy-In for Workers with a Disability program for workers with disabilities age 65 or older.

Continuous Medicaid enrollment for young children

- Requires the Medicaid Director to establish a Medicaid waiver component to provide continuous enrollment for Medicaid-eligible children from birth through age three.

Post-COVID Medicaid unwinding

- Requires 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.

Medicaid program cost savings report

- Requires ODM to conduct an annual cost savings study of the Medicaid program and submit a report to the Governor recommending measures to reduce Medicaid program costs.

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 Medicaid 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.

HHA and PCA training

- Prohibits ODM from requiring more than eight hours of pre-service training or six hours of annual in-service training for home health aides (HHAs) and personal care aides (PCAs) providing services under the Integrated Care Delivery System (MyCare).
- Permits a registered nurse, licensed practical nurse, or nurse aide to supervise an HHA or PCA providing services under MyCare.

Programs

Voluntary community engagement program

- Requires the 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 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 GEMT supplemental payment program

- Requires the Director to submit a state plan amendment seeking to establish and administer a supplemental payment program for specified ground emergency medical transportation service providers.

Medicaid in Schools Program

- Requires ODM to seek approval from CMS to expand the Medicaid in Schools Program to include payment for any covered service that is performed in a school setting by a qualified provider and provided to an eligible individual.

ODM doula program

- Establishes a five-year program to cover doula services provided by a certified doula with a Medicaid provider agreement.
- Requires the Medicaid Director to complete an annual report regarding program outcomes.

Hospital Care Assurance Program; franchise permit fee

- Continues, until October 2023, the Hospital Care Assurance Program and the franchise permit fee imposed on hospitals under Medicaid.

Medicaid payment rates

Payment rates for community behavioral health 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

- Requires ODM, in consultation with ODA, to establish both (1) an assisted living services base payment rate, (2) an assisted living memory care service payment, and (3) a critical access payment rate for assisted living facilities participating in the Medicaid-funded component of the Assisted Living program.

Direct care provider payment rates

- Increases direct care wages to $17 an hour in FY 2024 beginning January 1, 2024, and to $18 an hour for all of FY 2025 for certain direct care services provided under the Medicaid home and community-based services waivers administered by ODM or ODA.

Federally qualified health center payment rates

- Appropriates funds to increase payment rates to federally qualified health centers (FQHCs) and FQHC look-alikes.

Vision and eye care services provider payment rate

- Earmarks funds to increase Medicaid provider payment rates for vision services and medically billed eye care provided to Medicaid recipients during FY 2024.

Dental provider payment rates

- Appropriates $122 million in FY 2024 and $244 million in FY 2025 to increase the payment rate to dental providers treating Medicaid enrollees.

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

Debt summary reports; 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 the Centers for Medicare and Medicaid Services (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.

Nursing facility workforce relief funds

- Expands the facilities eligible to receive workforce relief funds appropriated in H.B. 45 of the 134th General Assembly to include nursing homes that are not certified by CMS to participate in the Medicaid program.
- Removes the requirement that the funds be distributed no later than April 1, 2023.
- Specifies that nursing homes are to receive payments based on the median number of Medicaid days and median quality score for nursing facilities.
- Specifies that the above provisions are remedial in nature and apply retroactively beginning January 6, 2023.

Nursing facility per Medicaid day payment rate

- Modifies the nursing facility per Medicaid day payment rate calculation by removing a $1.79 deduction, including a deduction for low occupancy nursing facilities, and increasing the add-on to the initial rate for new nursing facilities.

Ancillary and support costs and direct care costs

- Determines a nursing facility's ancillary and support costs and direct care costs rates by using the median rate for the facility's peer group, instead of the rate at the 25th percentile of that peer group.
- Beginning on January 1, 2024, during the remainder of FY 2024 and all of FY 2025, requires ODM to determine each nursing facility's direct care costs rate by multiplying the per case-mix unit determined for the peer group by the case-mix score selected by the nursing facility.

Low occupancy deduction

- To the per Medicaid day payment rate formula, adds a low occupancy deduction for a nursing facility that has an occupancy rate lower than 65%.

Private room incentive payment

- Beginning July 1, 2023, adds a private room incentive payment rate to the per Medicaid day payment rate formula for nursing facilities with private rooms.
- Sets the private room incentive payment at $30 for FY 2024 and permits ODM to increase the rate in subsequent fiscal years.
- Requires nursing facility providers to apply for approval of their private rooms in the form and manner prescribed by ODM and permits ODM to specify evidence that an applicant must supply to demonstrate that a room is a private room.
- Limits ODM to considering only those private room applications that meet specified criteria.
- Permits ODM to deny an application if it determines that the rooms included in the application do not meet the definition of a private room or the specified criteria, or if the applicant created private rooms by reducing the number of available beds without reducing the facility's licensed capacity.

Quality incentive payments

- Extends nursing facility quality incentive payments indefinitely.
- Regarding the quality incentive payment rate calculation, adds an occupancy metric beginning in FY 2024 for facilities with occupancy rates above 75% and adds three new quality incentive metrics beginning in FY 2025.
- Eliminates exclusions from the quality incentive payment for facilities that meet enumerated criteria.

- Adds to the calculation of the total amount to be spent on quality incentive payments an additional component based on 60% of the amount the facility's ancillary and support costs and direct care costs changed as a result of the FY 2024 rebasing.
- Caps the add-on to the total amount to be spent on quality incentive payments at $125 million in each fiscal year.
- Grants an operator of a new nursing facility or, under certain circumstances, a facility that undergoes a change in operator, a quality incentive payment.

Rebasing

- Expedites the rate of rebasing beginning in FY 2024 to at least every two years, from at least every five years.
- Specifies that the costs are measured from the calendar year immediately before the start of the fiscal year in which a rebasing is conducted, instead of two calendar years before.
- In calculating a facility's FY 2024 and FY 2025 base rates, limits any increases in the direct care cost and ancillary and support cost centers from the most recent rebasing to only 40% of the increase.

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.

Report on projected program trends

(R.C. 103.414)

The bill requires the Department of Medicaid (ODM), not later than October 1 of every even-numbered year, to submit a report to the Joint Medicaid Oversight Committee (JMOC) that details the historical and projected Medicaid program expenditures and utilization trend rates for each year of the upcoming fiscal biennium broken down by Medicaid program and service category. The report must include all actuarial data utilized by ODM in producing these trends. Additionally, the bill requires that the report detail the interventions taken by ODM to restrain the growth in the per member per month cost of the Medicaid program.

Report on Medicaid reforms

(R.C. 5162.70)

Not later than October 1 of every even-numbered year, the bill requires the Medicaid Director to submit a report to JMOC detailing the reforms required by existing law unchanged by the bill that ODM implemented in the preceding two fiscal years. Under continuing law, the Director is required to implement reforms that (1) limit the growth in the per member per month cost of the Medicaid program, (2) achieve the limit in the growth of the per member per month cost of the Medicaid program, (3) reduce the prevalence of comorbid health conditions among, and the mortality rates of, Medicaid recipients, and (4) reduce infant mortality rates among Medicaid recipients.

Coverage of obesity treatment

(R.C. 5164.11, primary; conforming changes in R.C 5162.20 and 5167.12)

The bill requires the Medicaid program, including Medicaid MCOs, to provide coverage for obesity treatment, including (1) prevention and wellness services, (2) nutrition counseling, (3) intensive behavioral therapy, (4) bariatric surgery and follow-up services, and (5) prescription drugs approved by the FDA to treat overweight and obesity, with an indication for chronic weight management in patients with obesity.

The bill prohibits ODM from imposing any of the following conditions on the coverage:

- Limits on obesity treatment coverage that are different from the coverage for the treatment for other illnesses, conditions, or disorders that are covered by the Medicaid program, including annual and lifetime limits on obesity treatment;
- Cost sharing requirements; or
- Concerning the prescription drugs described above, coverage restrictions that are more restrictive than the indicated used for the drug.

The bill does permit ODM to impose utilization review requirements to determine the medical necessity for covered obesity treatments. However, if ODM establishes utilization review requirements, they must be the same as any utilization review requirements established for the treatment of other illnesses, conditions, and disorders covered by the Medicaid program.

The bill requires ODM to inform Medicaid recipients in writing and in other correspondence to recipients about the availability of Medicaid coverage for obesity treatment. Additionally, ODM must market this coverage to recipients in annual information notices.

Coverage of donor breast milk and milk fortifiers

(R.C. 5164.072)

The bill requires Medicaid coverage for pasteurized donor human milk and human milk fortifiers in both hospital and home settings in specified circumstances. The milk or fortifier must be determined medically necessary by a licensed health professional for an infant whose

gestationally corrected age is less than 12 months. The milk or fortifier is medically necessary when any of the following apply:

- The infant has a body weight below healthy weight levels;
- The infant was less than 1,800 grams at birth;
- The infant was born at or before 34 weeks gestation; or
- The infant has any congenital or acquired condition that a licensed health professional indicates would be supported by human milk or fortifier.

Additionally, the bill requires Medicaid coverage for donor human milk and fortifier only when the infant is unable to receive maternal breast milk because either the infant is unable to participate in breast feeding or the mother cannot produce enough calorically sufficient milk. The mother and infant must participate in lactation support before donor human milk or fortifier may be covered by Medicaid.

The bill permits ODM to adopt any rules necessary to implement these provisions.

Lockable and tamper-evident containers

(Sections 333.270 and 333.10)

The bill requires ODM to reimburse pharmacists and physicians for expenses related to dispensing or personally furnishing, respectively, drugs used in medication-assisted treatment in lockable containers or tamper-evident containers. The bill defines "lockable container" as a container that (1) has "special packaging," which is generally defined under federal law as packaging designed to be significantly difficult for children to open, but not difficult for normal adults to use,[121] and (2) can be unlocked physically using a key, or physically or electronically using a code or password. "Tamper evident container" is defined by the bill as a container that has special packaging and displays a visual sign in the event of unauthorized entry or displays the time the container was last opened.

The reimbursements are to be made during FY 2024 and FY 2025, or until appropriated funds – $500,000 in each fiscal year – run out.

Obsolete Medicaid waiver repeal

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

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

[121] "Poison Prevention Packaging Act of 1970," 15 U.S.C. 1471.

Medicaid eligibility

Medicaid optional 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.[122]

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.

Neonatal Abstinence Syndrome

(R.C. 5103.603)

Additionally, the bill grants Medicaid coverage to the optional eligibility group consisting of infants with neonatal abstinence syndrome who receive services at a pediatric recovery center. For purposes of this added optional eligibility group, the bill specifies that a residential infant care center certified under existing law unchanged by the bill constitutes a residential pediatric recovery center.

Medicaid coverage for workers with a disability

(R.C. 5163.06 and 5163.063; Sections 333.310 and 812.40)

The bill requires the Medicaid program to provide coverage to employed individuals with disabilities whose family income is less than 250% of the federal poverty level. Under federal law, states have the option of extending Medicaid coverage to this group of individuals.[123] The bill requires the Director to adopt any rules necessary to provide the coverage.

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

[123] 42 U.S.C. 1396a(a)(10)(A)(ii)(XIII).

In requiring the Medicaid program to cover this group of individuals, the bill declares that it is the intent of the General Assembly to establish Medicaid coverage for employed individuals with disabilities who are 65 years of age or older in a manner that is consistent with the coverage that is provided to individuals who participate in the Medicaid Buy-In for Workers with Disabilities (MBIWD) program established under existing law.

Under continuing law unchanged by the bill, the MBIWD program provides Medicaid coverage to employed individuals with disabilities and employed individuals with medically improved disabilities who are between 16 and 64 years of age.[124] The individuals covered under the MBIWD program are individuals who make up two other optional eligibility groups under federal law.[125] However, under federal law, an employed individual with a disability is no longer eligible to participate in the MBIWD program upon reaching 65 years of age. The optional eligibility group the bill requires the Medicaid program to cover also consists of employed individuals with a disability, but federal law authorizing Medicaid coverage for this group does not include an age limit.

The bill delays, for one year after its effective date, implementation of Medicaid coverage for this new group. Additionally, the bill provides that upon approval of a state plan amendment by CMS that authorizes the Medicaid coverage, the Medicaid Director may certify to the OBM Director the necessary amount needed to pay for coverage of the optional eligibility group in FY 2025. Upon this certification, the bill appropriates that amount to ODM.

Continuous Medicaid enrollment for young children

(R.C. 5166.45)

The bill requires the Director to establish a Medicaid waiver component to provide continuous Medicaid enrollment for Medicaid-eligible children from birth through age three. A child who is eligible for Medicaid will remain eligible until the earlier of (1) the end of a continuous 48-month period, or (2) the date the child exceeds age four. The waiver does not apply to a child who is deemed presumptively eligible for Medicaid, is eligible for alien emergency medical assistance, or is eligible for the refugee medical assistance program.

Post-COVID Medicaid unwinding

(Section 333.210; repealed R.C. 5163.52)

After the expiration of the federal COVID-19 emergency period,[126] 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

[124] R.C. 5163.09 through 5163.098, not in the bill.

[125] 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and (XVI).

[126] 42 U.S.C. 1320b-5(g)(1)(B).

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, H.B. 110 of the 134th General Assembly, 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).[127] First, ODM must conduct eligibility redeterminations for the Medicaid 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

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

Appropriations Act, 2023,[128] 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.

Medicaid program cost savings report

(R.C. 5162.137)

The bill requires ODM to annually (1) conduct a cost savings study of the Medicaid program and (2) prepare a report based on the study, recommending measures to reduce Medicaid program costs, and submit the report to the Governor.

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. It directs ODM to specify by rule what constitutes good cause as

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

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 suspension must 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.

HHA and PCA training

(R.C. 5164.913)

The bill prohibits the Department from requiring HHAs and PCAs providing services under MyCare to receive more than eight hours of pre-service training and six hours of annual in-service training. The Department determines what training is acceptable. The bill also permits a registered nurse, licensed practical nurse, or nurse aide to supervise an HHA or PCA.

Under federal regulations, HHAs providing services through Medicare or Medicaid will continue to be required to receive 75 hours of pre-service training and 12 hours of annual in-service training. Additionally, federal regulations require that an HHA providing Medicare or Medicaid services be supervised by a registered nurse or other appropriate professional (such as a physical therapist, speech-language pathologist, or occupational therapist).[129]

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.[130]

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[129] 42 C.F.R. 484.80.

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

Care Innovation and Community Improvement Program

(Section 333.60)

The bill requires the 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.[131]

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.

[131] 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.[132] Therefore, the bill requires the Director to seek CMS approval to operate the program.

Physician directed payment program

(Section 333.260)

The bill also permits the Medicaid Director to seek CMS approval 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.

[132] CMS directed payments letter (PDF), January 8, 2021, available by conducting a keyword search of that date on CMS's website: medicaid.gov.

Medicaid GEMT supplemental payment program

(R.C. 5164.96)

The bill requires the Director to submit a Medicaid state plan amendment to CMS seeking authorization to establish and administer a supplemental payment program that provides supplemental Medicaid payments to eligible EMS organizations. If the state plan amendment is approved, the Director must establish and administer the program and adopt rules to implement the program.

Under the bill, an EMS organization is eligible to receive supplemental Medicaid payments under the supplemental payment program if it meets all of the following requirements: (1) the EMS organization is a public organization operated by a governmental entity, (2) the EMS organization holds a valid Medicaid provider agreement, and (3) the EMS organization provides emergency medical transportation services to Medicaid recipients.

Medicaid in Schools Program

(Section 333.280)

Requires ODM to seek approval from CMS by December 31, 2023, to expand the existing Medicaid in Schools Program to include payment for any Medicaid covered services to an eligible individual when performed by a qualified provider in a school setting. Continuing law specifies which occupational therapy, physical therapy, speech-language pathology, audiology, nursing, and mental health services are eligible for coverage as a part of the program.[133]

ODM doula program

(R.C. 5164.071)

The bill requires ODM to operate a program to cover doula services. The program is to begin one year after the bill's effective date and conclude five years after that date. The doula services must be provided by a doula who has a valid Medicaid provider agreement and is certified by the Ohio Board of Nursing (see "**Doula certification**").

Medicaid payments

Under the program, Medicaid payments for doula services are to be determined on the basis of each pregnancy, regardless of whether multiple births occur as a result of that pregnancy.

Annual reports

The bill establishes several reporting requirements related to the Medicaid Program, including the following:

- Outcome measurements and incentives for the program must be consistent with the state's Medicare-Medicaid Plan Quality Withhold methodology and benchmarks.

[133] R.C. 5162.364; O.A.C. 5160-35-05.

- The Director must complete an annual report regarding program outcomes, including those related to maternal health and morbidity and estimated fiscal impacts.
- The final annual report must include recommendations related to whether the program should be continued.
- The Medicaid Director must provide a copy of the annual report to the Joint Medicaid Oversight Committee.

Rulemaking

The Director must adopt rules implementing the bill's provisions. The bill exempts the rules adopted under it from existing law that limits regulatory restrictions adopted by certain agencies.

Hospital Care Assurance Program; franchise permit fee

(Sections 610.80 and 610.81, amending Sections 125.10 and 125.11 of H.B. 59 of the 130th G.A.)

The bill continues the Hospital Care Assurance Program (HCAP) for two additional years. The program had been scheduled to end October 16, 2023. The act extends it to October 16, 2025. Under HCAP, hospitals are annually assessed an amount based on their total facility costs, and government hospitals make annual intergovernmental transfers. The Department distributes to hospitals money generated by the assessments and intergovernmental transfers along with federal matching funds. A hospital compensated under the program 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 also continues for two additional years another assessment imposed on hospitals; that assessment is to end on October 1, 2025, rather than October 1, 2023. The assessment is in addition to HCAP, but like that program, it raises money to help pay for the Medicaid program. To distinguish the assessment from HCAP, the assessment is sometimes called a hospital franchise permit fee.

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 Department of Developmental Disabilities and ODA, 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 requires ODM, in consultation with ODA, to adopt rules, effective November 1, 2023, to do both of the following:

1. Establish an assisted living services base payment rate of at least $130 per day for residential care facilities (commonly known as "assisted living" facilities) participating in the Medicaid-funded component of the Assisted Living program.

2. Establish an assisted living memory care service payment rate for such facilities that is at least $25 more per day than the base payment rate described above. The memory care service payment rate must be based on additional costs that a provider may incur from serving individuals with dementia. It is only available for patients who were determined by a practitioner to need a memory care unit and who reside in units with a direct care staff to resident ratio that is at least 20% higher for individuals with dementia than for individuals without.

The bill also requires the departments to adopt rules establishing an assisted living critical access payment rate for residential care facilities participating in the Medicaid-funded Assisted Living program that averaged at least 50% of their residents receiving Medicaid-funded services during the last fiscal year. For such facilities, the critical access payment must be at least $15 more per day than the base payment rate described above and the memory care service payment rate must be at least $10 higher than the critical access payment rate. No date is specified for the adoption of these rules.

Finally, the departments must, in consultation with industry stakeholders, adopt rules by July 1, 2024, establishing a methodology for determining assisted living service rates, including memory care services and critical access services, that provide for adjusting the rates annually based on changes to the Consumer Price Index for All Items for All Urban Consumers for the Midwest Region, as published by the U.S. Bureau of Labor Statistics.

Direct care provider payment rates

(Section 333.29)

The bill earmarks Medicaid funds to be used to increase the provider base wages to $17 an hour in FY 2024, beginning January 1, 2024, and $18 an hour in FY 2025, beginning July 1, 2024, for the following services provided under Medicaid components of the home and community-based services waivers administered by ODM or ODA:

1. Personal care services;

2. Adult day services;

3. Community behavioral health services; and

4. Other waiver services under the HCBS waivers administered by the departments.

Federally qualified health center payment rates

(Section 333.17)

The bill earmarks $20.7 million in each fiscal year to increase payment rates to federally qualified health centers (FQHCs) and FQHC look-alikes. FQHCs are nonprofit health clinics that qualify for and receive federal funds, where services are provided on a fee based on a patient's ability to pay. FQHC look-alikes qualify for but do not receive federal funding.

Vision and eye care services provider payment rate

(Section 333.25)

The bill earmarks funds to increase Medicaid provider payment rates for vision services and medically billed eye care provided to Medicaid recipients during FY 2024. The increase is added to FY 2023 payment rates and must be maintained during FY 2025.

Dental provider payment rates

(Section 333.27)

The bill earmarks $122 million in FY 2024 and $244 million in FY 2025 to increase the payment rate to dental providers treating Medicaid enrollees.

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 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 terminology relating to nursing facility case-mix scores from "low resource utilization resident" to "low case-mix resident" to accord with the new model.

Debt summary reports; 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; and
- 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)

Under continuing law, 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.

Nursing facility workforce relief funds

(Sections 610.30, 610.31, and 803.200, amending section 280.28 of H.B. 45 of the 134th G.A.)

The bill expands the facilities eligible to receive workforce relief funds appropriated in H.B. 45 of the 134th General Assembly by including nursing homes that are not certified by CMS to participate in the Medicaid program, instead of only those that are certified by CMS (nursing facilities).

That act appropriated $350 million in American Rescue Plan Act (ARPA) funds to be used by OBM to make lump-sum payments to nursing facilities that are Medicaid providers, for workforce relief payments to be used for general relief and items not covered by Medicaid rates or Medicaid MCO contracts. Existing law requires OBM to distribute the funds as soon as practicable, but no later than April 1, 2023, as follows:

1. 40% of the funds as payments to nursing facilities based on each facility's total number of Medicaid days in calendar year 2021; and

2. 60% as quality payments to nursing facilities.

A nursing facility's quality score is calculated according to a specified formula that is similar to the quality incentive payment formula used to calculate nursing facility per Medicaid day payment rates under continuing law.

In including nursing homes as recipients of the funds, the bill removes the requirement that the recipient be a Medicaid provider and that OBM distribute the funds no later than April 1, 2023. Additionally, the bill provides that nursing homes are to receive payments under (1) above based on the median number of Medicaid days for all nursing facilities in this state during calendar year 2021 and under (2) above based on the median quality score for all nursing facilities for which a quality score was determined.

Nursing facility per Medicaid day payment rate

(R.C. 5165.15 and 5165.151)

The bill modifies the formula used to calculate the Medicaid payment amount ODM makes to nursing facilities for Medicaid residents (referred to as the per Medicaid day payment rate in the Revised Code) as follows:

- Removes the $1.79 deduction that is part of calculating a facility's base rate;
- Incudes a deduction for low occupancy nursing facilities;
- For the initial rate paid to new nursing facilities, increases the add-on to $16.44 from $14.65.

Ancillary and support costs and direct care costs

(R.C. 5165.16 and 5165.19)

The bill makes changes to two of the cost center calculations that are used as part of the per Medicaid day payment rate formula. Under the bill, a nursing facility's ancillary and support costs and direct care costs rates are determined based on the median rate for those costs in that year for the peer group, instead of the rate at the 25th percentile of that peer group. Additionally, the bill removes inflationary adjustments for those cost centers.

During FY 2024 and FY 2025, the bill adds another modification to the direct care costs calculation. Beginning on January 1, 2024, through the end of the biennium, ODM must determine each nursing facility's direct care costs rate by multiplying the per case-mix unit determined for the peer group under the calculation by the case-mix score selected by the nursing facility. A facility may select either of the following for its case-mix score:

1. The semi-annual case-mix score determined under the regular calculation; or

2. The facility's quarterly case-mix score from March 31, 2023, which will apply during the period from January 1, 2024, through June 30, 2025.

If a facility does not select its case-mix score mechanism by October 1, 2023, the case-mix score determined under the regular calculation applies.

Low occupancy deduction

(R.C. 5165.23 and 5165.15)

Under the bill, a nursing facility that has an occupancy rate lower than 65% is considered a low occupancy nursing facility and receives a low occupancy deduction as part of its per Medicaid day payment rate. Each state fiscal year, ODM must determine the low occupancy

deduction for each low occupancy nursing facility, equal to 5% of the facility's total per Medicaid day payment rate for that fiscal year.

For purposes of this deduction, ODM must calculate the facility's occupancy rate based on the occupancy rate of the licensed beds listed on its cost report for the calendar year before the fiscal year for which the rate is determined, or if the facility is not licensed, the occupancy rate for its certified beds. If the facility surrenders licensed or certified beds before May 1 of the calendar year in which the fiscal year begins, ODM must calculate the facility's occupancy rate by dividing the number of inpatient days reported on the facility's cost report for the calendar year preceding the fiscal year for which the rate is determined by the product of (1) the number of days in the calendar year and (2) the facility's number of licensed or certified beds on May 1. A nursing facility that is owned by a county and operated by a person other than a county is ineligible for the low occupancy deduction.

Private room incentive payment

(R.C. 5165.158 and 5165.01)

Beginning July 1, 2023, the bill adds a private room incentive payment rate to the per Medicaid day payment rate formula. The private room incentive payment is $30 for FY 2024, and ODM may increase the rate in subsequent fiscal years. Nursing facilities with private rooms are eligible for the incentive payment. A private room is a bedroom that:

1. Has four permanent, floor-to-ceiling walls and a full door;

2. Contains one licensed or certified bed occupied by only one individual;

3. Has access to a hallway without traversing another bedroom;

4. Has direct, unshared access to a toilet and sink shared by not more than one other resident without traversing another bedroom; and

5. Meets all applicable licensure or other standards pertaining to furniture fixtures, and temperature control.

Beginning on July 1, 2023, ODM must approve rooms in nursing facilities for the private room incentive payment. A nursing facility provider must apply for approval of its private rooms in the form and manner prescribed by ODM. ODM may specify evidence that an applicant must supply to demonstrate that a room meets the definition of a private room. ODM may consider only applications that meet the following criteria, and may specify evidence an applicant must supply to demonstrate it meets those criteria:

1. Rooms that are reported on the nursing facility provider's cost report for calendar year 2022, or a new nursing facility licensed after October 1, 2022;

2. Rooms created by surrendering licensed or certified beds from the facility's licensed or certified bed capacity; or

3. Rooms created by adding space to the facility or renovating nonbedroom space, without increasing the facility's licensed bed capacity.

ODM must approve an application for rooms that meet the definition of a private room described above, but may deny an application if it determines that the rooms included in the application do not meet the definition of a private room or the criteria listed above or that the applicant created private rooms by reducing the number of available beds without reducing the facility's licensed capacity. An applicant can request a reconsideration of a denial.

Quality incentive payments

(R.C. 5165.26 and 5165.15; Section 333.290)

Under continuing law, a nursing facility's per Medicaid day payment rate includes a quality incentive payment, which is determined through a specified calculation. The bill modifies the quality incentive payment rate calculation by adding new components and removing existing components, as follows.

First, the bill extends the quality incentive payments. Under H.B. 110 of the 133rd General Assembly, the quality incentive payments were only in effect during FY 2022 and FY 2023. The bill removes that limitation and continues the quality incentive payments in perpetuity.

Second, the bill includes provisions in the event CMS develops new nursing facility metrics. A nursing facility's quality points are based on the number of points that CMS assigned to the facility using its five-star quality rating system, known as the Nursing Home Care Compare, for specified quality metrics. The bill specifies that in the event CMS develops new quality metrics, the calculation is to be based on the successor metrics on the same topics.

Third, the bill adds an occupancy adjustment to the calculation. If a nursing facility's occupancy rate is above 75%, the facility receives an additional 7.5 points. ODM must calculate a nursing facility's occupancy rate using the facility's occupancy rate for licensed beds on its cost report for the calendar year preceding the fiscal year for which the rate is determined, or if the facility is not licensed, its occupancy rate for certified beds. If the facility surrenders licensed or certified beds before May 1 of the calendar year in which the fiscal year begins, ODM must calculate the facility's occupancy rate by dividing the number of inpatient days reported on the facility's cost report for the calendar year preceding the fiscal year for which the rate is determined by the product of (1) the number of days in the calendar year and (2) the facility's number of licensed or certified beds on May 1 of the calendar year in which the fiscal year begins.

Fourth, beginning with FY 2025, the bill adds three new quality metrics to the calculation. Beginning on July 1, 2024, ODM must add the number of points the facility receives in ODM's Nursing Home Care Compare, or successor metrics, for the following metrics:

1. The percentage of the facility's long-stay residents whose need for help with daily activities has increased;

2. The percentage of the facility's long-stay residents experiencing one or more falls with major injury; and

3. The percentage of the facility's long-stay residents who were administered antipsychotic medication.

In its notice to nursing facilities with their FY 2024 rates, ODM must notify each facility of how many quality points the facility would have received, based on calendar year 2022 data, for the new quality metrics.

Fifth, the bill removes exemptions to the quality incentive payments. Under current law, nursing facilities do not receive quality payments under the following circumstances that the bill removes:

- If a nursing facility's total number of points for the quality metrics is less than the 25th percentile of all nursing facilities, its points are reduced to zero.
- A facility does not receive a quality incentive payment if its occupancy percentage was less than 80% in the applicable fiscal year, *unless* (1) the facility had a quality score of at least 15 points, (2) the facility was initially certified for participation in Medicaid on or after January 1, 2019, (3) one or more of the beds were unable to be used due do causes beyond the reasonable control of the operator, or (4) the facility underwent a renovation between 2018 and 2020 that involved capital expenditures of at least $50,000 and that directly impacted the area where the facility's licensed beds were located.
- A facility does not receive a quality incentive payment if the facility was designated on the Special Focus Facility List maintained by the U.S. Department of Health and Human Services of facilities with quality issues.

Sixth, the bill adds a component to be included in the calculation for the total amount to be spent on quality incentive payments based on the facility's cost centers. As part of the calculation, ODM must include 60% of the sum of the per diem amount by which the nursing facility's rate for ancillary and support costs and its rate for direct care costs changed as a result of the rebasing conducted for FY 2024.

Seventh, the bill caps the amount that is to be added to the amount to be spent on quality incentive payments in a fiscal year at $125 million in each fiscal year, instead of $25 million in FY 2022 and $125 million in FY 2023.

Eighth, the bill grants quality incentive payments to new nursing facilities and, under certain circumstances, nursing facilities that undergo a change of operator. Under current law, neither receive a quality incentive payment for the initial year or the year of the change, as applicable. Under the bill, beginning July 1, 2023, a new nursing facility receives a quality incentive payment for the fiscal year of its initial provider agreement and the immediately following fiscal year equal to the median quality incentive payment amount determined for nursing facilities for the fiscal year. After those years, the facility receives a payment based on the normal calculation.

A nursing facility that undergoes a change of operator effective April 1, 2023, or after will not receive a quality payment until the earlier of the January 1 or July 1 that is six months after the effective date of the change. Thereafter, the payment rate will be determined by the normal calculation. To receive the payment, the entering operator must own the physical assets

of the nursing facility or have at least a majority ownership of the entity that owns the assets of the nursing facility.

Rebasing

(R.C. 5165.36; Section 333.300)

Under continuing law, at least every five years, ODM must recalculate each nursing facility's cost centers to account for increasing costs over time and use those figures when determining a nursing facility's per Medicaid day payment rate. The bill increases the frequency of rebasing to at least once every two years beginning in FY 2024. The bill also removes provisions, added in H.B. 110 of the 134th General Assembly, that require nursing facility providers to spend additional money received as a result of the FY 2022 rebasing on direct care costs, ancillary and support costs, and tax cost centers only. The bill further provides that for FY 2024 and FY 2025, ODM must include in each nursing facility's per Medicaid day payment base rate only 40% of the sum of the increase in the facility's rate for direct care costs and its rate for ancillary and support costs that result from the FY 2024 rebasing.