DEPARTMENT OF MEDICAID

Medicaid eligibility

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.

Medicaid eligibility verification

- Prohibits the Department of Medicaid (ODM) from taking certain actions related to verifying income and nonincome-related Medicaid program eligibility.

Applied behavioral analysis coverage report

- Requires ODM to submit an annual report regarding applied behavioral analysis (ABA) coverage to the General Assembly.
- Requires the report to address data from the previous fiscal year, be organized by current procedural terminology (CPT) code, and include specified information such as how many enrolled children with autism spectrum disorder were prescribed and received ABA services and the number of prior authorization denials and subsequent appeals for ABA coverage.
- Requires ODM to develop outreach material regarding services for children with autism spectrum disorder.

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 the Joint Medicaid Oversight Committee (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.

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; 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 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

- 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.

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 specified occupancy thresholds 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 $100 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 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 provider 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.

Payment of claims by third parties

- Decreases to 60 days (from 90 days) the time period in which specified third parties must respond to a request by ODM for payment of a claim.

Medicaid payment rate for neonatal and newborn services

- Specifies that the Medicaid payment rate for certain neonatal and newborn services must be *at least* 75% of the Medicare payment rate for the services, rather than equaling 75% of the Medicare payment rate.

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 hours of pre-service training and annual in-service training than required by federal law for home health aides (HHAs) providing services under the Integrated Care Delivery System (MyCare).
- Prohibits ODM from requiring more than 30 hours of pre-service training and six hours of annual in-service training for personal care aides (PCAs) providing services under MyCare.
- Permits a registered nurse or a licensed practical nurse to supervise an HHA or PCA providing services under MyCare.

ICF/IID bed conversion to OhioRISE program

- Prohibits an ICF/IID from reserving or converting a portion of its beds from beds that provide ICF/IID services to beds that provide services to individuals enrolled in the OhioRISE program, if reserving or converting a bed would require the ICF/IID operator to discharge or terminate services to a resident occupying that bed.

Medicaid MCO medical loss ratio report

- Requires each Medicaid MCO to submit an annual medical loss ratio report with the information required under federal law.
- Requires ODM to post on its public website the information used to calculate a Medicaid MCO's medical loss ratio and each Medicaid MCO's medical loss ratio report.

Special programs

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.

Hamilton County hospital directed payment program

- Permits ODM to establish a hospital directed payment program for directed payments to hospitals in Hamilton County that meet enumerated criteria.
- Permits eligible public entities to transfer funds, through intergovernmental transfer, to ODM for the directed payments, and limits payment amounts to not more than the average commercial level paid for inpatient and outpatient services under the care management system.

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.

General

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 ODM to submit a report to the 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.

Medicaid program reforms

- When calculating the per member per month growth rate in the Medicaid program for purposes of required Medicaid program reforms, requires the Director to include all

Medicaid costs, with the exception of one-time expenses or expenses unrelated to enrollees.

- 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.

HCBS Direct Care Worker Wages Task Force

- During the fiscal biennium, requires ODM, ODA, and the Department of Developmental Disabilities to jointly submit an annual report outlining the wages paid to direct care staff providing services to enrollees under the Medicaid home and community-based services waivers.
- Establishes the HCBS Direct Care Worker Wages Task Force made up of representatives of enumerated organizations to analyze specified matters relating to HCBS direct care staff and to submit a report of its findings to the General Assembly and JMOC.
- Specifies that the Task Force ceases to exist after submitting its report.

In-home care professionals study committee

- Requires ODM to establish a study committee to examine the training requirements for professionals providing in-home services to patients through ODM and ODA.

General Assembly oversight of Medicaid program changes

- Requires the Medicaid Director to provide written notice to JMOC not later than 65 days before applying for a Medicaid waiver or seeking federal approval for a change to the Medicaid program.
- If JMOC determines that the waiver or change should not proceed, permits JMOC to recommend that the General Assembly adopt a concurrent resolution to invalidate the proposed waiver or change, either in whole or in part.
- If the General Assembly adopts a concurrent resolution invalidating a waiver or change, generally prohibits ODM from seeking any version of the waiver or change for the duration of that term of the General Assembly, unless authorized to do so by the General Assembly.

Medicaid work requirements

- Between November 1, 2024, and December 1, 2024, requires the ODM Director to apply to CMS for a new waiver establishing Medicaid work requirements.

MyCare Ohio expansion

- Requires the Medicaid Director to seek CMS approval to expand the Integrated Care Delivery System, or its successor program, to all Ohio counties.
- Requires the Director to select the managed care entities for the expanded program from among the existing Medicaid managed care organizations.

- Requires ODM to establish requirements for care management and coordination of waiver services, subject to enumerated requirements.

Medicaid presumptive eligibility error rate training

- Requires each entity or provider qualified to make presumptive eligibility determinations to submit a corrective action plan to ODM and provide training when the entity or provider's error rate exceeds 7.5% in a calendar month.
- Provides that any qualified entity or provider that exceeds a presumptive eligibility error rate of 7.5% in six or more months in a 24-month period is disqualified from making presumptive eligibility determinations for 60 months.

Medicaid coverage of remote ultrasounds and fetal nonstress tests

- Requires Medicaid coverage of remote ultrasound procedures and remote fetal nonstress tests under certain circumstances.

Payments for family caregivers prohibited

- Prohibits the Medicaid Director from adopting rules that allow family members in the same household as a minor child receiving covered services administered by a county board of developmental disabilities from receiving Medicaid payments for providing services to the child.

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 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.[137] The bill requires the Director to adopt any rules necessary to provide the coverage.

[137] 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.[138] The individuals covered under the MBIWD program are individuals who make up two other optional eligibility groups under federal law.[139] 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 the Department of Medicaid (ODM).

Medicaid eligibility verification

(R.C. 5163.51; Section 812.60)

The bill prohibits ODM, to the extent permitted by federal law, from taking the following actions related to Medicaid program eligibility:

- Conducting post-enrollment verification of income or nonincome-related eligibility;
- Designating itself as a qualified health entity to conduct presumptive eligibility determinations, unless expressly authorized to do so by statute;
- Accepting self-attestations of income;
- Accepting self-attestations of alternate insurance coverage; and
- Requesting approval from CMS to forgo the federal requirements that ODM (1) periodically check any available income-related data sources for eligibility, and (2) comply with public notice requirements when changes to the Medicaid state plan are proposed.

The bill delays these eligibility-related prohibitions until the later of either January 1, 2024, or the date a Medicaid state plan amendment is approved if an amendment is necessary.

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

[139] 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and (XVI).

If an amendment to the Medicaid state plan is not required, the provisions take effect January 1, 2024.

Applied behavioral analysis coverage report

(R.C. 5162.138)

The bill requires ODM to submit an annual report to the General Assembly regarding access to applied behavioral analysis (ABA) for enrolled children diagnosed with autism spectrum disorder. The data in the report must be organized by current procedural terminology (CPT) code. The report must include the following:

- The number of certified behavior analysts practicing in Ohio who are Medicaid providers;
- The number of Medicaid enrollees who are children with an autism spectrum disorder diagnosis who received ABA services;
- The number of Medicaid enrollees who are children with an autism spectrum disorder diagnosis who did not receive health care provider-recommended ABA services;
- The number of prior authorization requests for ABA services that were denied and the number of appeals resulting from the denials;
- The median of recommended hours and the median of received hours of ABA services for Medicaid enrollees who are children with an autism spectrum disorder diagnosis who were approved for and received ABA but did not receive the number of hours recommended by the child's health care provider;
- The median of recommended hours and the median of covered hours of ABA services for Medicaid enrollees who are children with an autism spectrum disorder diagnosis for whom the Medicaid program covered fewer ABA hours than were recommended by the child's health care provider;
- Recommendations to improve the adequacy of the network of ABA providers who are Medicaid providers;
- Other recommendations to improve access to ABA services.

The bill requires ODM to make every effort to collect the data for the report mentioned above from ABA providers and enrollees. ODM must also develop education and outreach materials in order to inform and educate the parents and legal guardians of enrolled children with autism spectrum disorder diagnoses about relevant services the children are eligible for and to explain how to access those services.

Post-COVID Medicaid unwinding

(Section 333.210; repealed R.C. 5163.52)

After the expiration of the federal COVID-19 emergency period,[140] 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, 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).[141] 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.

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[140] 42 U.S.C. 1320b-5(g)(1)(B).

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

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,[142] 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.

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.

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

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 the terminology and formula used to calculate the case-mix scores, 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" 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 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. First, the bill removes inflationary adjustments for those cost centers.

Additionally, 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.

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 greater than 75% but no more than 80%, the facility receives an additional 2.5 points. If the facility's occupancy rate is greater than 80% but no more than 85%, the facility receives an additional five points. If the facility's occupancy rate is more than 85%, it 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 $100 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 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.

Medicaid provider 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.

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; R.C. 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.

Payment of claims by third parties

(R.C. 5160.40)

The bill decreases to 60 days the time period in which a third party must respond to a claim for payment of a medical item or service submitted to the third party by ODM. Under current law, a third party must respond to a claim described above not later than 90 days after receiving written proof of the claim.

Medicaid payment rate for neonatal and newborn services

(R.C. 5164.78)

The bill requires that the Medicaid payment rate for the neonatal and newborn services specified in continuing law must be *at least* 75% of the Medicare payment rate for the services, rather than equaling 75% of the Medicare payment rate as required by current law.

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 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 PCAs providing services under MyCare to receive more than 30 hours of pre-service training and six hours of annual in-service training. The Department determines what training is acceptable. The Department may not require HHAs providing services under MyCare to receive more pre-service training and annual training than required by federal law. The bill also permits a registered nurse or licensed practical nurse to supervise an HHA or PCA.

Under federal regulations, HHAs providing services through Medicare or Medicaid are 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).[143]

ICF/IID bed conversion to OhioRISE program

(R.C. 5124.75)

The bill prohibits an ICF/IID operator from reserving or converting any portion of the ICF/IID's beds from beds that provide ICF/IID services to beds that provide services to individuals receiving services through the OhioRISE program for children and youth involved in multiple state systems or children and youth with other complex behavioral health needs, if reserving or converting a bed would require the ICF/IID operator to discharge or terminate services to a resident occupying that bed.

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[143] 42 C.F.R. 484.80.

Medicaid MCO medical loss ratio report

(R.C. 5167.50; Section 803.250)

Medical loss ratio in Medicaid managed care is a rate setting approach that requires a certain percentage of the per member per month rate paid by ODM to Medicaid managed care organizations be spent on services and quality improvement and that health plan administrative expenses be kept at a sufficient level to meet that percentage.

The bill requires each Medicaid managed care entity to prepare and submit to ODM an annual medical loss ratio report, which is required under federal law. As defined in the bill, a Medicaid managed care entity includes all Medicaid managed care organizations, the care management system's state pharmacy benefit manager, the Integrated Care Delivery System known as MyCare Ohio, the Ohio Resilience through Integrated Systems and Excellence (OhioRISE) Program, or other similar entity contracted with ODM. The report must include all of the following under the bill and federal law:

- Total incurred claims;
- Expenditures on quality improvement activities;
- Fraud prevention activities;
- Nonclaims costs;
- Premium revenue;
- Taxes, licensing, and regulatory fees;
- Methodology for allocation of expenditures;
- Any credibility adjustment applied;
- The calculated medical loss ratio;
- Any remittance owed to the state, if applicable;
- A description of the aggregation method used to calculate any remittance owed to the state;
- A comparison of this information with the Medicaid MCO's audited financial report required;
- The number of member months.

Website

ODM must post the following information on its public website:

1. Information used to calculate a Medicaid managed care entity's medical loss ratio, including any prescription drug rebates it receives;

2. Each Medicaid managed care entity's cost report.

Subcontractors

The bill requires a subcontractor of a Medicaid managed care entity, upon the request of ODM, the Auditor of State, or the Attorney General, to do all of the following:

- Provide all requested data in the format and manner requested within 30 days of the request, unless the requestor grants an extension;
- Cooperate fully in any investigation or prosecution by the requestor;
- Make personnel available for interviews with the requestor;
- Permit consultants or other experts engaged by a requestor to receive copies of any provided data.

Confidentiality and rules

The bill specifies that any information described above must be provided, regardless of whether it is considered proprietary, confidential, or a trade secret by the holder. ODM must adopt rules as necessary to implement these medical loss ratio provisions.

Special programs

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.[144]

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

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[144] 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.

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 the Joint Medicaid Oversight Committee (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.

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.[145] 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

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

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.

Hamilton County hospital directed payment program

(Section 333.265)

The bill requires the Medicaid Director to create a hospital directed payment program for a hospital that meets the following criteria:

- It is located in Hamilton County;
- It is a nonprofit hospital;
- It has a Level 1 trauma center;
- It is affiliated with an Ohio public medical school; and
- It is not a children's hospital.

The program must advance at least one of the health goals established in ODM's quality strategy, which must be submitted to and approved by CMS. Under the program, participating hospitals will receive payments directly for inpatient and outpatient services provided to Medicaid enrollees and remit to ODM the nonfederal share of those services through intergovernmental transfer. Payments under the program cannot exceed the average commercial level paid for inpatient and outpatient services provided to Medicaid recipients under the care management system. The bill requires transfers for the program to be deposited into the Health Care/Medicaid Support and Recoveries Fund and permits the Director to adjust payment amounts or terminate the program if receipts credited to the program exceed available funds in the account.

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.

General

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.

Medicaid program reforms

(R.C. 5162.70)

Under continuing law, the Director must limit the growth in the Medicaid program for a fiscal biennium to not more than the lesser of the average increase in inflation for the most recent three-year period for which there is data on the first day of the biennium, or the JMOC projected medical inflation rate for the fiscal biennium. The Director must limit the growth by implementing reforms that utilize cost-savings measures and fraud and abuse prevention, reduce the prevalence of comorbid health conditions among, and the mortality rates of, Medicaid recipients, and reduce infant mortality rates among Medicaid recipients. The bill prohibits the Director from excluding any Medicaid eligibility group, provider wages, or Medicaid service when calculating the growth in the per member per month cost of the Medicaid program. The Director may, however, exclude one-time expenses or expenses that are not directly related to enrollees. 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.

HCBS Direct Care Worker Wages Task Force

(Sections 751.20 and 751.21)

The bill requires ODM, ODA, and the Department of Developmental Disabilities to work jointly to submit a report regarding wages paid to direct care workers providing home and community-based services to enrollees in Medicaid waiver components administered by those agencies. The report, submitted to the General Assembly not later than July 1 each year, must be divided by service type and detail the wages paid by each agency to direct care workers in the previous fiscal year.

The bill also creates the HCBS Direct Care Worker Wages Task Force and stipulates technical and administrative support must be provided by ODM staff. The task force is responsible for submitting a report to the General Assembly and Joint Medicaid Oversight Committee on its findings in the following areas:

- Analysis and evaluation of the cost of providing services under Medicaid HCBS waivers;
- Evaluation and review of direct care worker wages in other states;
- Analysis and evaluation of existing HCBS services and strategies for (1) expansion of services, and (2) cost of service reduction;
- Analysis and evaluation of options to ensure HCBS reimbursement rates and direct care wages are reviewed regularly and adjusted to reflect the cost of providing services; and
- Identification and cost estimation of regulatory burdens on Medicaid and HCBS providers and recommendations to reduce the regulatory burden.

Members of the task force must be appointed within 60 days of the bill's effective date and must include one representative from each of the following interested parties:

- Coalition of Age-Friendly Communities;
- LeadingAge Ohio;
- The Ohio Adult Day Healthcare Association;
- The Ohio Alzheimer's Association;
- The Ohio Association of Area Agencies on Aging;
- The Ohio Association of Senior Centers;
- The Ohio Coalition for Adult Protective Services;
- The Ohio Council for Home Care & Hospice;
- The Ohio Health Care Association; and
- The Ohio Provider Resource Association.

The bill provides that the task force will cease to exist after the submission of its report.

In-home care professionals study committee

(Section 333.330)

The bill requires ODM to establish a study committee to examine the training requirements for professionals providing in-home and community-based services to patients through Medicaid or Medicaid waivers administered by ODM or ODA. Committee members include the Medicaid Director, the Director of Aging, or the Directors' designees, and any industry stakeholders designated and appointed by the Medicaid Director. The industry stakeholders may not include members of the General Assembly.

The study committee is responsible for reviewing the training requirements for all professionals, including home health aides and personal care aides, who provide home and community-based services through ODM or ODA. This includes services provided through the PASSPORT program and the Integrated Care Delivery System (known as "MyCare Ohio"). By April 1, 2024, ODM must submit a report to JMOC detailing the training requirements for in-home and community-based care providers that specifies which training requirements are federal and which are established by Ohio law or rule. The report must also include suggestions for how to modify training requirements to increase the in-home care workforce while maintaining high standards of care.

General Assembly oversight of Medicaid program changes

(R.C. 5162.07)

The bill requires the Medicaid Director to provide written notice to JMOC not later than 65 days before applying for a Medicaid waiver or seeking federal approval to make a change to the Medicaid program. Upon review of the proposed waiver or change, and a determination that the waiver or change should not proceed, the bill permits JMOC to recommend that the General Assembly adopt a concurrent resolution to invalidate the proposed waiver or change, either in whole or in part.

If the General Assembly adopts a concurrent resolution to invalidate a proposed waiver or change, the bill prohibits ODM from seeking any version of that waiver or change for the remainder of that term of the General Assembly. If the 65-day notice period described above has lapsed but federal approval has not yet been obtained for the proposed waiver or change when the concurrent resolution is adopted, ODM must immediately withdraw its request for a waiver or change. Following the adoption of a concurrent resolution to invalidate a proposed waiver or change, the General Assembly may adopt a subsequent concurrent resolution authorizing ODM to seek a new waiver or change. A new waiver or change is subject to the 65-day notice requirement described above.

Medicaid work requirements

(R.C. 5166.37)

The bill requires the ODM Director, not earlier than November 1, 2024, and not later than December 1, 2024, to apply to the U.S. Centers for Medicare and Medicaid Services (CMS) to implement a new waiver establishing Medicaid work requirements.

H.B. 49 of the 132nd General Assembly required the ODM Director to establish a Medicaid waiver component under which individuals eligible for Medicaid on the basis of being included in the Medicaid expansion eligibility group were required to meet work requirements to be eligible to receive Medicaid benefits. ODM applied for this waiver in April 2018, and the request was approved by CMS in March 2019. However, before it could be implemented, the work requirement waiver was placed on hold as a result of the COVID-19 pandemic, and approval of the waiver was subsequently withdrawn by CMS in August 2021.

MyCare Ohio expansion

(Section 333.320)

The bill requires the Medicaid Director, by July 1, 2024, to seek approval from CMS to expand the MyCare Ohio program (known in the Revised Code as the "Integrated Care Delivery System") to all Ohio counties. If the Medicaid Director terminates MyCare Ohio, the bill requires the successor program to expand to all Ohio counties as well. The entities selected to function as the managed care organizations for the expanded system must be selected by the Director from among Medicaid managed care organizations that have a current managed care contract with ODM on the bill's effective date.

The bill requires ODM to establish requirements for care management and coordination of wavier services in the expanded program, subject to the following:

- The selected managed care organizations must employ the applicable area agency on aging to be coordinators of home and community-based services under a Medicaid waiver component available for eligible individuals over age 59;
- The managed care organizations may delegate to the area agency on aging full care coordination function for home and community-based services and other health care services received by those eligible individuals;
- Individuals enrolled in the managed care organization's plan may choose the organization or its designee as the care coordinator, as an alternative to the area agency on aging;
- ODM may specify an alternative approach to care management and coordination of waiver services if the area agency on aging's performance does not meet the program requirements or if ODM determines that the needs of a defined group of individuals require an alternative approach.

Medicaid presumptive eligibility error rate training

(R.C. 5163.103)

The bill imposes requirements related to presumptive eligibility, which, under federal law, is an option by which states may elect to grant temporary Medicaid benefits to certain eligible individuals as a result of an initial, simplified eligibility determination while the individual applies for full Medicaid coverage. Related to presumptive eligibility determinations, the bill defines presumptive eligibility error rate as the rate at which entities or providers that are qualified to conduct presumptive eligibility determinations deem an individual presumptively eligible for Medicaid but the individual is ineligible. Under the bill, ODM must require qualified entities and providers to take the following steps when the entity or provider has a presumptive eligibility error rate greater than 7.5% in a calendar month:

1. Submit for ODM's approval a corrective action plan specifying the steps the entity or provider will take to reduce its error rate, including required trainings; and

2. Provide training for all presumptive eligibility determination staff to ensure thorough knowledge of prescreening procedures.

The bill imposes penalties when a qualified entity or provider exceeds this error rate limit. When a qualified entity or provider's error rate exceeds 7.5% in six or more months in a 24-month period, ODM must notify the entity or provider that it is no longer qualified to make eligibility determinations. A qualified entity or provider that receives such a notice is no longer qualified to conduct presumptive eligibility determinations for 60 months.

Medicaid coverage of remote ultrasounds and fetal nonstress tests

(R.C. 5164.092)

The bill requires the Medicaid program to cover remote ultrasound procedures and remote fetal nonstress tests when the patient is in a different location from the patient's Medicaid provider. ODM must adopt rules to implement the coverage requirement. The coverage applies only if the Medicaid provider uses digital technology that:

- Is used only to collect medical and other data from a patient and electronically transmit that data securely to a health care provider in a different location for the provider's examination of the data; and
- Has been approved by the U.S. Food and Drug Administration for remote data acquisition, if required.

Medicaid reimbursement for remote fetal nonstress tests is applicable only if the current procedural terminology (CPT) code that was used includes a place of service modifier for at home monitoring using remote monitoring solutions that are cleared by the FDA for monitoring fetal heart rate, maternal heart rate, and uterine activity.

Payments for family caregivers prohibited

(R.C. 5164.02)

The bill prohibits the Medicaid Director from adopting rules allowing family members to receive Medicaid payment for certain services provided to minor children. Under the bill, ODM is prohibited from rulemaking that would allow family members living in the same household as a minor child eligible for services administered by a county board of developmental disabilities to receive Medicaid payments for providing those services.

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, 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.