DEPARTMENT OF MEDICAID

Medicaid eligibility

Federal medical assistance percentage for expansion eligibility group

- Requires the Department of Medicaid (ODM) to immediately terminate medical assistance for members of the Medicaid expansion eligibility group (Group VIII) if the federal government sets the federal medical assistance percentage (FMAP) below 90%.
- Requires ODM, not later than 15 days following a change in the FMAP as described above, to certify the state and federal shares of the total actual expenditures for Group VIII for the most recently completed month before the change.
- Establishes procedures for keeping those state share amounts within the General Revenue Fund during each fiscal year in the biennium, before transferring those amounts to the Budget Stabilization Fund or Expanded Sales Tax Holiday Fund under continuing law.
- If medical assistance is terminated as described above during FY 2026 or FY 2027, requires ODM to establish a phased transition plan to assist former members of Group VIII by redirecting them to private insurance subsidies or charity care programs.

Group VIII eligibility redeterminations

- To the extent permissible under federal law, requires ODM to conduct eligibility redeterminations for members of Group VIII every six months.

Medicaid coverage of aged, blind, and disabled (ABD) individuals

- Eliminates outdated law that (1) permits Medicaid eligibility requirements for the aged, blind, and disabled (ABD) population to be more restrictive than those under the Supplemental Security Income Program and (2) requires those more restrictive requirements to be consistent with the federal 209(b) option for Medicaid eligibility.

Change in circumstances eligibility verification

- Requires ODM to issue one or more requests for information relating to Medicaid eligibility data and operations, to identify and assess systems and solutions that may be able to improve or augment the management, efficiency, frequency, and accuracy of Medicaid eligibility determinations and processing.
- Requires ODM to consider augmenting existing vendor arrangements relating to processing and managing Medicaid eligibility cases.
- Authorizes ODM to procure one or more vendors to implement any solutions identified as cost effective and feasible.
- Requires any vendor compensation to be performance based.

- Requires ODM to prepare and submit a report to the chairpersons of the House and Senate committees overseeing Medicaid detailing findings from the requests for information and any considerations related to those requests.

Medicaid waiver for reentry services

- Requires ODM to establish a Medicaid waiver component to provide services to Medicaid-eligible inmates for 90 days prior to release.

Continuous Medicaid enrollment for children (VETOED)

- Would have repealed law that requires ODM to seek approval to provide continuous Medicaid enrollment for Medicaid-eligible children from birth through age three (VETOED).

Medicaid eligibility fraud restitution

- Permits a court to order restitution of 200% of the amount paid for Medicaid services provided for a person found guilty of Medicaid eligibility fraud, instead of requiring restitution of 100% of the amount paid.

Medicaid workforce development study

- Requires ODM to conduct a comprehensive study on the feasibility, legality, and potential cost savings of establishing a Medicaid waiver component imposing work requirements for Medicaid recipients and includes additional supplemental workforce development requirements.
- Requires the Medicaid Director to submit a report by September 1, 2026, detailing ODM's findings and any policy recommendations.

Nursing facilities

Case-mix score grouper methodology for nursing facilities

- When determining a nursing facility's case-mix score, requires ODM to use the grouper methodology used on October 1, 2019 (instead of June 30, 1999), for the patient driven payment model nursing index for prospective payments of skilled nursing facilities under the Medicare program.
- Adds a multiplier to nursing facility direct care cost per case-mix units, due to the difference in scale between the old resource utilization group (RUG) model and the new patient driven payment model (PDPM).
- Modifies the authority of ODM to adopt rules concerning case-mix scores.

Gradual implementation of the patient driven payment model

- Provides for a gradual implementation of the PDPM by providing an alternative calculation for the first half of FY 2026.
- Requires ODM to report quarterly to the General Assembly on the progress of transitioning to the patient driven payment model.

- States that these changes are intended to be budget neutral during FYs 2026 and 2027.

Nursing facility quality incentive payment

- Eliminates law specifying that if a nursing facility undergoes a change of owner with an effective date of July 1, 2023, or later, the facility cannot receive a Medicaid quality incentive payment for a specified period of time.
- Extends from July 1, 2023, to July 1, 2025, the law prohibiting a nursing facility from receiving a Medicaid quality incentive payment for a specified period of time if the facility undergoes a change of operator.

Personal needs allowance (VETOED)

- Would have increased the Medicaid personal needs allowance for nursing facility and ICF/IID residents on Medicaid from $50 to $75 for individuals and from $100 to $150 for married couples (VETOED).

Waiver of ineligibility period

- Permits, rather than requires, ODM under certain circumstances to grant a waiver to a resident of a nursing facility who is ineligible to receive nursing facility services due to the individual or individual's spouse disposing of assets for less than fair market value.

Nursing facility dialysis services (VETOED)

- For FY 2026 and FY 2027, would have required ODM to provide a rate add-on of $110 per treatment for dialysis services provided in a nursing facility to a Medicaid recipient (VETOED).

Medicaid providers

Home and community-based services (HCBS) direct care worker wages

- Requires ODM, jointly with the Department of Aging and the Department of Developmental Disabilities, to collect provider data regarding direct care worker wages paid for services provided under Medicaid HCBS waivers, and submit a report to the Governor and specified members of the General Assembly.

Freestanding birthing centers (VETOED)

- Would have required a hospital with a maternity unit that accepts Medicaid to enter into a transfer agreement with any freestanding birthing center located within a 30-mile radius that requests one (VETOED).

Medicaid services

Social gender transition

- Prohibits the distribution of Medicaid funds to provide mental health services that promote or affirm social gender transition.

Rapid whole genome sequencing

- Requires the Medicaid Director to provide Medicaid reimbursement for rapid whole genome sequencing to infants under one year old with complex or acute unexplained illnesses.

Care management system

Medicaid MCO data cross checks

- Requires ODM to conduct a request for information to establish the feasibility of requiring Medicaid managed care organizations (MCOs) to conduct internal data cross checks.

Automatic enrollment in Medicaid MCO plan (VETOED)

- Would have permitted individuals participating in the Medicaid care management system to select a Medicaid MCO plan in which to enroll (VETOED).
- Would have required ODM to randomly assign the individual to a plan without giving preference to a specific MCO plan or group of plans, if an individual does not select a Medicaid MCO plan (VETOED).
- Would have required ODM to notify the General Assembly, the LSC Director, and the Auditor of State within 30 days if it determines it cannot satisfy those requirements (VETOED).

Managed care financial dashboard

- Requires ODM to include on its managed care financial dashboard both (1) actuarial metrics for annual and quarterly cost reports for specified Medicaid populations and (2) quarterly and annual composite per member per month category of service reports.

Special programs

Medicaid buy-in for workers with disabilities program premiums

- Eliminates the requirement that individuals whose income exceeds 150% of federal poverty guidelines must pay an annual premium as a condition of qualifying for the Medicaid buy-in for workers with disabilities program.

Hospital Additional Payments Program

- Establishes the Hospital Additional Payments Program for inpatient and outpatient hospital services provided to enrollees in the Medicaid care management system at in-state hospitals.

Rural Ohio Hospital Tax Pilot Program and assessment

- Permits the Medicaid Director to establish the Rural Ohio Hospital Tax Pilot Program for directed payments to certain rural Ohio hospitals.

- Permits counties in which the pilot program operates to establish a local hospital assessment to provide the nonfederal share of Medicaid payments made under the pilot program.

Medicaid state directed payment programs

- Establishes conditions that must be satisfied upon the creation of a Medicaid state directed payment program that is funded in a manner other than by ODM or the hospital franchise fee program.
- Generally limits state directed payment programs to those established for hospital providers and services or professional services provided by hospitals, and to one state directed payment program per identified provider class.
- Prohibits ODM from establishing more than 50 state directed payment programs during a fiscal biennium.
- Prohibits the Medicaid Director from establishing a state directed payment program if there is no available or sufficient federal or local funding to sustain the program or the federal government requires the state to utilize general revenue funds as a condition of establishing the program.
- Prohibits ODM from utilizing more than 2% of funds received to support a state directed payment program for administration of state directed payment programs, and not more than 2% of those funds for administration of ODM and the Medicaid program.
- Requires ODM to prepare and submit quarterly reports to LSC and the chairpersons of the House and Senate standing committees overseeing Medicaid regarding any new state directed payment programs.

340B grantees

- For purposes of the interaction between Medicaid MCOs, third-party administrators, and 340B covered entities under the federal 340B Drug Pricing Program, removes certain hospitals from the list of entities included as 340B covered entities and instead refers to these entities as 340B grantees.
- Prohibits a contract between a Medicaid MCO, third-party administrator, and 340B grantee from including a payment rate for a prescribed drug provided by a 340B grantee that is less than the payment rate for health care providers that are not 340B grantees.
- Requires a Medicaid MCO or third-party administrator to provide a payment rate for all prescribed drugs obtained through the federal 340B Pricing Program by providers that are not 340B grantees that equals the payment rate for those drugs under the Medicaid state plan.
- Specifies that payments made under payment rates specified in a contract between Medicaid MCOs, third-party administrators, and 340B grantees are subject to audit by ODM.

General

Diversity, equity, and inclusion

- Prohibits Medicaid funds from being used for diversity, equity, and inclusion initiatives.

Medicaid separate health care services line items

- Requires the OBM Director, in consultation with the Medicaid Director, to request and propose multiple Medicaid health care services GRF appropriation line items in subsequent state budgets.

Right of recovery for cost of medical assistance

- Permits an individual who was a recipient of medical assistance and repaid money between April 6, 2007, and September 28, 2007, to ODM or a county department of job and family services pursuant to a right of recovery, to request a hearing regarding those payments.
- Authorizes any of the following to request a hearing: (1) a medical assistance recipient, (2) the authorized representative, (3) the executor or administrator of the estate, (4) a court-appointed guardian, or (5) an attorney directly retained by a recipient, or the recipient's parent, or legal or court-appointed guardian.

MyCare Ohio

- Requires the Director to continue to expand the Integrated Care Delivery System (ICDS, also known as "MyCare Ohio"), or its successor program, to all Ohio counties.
- Requires the Director to select the entities for the expanded program.
- Requires ODM to establish requirements for care management and coordination of waiver services, subject to enumerated requirements.
- Authorizes ODM to include a Fully Integrated Dual Eligible Special Needs Plan established in accordance with federal law as a replacement for the ICDS.

Hospital Care Assurance Program; franchise permit fee

- Eliminates the sunset of the Hospital Care Assurance Program and franchise permit fee that were set to terminate the program and assessment on October 16, 2025.

Appeal of hospital assessment or audit

- Specifies that a final reconciliation of an annual hospital assessment constitutes an interim final order.
- Permits a hospital that requests reconsideration of a preliminary determination of an assessment imposed on the hospital to submit its written materials to ODM by (1) regular mail, (2) electronic mail, or (3) in-person delivery.

- Eliminates a requirement that ODM hold a public hearing if one or more hospitals requests a reconsideration of a preliminary determination of an assessment to be imposed upon the hospital.
- When a hospital appeals a final determination of its annual assessment, clarifies that the complete record of the proceedings includes all documentation considered by ODM in issuing the final determination.
- Requires a hospital to seek a declaratory judgment, rather than appeal the results of an audit conducted by ODM, when the audit determines the hospital paid amounts to ODM that the hospital should not have been required to pay or paid amounts it should have been required to pay.
- When seeking a declaratory judgment, requires a hospital to deposit any funds that are not in dispute into the Hospital Care Assurance Program fund while judicial proceedings are pending.

Medicaid visit verification system (VETOED)

- Would have imposed duties on, and granted authority to, ODM, the Department of Developmental Disabilities, Medicaid MCOs, and other entities authorized to pay Medicaid claims in the event the Medicaid Director established an electronic visit verification system in rule.

Reports, notifications, and audits

Audit and corrective action plan for Medicaid ABD group

- Requires the Auditor of State to conduct an audit of the Medicaid program to determine whether individuals in the ABD group are ineligible for Medicaid.
- Requires the audit to specifically examine if individuals in the ABD group have countable assets that exceed the federal asset limits for Medicaid.
- Upon the conclusion of the audit, requires ODM to implement a corrective action plan including enumerated components, designed to reduce spending for individuals in the ABD group.

Quarterly Medicaid statement of expenditures form

- Requires the Director to immediately provide notice if the federal government takes certain actions related to the Quarterly Medicaid Statement of Expenditures Form submitted by ODM

Medicaid reports regarding fraud, waste, and abuse

- Modifies ODM's existing reporting requirements regarding fraud, waste, and abuse in the Medicaid program to require additional information.
- Requires that these reports be submitted to LSC and the chairs and ranking members of the House and Senate committees overseeing Medicaid.

- Removes a requirement that ODM's report be made available to the public on request.

Presumptive eligibility error rate quarterly report

- Requires ODM to submit a quarterly report to the General Assembly detailing the presumptive eligibility error rate for the previous quarter.

Legislative notice of amendments and waivers

- Requires ODM to provide notice to LSC and the House and Senate committees overseeing Medicaid before seeking an amendment to the Medicaid state plan or a Medicaid waiver that would (1) expand Medicaid coverage to any additional class of individuals or (2) increase any net costs to the state.
- Requires ODM to provide those committees with updates regarding the status of any amendment or waiver.

Audit of Next Generation

- Requires the Auditor of State to conduct a performance and fiscal audit of ODM's Next Generation system and submit copies of the audit report to the standing committees of the House and the Senate that oversee Medicaid and to LSC by December 31, 2027.

Medicaid eligibility

Federal medical assistance percentage for expansion eligibility group

(R.C. 5163.04; Sections 333.360 and 513.10)

Under current federal law, the federal medical assistance percentage (FMAP) for services provided to Medicaid enrollees in Group VIII (nondisabled adults under age 65 with no dependents and incomes at or below 138% of federal poverty guidelines) is 90%.[109] The act specifies that if the FMAP for medical assistance provided to Group VIII enrollees is set below 90%, ODM must immediately terminate medical assistance for members of the group.

In addition to terminating medical assistance for members of Group VIII, the act additionally requires ODM, within 15 days after such a change to the FMAP, to certify to (1) the OBM Director, (2) LSC, (3) the Speaker of the House, and (4) the Senate President the total state and federal shares of Medicaid expenditures for Group VIII in the most recently completed month before the change to the FMAP.

The act specifies that the state share amount certified by ODM is to be multiplied by the number of months remaining in the fiscal year. This amount is to remain in the General Revenue Fund until the end of the fiscal year, at which time it must be transferred in accordance with continuing law to the Budget Stabilization Fund or Expanded Sales Tax Holiday Fund. If the change

[109] 42 U.S.C. 1396d(y).

to the FMAP occurs in the first year of a fiscal biennium, the state share amount is multiplied by 12 to calculate the amount for the second fiscal year of the biennium. The act exempts these transfers from its general requirement that the balance of the General Revenue Fund on June 30, 2025, and June 30, 2026, remain in the General Revenue Fund.

If the FMAP for Group VIII is set below 90% during FY 2026 or FY 2027, ODM must establish a phased transition plan to assist former Group VIII enrollees by redirecting them to private insurance subsidies or charity care programs that provide medical assistance.

Group VIII eligibility redeterminations

(R.C. 5163.11)

The act requires ODM, to the extent permissible under federal law, to conduct eligibility redeterminations for members of Group VIII every six months. Current federal Medicaid regulations restrict eligibility redeterminations for Medicaid enrollees to once every 12 months.[110] However, H.R. 1 (the 2025 federal budget reconciliation bill, signed on July 4, 2025) implements six-month eligibility redeterminations for members of Group VIII beginning for redeterminations on or after December 31, 2026.

Medicaid coverage of aged, blind, and disabled individuals

(R.C. 5163.05, repealed; conforming changes in R.C. 5163.03)

The act eliminates outdated language granting ODM authority to impose more restrictive Medicaid eligibility requirements for the aged, blind, and disabled (ABD) eligibility group than the eligibility requirements for individuals receiving benefits under the Supplemental Security Income (SSI) Program. The act also eliminates a related requirement that any more restrictive eligibility requirements established for the ABD group must be consistent with the federal 209(b) option for Medicaid eligibility. ODM has not exercised this option since 2016 and has instead based eligibility for individuals in the ABD eligibility group on SSI eligibility requirements.

Change in circumstances eligibility verification

(R.C. 5163.50)

The act requires ODM to issue one or more requests for information related to Medicaid eligibility data and operations, to identify and assess systems and solutions that may be available to improve or augment the management, efficiency, frequency, and accuracy of Medicaid eligibility determinations and processing. The requests for information must include data systems related to: (1) Medicaid enrollee or applicant identity verification, (2) Medicaid enrollee death verification, (3) employment and wages, (4) lottery winnings, (5) residency verification including residency relating to concurrent enrollment in Medicaid in other states, (6) household composition, (7) Medicaid enrollee incarceration status, (8) third-party liability verification, (9) asset verification, and (10) any other records or systems ODM considers appropriate to strengthen program integrity, reduce costs, and to reduce fraud, waste, and abuse in Medicaid.

[110] 42 C.F.R. 435.916.

As part of the considerations, ODM must consider augmenting existing vendor arrangements relating to processing and managing Medicaid eligibility cases. The act further authorizes ODM to procure one or more vendors to implement any solutions identified as cost effective and feasible, but requires that any vendor compensation must be performance-based.

ODM must submit a report to the chairpersons of the House and Senate committees with jurisdiction over Medicaid detailing any findings from the requests for information issued and the considerations related to them.

Medicaid waiver for reentry services

(R.C. 5166.50)

By September 30, 2026, the act requires ODM to apply for a Medicaid waiver component that provides reentry services to Medicaid-eligible imprisoned individuals for 90 days prior to their expected release date. The reentry services include mental and behavioral health services and substance use disorder treatment and related services. The act also requires the provision of a 30-day supply of prescription medicine to an eligible inmate who is being released, including medication administered by injection. ODM must implement the waiver component within one year of federal approval.

If ODM is unable to apply for the waiver by September 30, 2026, it may request an extension of up to 30 days from the Speaker of the House and the Senate President. Similarly, if ODM is unable to implement the waiver in the required timeframe, it may request an extension.

If the federal Centers for Medicare and Medicaid Services (CMS) does not approve the waiver, ODM must reapply before September 30, 2029.

Although federal law prohibits Medicaid payment for most health care services to incarcerated individuals,[111] recently, CMS released guidance encouraging states to apply for a Section 1115 demonstration waiver to test strategies to support community reentry for incarcerated individuals.[112]

Continuous Medicaid enrollment for children (VETOED)

(R.C. 5166.45)

The Governor vetoed the act's repeal of law that requires ODM to seek CMS approval to provide continuous Medicaid enrollment for Medicaid-eligible children from birth through age three. Thus, ODM will continue to be required to establish a Medicaid waiver component that allows a Medicaid-eligible child to remain eligible until the earlier of (1) the end of a continuous 48-month period, or (2) the date the child exceeds age four.

[111] 42 U.S.C. 1396d(a)(A), not in the act.

[112] As of July 1, 2025, according to the KFF Medicaid Waiver Tracker, CMS has approved waivers for 19 states: AZ, CA, CO, HI, IL, KY, MD, MA, MI, MT, NH, NM, NC, OR, PA, UT, VT, WA, and WV.

Medicaid eligibility fraud restitution

(R.C. 2913.401)

Regarding Medicaid eligibility fraud, the act *permits* a court to order restitution of *200%* of the amount of Medicaid services paid for which the individual was not eligible plus interest. Former law *required* a court to impose restitution of the full amount of the payment plus interest.

Medicaid workforce development study

(Section 751.20)

The act requires ODM to conduct a comprehensive study on the feasibility, legality, and potential cost savings of establishing a Medicaid waiver component that imposes work requirements for Medicaid recipients and includes additional supplemental workforce development requirements. As part of the study, ODM must evaluate the impact of requiring Medicaid recipients who maintain eligibility through satisfying work requirements for 12 consecutive months to enroll in a workforce development program that is either (1) a state-sponsored program that can be completed within 12 months or (2) is a program offered through a private or public training facility, community college, or university and can be completed within 12 months.

Through the study, ODM must assess the following:

- The legal feasibility of implementing work and supplemental workforce development requirements;
- Ohio's workforce development training capacity;
- The potential cost savings associated with implementing work and supplemental workforce development requirements;
- The projected impact on Medicaid enrollment if the requirements were to be implemented.

By September 1, 2026, ODM must submit a report detailing its findings from the study, as well as any policy recommendations, to the Governor, Speaker of the House, Senate President, and the chairpersons of the House and Senate Finance Committees.

Nursing facilities

Case-mix score grouper methodology for nursing facilities

(R.C. 5195.19 and 5165.192; Section 333.280)

The act requires ODM, when determining case-mix scores for a nursing facility, to use the federal grouper methodology used for the patient driven payment model index on October 1 2019, for prospective payment of skilled nursing facilities under the Medicare program, rather than the grouper methodology used on June 30, 1999, as required under former law.

As part of this change, the act includes an adjustment to nursing facility direct care cost per case-mix units, due to the difference in scale between the old resource utilization group (RUG) model and the new patient driven payment model (PDPM). ODM must multiply each cost

per case-mix unit by the nursing facility's peer group average case-mix score for the semiannual period beginning January 1, 2026. That product is the cost per case-mix unit used to determine the nursing facility's direct care costs beginning January 1, 2026, and continuing until ODM's next rebasing takes effect.

Additionally, the act eliminates ODM's authority to adopt rules concerning any of the following:

- Adjusting case-mix values to reflect changes in relative wage differentials that are specific to Ohio;
- Expressing case-mix values in numeric terms that are different from the terms specified by HHS but that do not alter the relationship of case-mix values to one another;
- Modifying the grouper methodology by (1) establishing a different hierarchy for assigning residents to case-mix categories under the methodology, and (2) allowing the use of the index maximizer element of the methodology.

Gradual implementation to patient driven payment model

(Section 333.280)

Due to the transition to the PDPM for nursing facility case-mix scores for direct care costs, the act provides for a gradual implementation of these new rates.

Due to H.B. 33's modifications to nursing facility direct care costs for FY 2024 and FY 2025, the act adjusts the rates calculated last biennium. From July 1, 2025, through December 31, 2025 (the first half of FY 2026), a nursing facility's direct care rate is to be determined by multiplying its cost per case-mix unit determined under the direct care rate formula for the nursing facility's peer group by the case-mix score under the standard formula, or, if the facility's case-mix score for FY 2025 was the alternate score above, then its semiannual case-mix score for the semiannual period beginning July 1, 2025. Additionally:

- From January 1, 2026, through the remainder of FY 2026, the increase or decrease to a nursing facility's direct care rate must equal ⅓ of the difference between the direct care rate in effect on January 1, 2025, and the direct care rate determined utilizing case-mix scores calculated in accordance with the changes to grouper methodology under the act.
- For FY 2027, the increase or decrease to a nursing facility's direct care rate is ⅔ of the difference between the direct care rate in effect on January 1, 2025, and the direct care rate determined utilizing case-mix scores calculated in accordance with the changes to grouper methodology under the act.

The act notes that the transition to the PDPM is intended to be budget neutral during FYs 2026 and 2027 and to not increase nursing facility payment rates during the fiscal biennium.

PDPM transition report

Beginning October 1, 2025, and quarterly during the fiscal biennium, ODM must report to the General Assembly on the progress of transitioning to the patient driven payment model. The report must cover the progress made during the previous quarter and must be submitted to the

chairperson and ranking member of the standing committees overseeing Medicaid in the House and Senate.

Nursing facility quality incentive payment

(R.C. 5165.26)

The act eliminates law that if a nursing facility underwent a change of owner with an effective date of July 1, 2023, or later, the facility was ineligible to receive a Medicaid quality incentive payment for a period of time. The facility could not receive a quality incentive payment until the earlier of the first day of January or the first day of July, at least six months after the effective date of the change of owner, if within one year after the change of owner, there was an increase in the lease payments or other financial obligations of the operator to the owner above the payments or obligations specified by the agreement between the previous owner and the operator.

The act extends from July 1, 2023, to July 1, 2025, law that if a nursing facility underwent a change of operator on or after that date, the facility was ineligible to receive a quality incentive payment until the earlier of the first day of January or the first day of July, at least six months after the effective date of the change of operator.

Personal needs allowance (VETOED)

(R.C. 5163.33)

The Governor vetoed a proposed increase to the Medicaid personal needs allowance for individuals and married couples. Federal law requires states to set personal needs allowances of at least $30. The act would have increased Ohio's nursing home personal needs allowance for nursing facility and ICF/IID residents to at least $75 (from at least $50) for an individual and to at least $150 (from at least $100) for married couples.

Waiver of ineligibility period

(R.C. 5163.30)

Under continuing law unchanged by the act, an institutionalized individual is ineligible to receive nursing facility services, nursing facility equivalent services, and home and community-based services under Medicaid for a period of time determined by ODM, if the individual or individual's spouse disposes of assets for less than fair market value on or after the designated look-back period.

The act makes it discretionary, rather than mandatory, that ODM grant a waiver of all or a portion of the ineligibility period if the administrator of a nursing facility in which the individual resides has notified the institutionalized individual of a proposed transfer or discharge from the facility for failure to pay for the care provided to the individual, and the transfer or discharge has been upheld by a final determination. Prior law required ODM to grant the waiver.

Nursing facility dialysis services (VETOED)

(Section 333.263)

The Governor vetoed a provision that, for FY 2026 and FY 2027, would have required that ODM provide a rate add-on of $110 per treatment for dialysis services provided in a nursing facility to a Medicaid resident.

Medicaid providers

Home and community-based services (HCBS) direct care worker wages

(Section 333.270)

The act requires ODM, jointly with the Department of Aging and the Department of Developmental Disabilities, to collect data from providers regarding the wages paid to direct care workers providing direct care services under Medicaid HCBS waiver components administered by the departments. Not later than December 31, 2025 and 2026, ODM must submit a report to the Governor, the Speaker and Minority Leader of the House, the President and Minority Leader of the Senate, and the chairpersons of the standing committees handling Medicaid matters in the House and Senate.

Freestanding birthing centers (VETOED)

(R.C. 3722.15)

The Governor vetoed a provision that would have required a hospital that is a Medicaid provider and that operates a maternity unit to agree to a transfer agreement with any freestanding birthing center within a 30-mile radius that requests one. The transfer agreement would have needed to specify an effective procedure for the safe and immediate transfer of a patient from the birthing center to the hospital. Transfers occur when medical care is needed beyond the care that can be provided at the center, including when emergency situations or medical complications arise. The center would have been responsible for filing a copy of the transfer agreement with the Director.

Medicaid services

Social gender transition

(Section 333.13)

The act prohibits the distribution of Medicaid funds to provide mental health services that promote or affirm social gender transition (to living as a gender different from the individual's biological sex).

Rapid whole genome sequencing

(R.C. 5164.093)

The act requires Medicaid, with federal approval, to cover rapid whole genome sequencing (an investigation of the entire human genome to identify genetic changes) for Medicaid patients under one year old who have an unexplained complex or acute illness and who

are receiving hospital services in an intensive care unit or other high acuity care unit. The Director may also provide coverage for other next-generation sequencing and genetic testing.

Any of the following medical necessity criteria may be required for Medicaid reimbursement of rapid whole genome sequencing:

- Symptoms that suggest a broad differential diagnosis that would require an evaluation by multiple genetic tests if whole rapid genome sequencing is not performed;
- Timely identification of a molecular diagnosis is necessary to guide clinical decision-making, and testing results may guide condition treatment or management;
- Relevant family genetic history;
- Complex or acute illness with an unknown cause including at least one of the following conditions:
  - Congenital anomalies involving at least two organ systems or complex multiple congenital anomalies in one organ system;
  - Specific organ malformation highly suggestive of a genetic etiology;
  - Abnormal laboratory tests or chemistry profiles suggesting the presence of a genetic disease, complex metabolic disorder, or inborn error of metabolism;
  - Refractory or severe hypoglycemia or hyperglycemia;
  - Abnormal response to therapy related to an underlying medical condition affecting vital organs or bodily systems;
  - Severe muscle weakness, rigidity, or spasticity;
  - A high-risk stratification for a brief, resolved, unexplained, and recurrent event that is any of (1) an event without respiratory infection, (2) a witnessed seizure-like event, or (3) a cardiopulmonary resuscitation event;
  - Refractory seizures;
  - Abnormal cardiac diagnostic testing results suggestive of possible channelopathies, arrhythmias, cardiomyopathies, myocarditis, or structural heart disease;
  - Abnormal diagnostic imaging studies or physiologic function studies suggestive of an underlying genetic condition;
  - Any other condition added by the Director based on new medical evidence.

A laboratory performing rapid whole genome sequencing for an infant through Medicaid must return preliminary positive results within seven days of receiving a sample and must return final results within 15 days.

Genetic data generated as a result of performing rapid whole genome sequencing is protected health information subject to the requirements established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The primary use of the data is to assist health care professionals in diagnosing and treating a patient. The patient, the patient's legal guardian,

or the patient's health care provider may request access to testing results for use in other clinical settings. A health care provider may charge a fee equal to the direct cost of producing the results for use in another clinical setting.

The genetic data may be used for scientific research if the patient's guardian consents. A patient or a patient's legal guardian may rescind consent at any time, and upon receiving written revocation of consent the entity using the data for research must cease use and expunge the patient's information from any data repository where it is held.

The Director may adopt rules or take other administrative action as necessary to implement Medicaid coverage of rapid whole genome sequencing for infants.

Care management system

Medicaid MCO data cross checks

(Section 751.120)

The act requires ODM to conduct a request for information to study the feasibility of requiring Medicaid managed care organizations (MCOs) to conduct internal data cross checks.

Automatic enrollment in Medicaid MCO plan (VETOED)

(R.C. 5167.03)

The Governor vetoed provisions that would have permitted an individual participating in Medicaid through the care management system to select a Medicaid MCO plan in which to enroll, during a time period specified by ODM. If an individual did not select a MCO plan during that period, ODM would have been required to randomly assign the individual to a plan without giving deference to any specific MCO plan or group of plans.

If ODM were unable to satisfy these requirements, it would have to notify the General Assembly, the LSC Director, and the Auditor of State within 30 days after making its determination. As part of the notice, ODM would have had to provide an explanation as to why it was unable to satisfy the requirements.

Managed care financial dashboard

(R.C. 5167.09)

The act requires ODM to include actuarial metrics for annual and quarterly cost reports on its managed care financial dashboard. These metrics must be delineated as follows:

- Adults for whom financial eligibility for Medicaid is determined utilizing the modified adjusted gross income standard, and who are not members of Group VIII;
- Children for whom financial eligibility for Medicaid is determined utilizing the modified adjusted gross income standard;
- Individuals in the ABD eligibility group who are age 21 or older;
- Individuals in the ABD eligibility group who are age 20 or younger;
- Individuals who are members of Group VIII;

- Individuals who are members of the adoption and foster kids eligibility groups;
- All other individuals eligible for Medicaid benefits.

The dashboard must also include quarterly and annual composite per member per month category of service reports for each Medicaid MCO, delineated by: (1) inpatient services, (2) outpatient facility services, (3) professional services, (4) radiology, pathology, and laboratory services, (5) pharmacy services, (6) behavioral health services, and (7) all other services.

Special programs

Medicaid buy-in for workers with disabilities program premiums

(R.C. 5162.133, 5163.091, 5163.093, 5163.094, and 5163.098)

The act eliminates a requirement that individuals whose income exceeds 150% of federal poverty guidelines must pay an annual premium as a condition of qualifying for the Medicaid buy-in for workers with disabilities (MBIWD) program, which allows certain disabled individuals who are employed to enroll in Medicaid so long as their income does not exceed 250% of federal poverty guidelines.

Hospital Additional Payments Program

(Section 333.140)

The act establishes the Hospital Additional Payments Program as a state directed payment program for inpatient and outpatient hospital services provided to enrollees in the Medicaid care management system who receive care at in-state hospitals. Under the program, participating hospitals and hospital industry representatives must work collaboratively with ODM to establish quality improvement initiatives that align with and advance the goals of ODM's quality strategy required under federal law. Participating hospitals will receive direct payments for services provided under the program.

Rural Ohio Hospital Tax Pilot Program and assessment

(Sections 333.290 and 333.300)

Pilot program

The act authorizes the Medicaid Director to establish the Rural Ohio Hospital Tax Pilot Program to provide directed payments to certain rural Ohio hospitals and their related health systems. To be eligible to participate, a hospital must (1) be enrolled as a provider in the Medicaid program, and (2) be either a rural hospital or a critical access hospital. For purposes of the pilot program, a "rural hospital" includes any hospital located in Fayette, Greene, Highland, Hocking, Muskingum, Perry, Pike, Ross, Scioto, or Washington County.

The pilot program must comply with all federal laws governing state directed payment programs, including all of the following:[113]

[113] 42 C.F.R. 438.6(c).

- The pilot program must be approved by CMS, and the Medicaid Director must seek approval for the pilot program in accordance with existing law.
- Directed payments may not exceed the average commercial rate under a preprint form as approved by CMS.
- The pilot program must be subject to an evaluation plan.

As a condition of participation in the pilot program, a hospital must enter into one or more contracts that ODM considers necessary. The act specifies that any required contracts must be executed by October 1 preceding the first fiscal year of a biennium (i.e., by October 1, 2026). Additionally, a hospital must comply with (1) average commercial rate reporting requirements established by ODM and (2) ODM's quality measure set, including the metrics and targets set by ODM to advance the goals and objectives of ODM's quality strategy, as required under federal regulations. Hospitals must also cooperate with any evaluation or reporting requirements established by ODM.

No hospital provider may participate in the pilot program unless sufficient tax funds are assessed, collected, obligated, and appropriated. The Medicaid Director may terminate or decline to establish the pilot program if federal or local tax funding is not available or sufficient to sustain the program, and at no time is ODM required to provide funding for the program. If at any time ODM is informed that the assessment established to fund the nonfederal share of the pilot program is an impermissible health care related tax, it must promptly refund the amounts paid by each hospital.

Local assessment

To provide the nonfederal share of payments made under the pilot program, the act permits counties in which the program will operate to establish a local hospital assessment. If a local hospital assessment is established, it must meet all federal requirements that apply to provider assessments.

Counties may set the annual rate of the local hospital assessment. An assessment must apply uniformly to all nonpublic hospitals with the jurisdiction of the county, and at the discretion of the counties, may also apply to public hospitals. The rate of an assessment, in the aggregate, must be sufficient to cover (1) the nonfederal share of Medicaid payments that benefit hospitals in the counties, and (2) the administrative expenses for administering the local hospital assessment, up to $150,000 annually. The act requires a local hospital assessment to further Ohio's evolving quality goals, including (1) improving mental health, (2) substance abuse prevention, and (3) advancing maternal health. Counties may impose penalties on hospitals that fail to pay the assessment in a timely manner.

Contiguous counties participating in the pilot program, which each contain two or fewer rural hospitals, may establish a multi-county funding district for the purposes of a local hospital assessment. The boundaries of a multi-county funding district are the combined boundaries of the counties that comprise the funding district. The act specifies that a multi-county funding district is a governmental entity.

To establish a multi-county funding district, the board of county commissioners of each county within the proposed district must pass a resolution or ordinance establishing the county's participation in the district and appointing a county commissioner to serve on the district's governing board. Before a new county may join the district, the resolution or ordinance of each county in the district must be amended. The appointed county commissioner from each member county constitutes the district's governing board. The act authorizes a governing board to delegate the operational and administrative burdens of the funding district to the counties within the district. Within 60 days after a funding district is established, a governing board must designate at least one county to serve as the operational and administrative lead. The designation may be changed at any time.

Medicaid state directed payment programs

(R.C. 5162.25 and 5162.251)

The act establishes conditions that must be satisfied upon the creation of a state directed payment program that is funded in a manner other than by ODM or the hospital franchise permit fee program. All new and existing state directed payment programs subject to the act's requirements must comply with all federal requirements governing state directed payment programs, including:[114]

- The program must be approved by CMS, and the Medicaid Director must seek approval in accordance with existing law.
- Directed payments may not exceed the average commercial rate for all providers participating under a preprint form approved by CMS, unless the payments are exempted by a value-based purchasing agreement approved by CMS.
- The program must be subject to an evaluation plan.

The act limits state directed payment programs to hospital providers and services or professional services provided by hospitals. At the discretion of the Director, one state directed preprint form approved by CMS may be approved for (1) inpatient and outpatient hospital services, (2) physician services, and (3) children's hospitals participating in the Acceleration for Kids Quality Initiative. Moreover, the act prohibits ODM from establishing more than 50 state directed payment programs during a fiscal biennium.

As a condition of participating in a state directed payment program, a hospital provider must enter into one or more contracts related to the program, as ODM considers necessary. The act specifies that, beginning for any preprint effective for a rating period beginning on or after January 1, 2027, any required contract must be executed not later than October 1 preceding the first fiscal year of a biennium.

Additionally, a hospital must comply with (1) average commercial rate reporting requirements established by ODM and (2) ODM's quality measure set, including the metrics and targets set by ODM to advance the goals and objectives of the Department's quality strategy, as

[114] 42 C.F.R. 438.6(c).

required under federal regulations. Hospitals must also cooperate with any evaluation or reporting requirements established by ODM.

The act requires ODM to enter into an agreement with the authorized representative of each entity participating in a state directed payment program. No agreement between ODM and an entity is valid and enforceable unless the OBM Director first certifies that there is a balance in the appropriation used to support state directed payment programs that is not already obligated under existing programs, in an amount at least equal to the cost of the program.

A hospital provider may not participate in a state directed payment program unless sufficient funds are obligated and appropriated. ODM is prohibited from providing general revenue funds or other state funds for a state directed payment program. The ODM Director must terminate or decline to establish a state directed payment program if (1) local funding is not available or sufficient to sustain the program, or (2) the federal government restricts or otherwise limits the availability of federal funds to support state directed payment programs or requires the state to utilize general revenue funds as a condition of establishing or maintaining a state directed payment program.

The act prohibits ODM from using more than 2% of funds received to support a state directed payment program for administration of such programs. The Director also may not use more than 2% of those funds for administration of ODM or the Medicaid program.

ODM must prepare and submit quarterly reports to LSC and the chairpersons of the House and Senate standing committees with jurisdiction over Medicaid regarding any newly established state directed payment programs.

340B grantees

(R.C. 5167.01 and 5167.123; conforming changes in R.C. 3902.70 and 4729.29)

The act includes provisions relating to the pricing of prescribed drugs under the Medicaid care management system obtained under the federal 340B Drug Pricing Program. For purposes of the interactions between a Medicaid MCO, third-party administrator, and 340B covered entity, the act removes most hospitals from the entities that are included as 340B covered entities. In making this change, the act instead refers to 340B covered entities as 340B grantees and specifies that to be considered a 340B grantee, an entity must be designated as an active entity under the Health Resources and Services Administration covered entity daily report. The act maintains the continuing law definition of a 340B covered entity outside the Medicaid program, for purposes of a contract between a health plan issuer, third-party administrator, and 340B covered entity, and for purposes of a contract between a terminal distributor of dangerous drugs and a 340B covered entity.

The act eliminates a prohibition against a contract between a Medicaid MCO, third-party administrator, and 340B grantee including a payment rate for a prescribed drug that is less than the national average drug acquisition costs rate for the drug as determined by CMS, or if no rate is available, a reimbursement rate that is less than the wholesale acquisition cost of the drug. Instead, the act prohibits a contract between these entities from including a provision for a payment rate for a prescribed drug provided by a 340B grantee to an individual as a result of

health care services provided by the grantee directly to the individual, that is less than the payment rate applied to health care providers that are not 340B grantees.

In addition, the act requires a Medicaid MCO or third-party administrator to provide a payment rate for all prescribed drugs obtained under the 340B Drug Pricing Program by providers that are not 340B grantees that equals the payment rate for those prescribed drugs under the Medicaid state plan. Any payment made under payments rates specified in contracts between Medicaid MCOs, third-party administrators, and 340B grantees are subject to audit by ODM.

General

Diversity, equity, and inclusion

(Section 333.12)

The act prohibits Medicaid funds from being used for diversity, equity, and inclusion initiatives, to the extent permitted by federal law. This prohibition does not apply to funds appropriated to provide services that support access to the community for Medicaid recipients with intellectual and developmental disabilities.

Medicaid separate health care services line items

(R.C. 126.024)

Beginning with the biennial state budget after H.B. 96, the act requires the OBM Director, in consultation with the Medicaid Director, to request and propose multiple Medicaid health care services general revenue fund appropriation items. At a minimum, the act requires that the Directors propose separate health care services appropriation items for the following:

- Services provided under the care management system;
- Nursing facility services;
- Hospital services;
- Behavioral health services;
- Services provided under Medicaid waiver components administered by ODA;
- Prescription Drug Services;
- Physician services;
- Services provided under the Ohio Home Care Waiver Program;
- Services provided under Medicaid waiver components administered by the Department of Developmental Disabilities;
- Services provided under the OhioRISE Medicaid waiver component;
- Any other services the Directors determine should have a separate appropriation item.

Right of recovery for cost of medical assistance

(R.C. 5160.37)

Under continuing law, ODM and county departments of job and family services have an automatic right of recovery against the liability of a third party that pays for the cost of medical assistance provided to a Medicaid recipient. There is a rebuttable presumption that ODM or the county department is entitled to the lesser of (1) one-half of the remaining amount after fees, costs, and expenses are deducted from the total judgment, award, settlement, or compromise, or (2) the actual amount of medical assistance paid.

The act permits an individual who was a recipient of medical assistance who repaid money to ODM or a county department under this automatic right of recovery, between April 6, 2007, and September 28, 2007, to request a hearing to rebut the presumption about the amount the individual repaid. A request must be made within 180 days after September 30, 2025. The presumption is successfully rebutted if the requestor demonstrates by clear and convincing evidence that a different allocation is warranted.

Any of the following may submit a request for a hearing:

- The medical assistance recipient;
- The recipient's authorized representative;
- The executor or administrator of a recipient's estate who is authorized to make or pursue a request;
- A court-appointed guardian;
- An attorney who has been directly retained by the recipient, or the recipient's parent, legal guardian, or court-appointed guardian.

MyCare Ohio expansion

(Section 333.250)

The act requires the Medicaid Director, in accordance with law established in 2023 in H.B. 33 of the 135th General Assembly, to continue to expand the Integrated Care Delivery System (ICDS, known as "MyCare Ohio") to all Ohio counties during FY 2026 and FY 2027. If the Director terminates MyCare Ohio, the successor program must serve all Ohio counties as well. ODM must establish requirements for care management and coordination of wavier services in the expanded program, subject to the following:

- The selected entities must employ the local 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 entities 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 an entity's plan may choose the entity 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.

MyCare Ohio successor program

(R.C. 5167.01 and 5167.03)

The act permits ODM to include a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) as a replacement, successor program for MyCare Ohio.

Hospital Care Assurance Program; franchise permit fee

(Section 610.10)

The Hospital Care Assurance Program (HCAP) is a program that distributes funds to hospitals that provide a disproportionate share of services to low-income individuals. To raise funds necessary to make payments under HCAP, ODM imposes annual assessment fees on all hospitals. In addition to the HCAP annual assessment, ODM also imposes a separate annual assessment on hospitals to help pay for the Medicaid program. To distinguish that assessment from HCAP, the assessment is sometimes called a hospital franchise permit fee.

H.B. 870 of the 119th General Assembly (1992) imposed a sunset (a delayed repeal) on HCAP and the hospital franchise permit fee. The initial sunset was scheduled for October 1, 1995. However, the sunset has been extended every two years by each subsequent General Assembly, most recently to October 16, 2025. The act repeals the sunset, thereby making the continued operation of HCAP and the hospital franchise permit fee permanent.

Appeal of hospital assessment or audit

(R.C. 5168.08, 5168.11, and 5168.22)

Hospital assessments

HCAP

The act makes substantive changes to the HCAP annual assessment imposed on all hospitals as a funding mechanism for the program. Continuing law, unchanged by the act, requires ODM to issue a preliminary determination of the amount the hospital is to be assessed during the program year. Upon receiving a preliminary determination, a hospital may request reconsideration of the preliminary determination. The act specifies that a final reconciliation constitutes a final interim order that may be subject to adjustments made by CMS. Under continuing law, if a hospital does not request reconsideration of the preliminary determination, the preliminary determination constitutes final reconciliation of the assessment.

The act expands the notice provisions by permitting delivery of the written materials by (1) regular mail, (2) electronic mail, or (3) in-person delivery. It also eliminates a requirement that ODM hold a public hearing if one or more hospitals seek redetermination of a preliminary

determination. The act's provisions specifying that a final reconciliation constitutes a final interim order that may be subject to adjustments made by CMS also apply to final reconciliations that are the result of a redetermination (continuing law provides that the redetermination result constitutes final reconciliation of a hospital's assessment).

Under continuing law unchanged by the act, ODM must issue each hospital a written notice of its assessment under the final reconciliation, and a hospital may appeal the final reconciliation to the Franklin County court of common pleas. The act clarifies that the complete record of the appeal proceedings includes all documentation considered by ODM in issuing the final reconciliation.

Hospital franchise permit fee

In addition to the HCAP assessment, Ohio law also imposes the hospital franchise permit fee upon hospitals. The act makes similar changes to the law governing the additional assessment to those made concerning the assessment imposed under HCAP, including (1) that written materials submitted to ODM by a hospital seeking redetermination of a preliminary determination of the assessment may be delivered to ODM by regular mail, electronic mail, or in-person delivery, and (2) that if a hospital appeals a final determination of its assessment, the complete record of the proceedings includes all documentation considered by ODM in issuing the final determination.

Hospital audit

Under continuing law unchanged by the act, funds paid by a hospital pursuant to the HCAP assessment are deposited into the Hospital Care Assurance Program fund. ODM may audit the amounts of payments made by a hospital and (1) make payments to a hospital that paid amounts it should not have been required to pay or did not receive amounts it should have, and (2) take action to recover from a hospital any amounts the hospital should have been required to pay but did not or that it should have not received but did.

The act eliminates the ability of a hospital to appeal the results of an audit and instead requires a hospital that disagrees with the results of an audit to seek a declaratory judgment in Franklin County court. While judicial proceedings are pending, the hospital must pay to the fund any amounts identified by an audit that are not in dispute.

Medicaid visit verification system (VETOED)

(Section 751.160)

The Governor vetoed provisions that would have established requirements pertaining to a Medicaid visit verification system during the fiscal biennium if the Director established an electronic visit verification (EVV) system. Through June 30, 2027, the act would have imposed duties on, and granted authority to, ODM, the Department of Developmental Disabilities, Medicaid MCOs, and other entities authorized to pay Medicaid claims in the event the Director established an EVV system in rule, including the following:

- Prohibiting the EVV system from exceeding minimum requirements specified in federal law;

- Requiring ODM and the Department to provide education and technical assistance to Medicaid providers to aid them in complying with the EVV system;
- Requiring a Medicaid provider to be notified if a claim submitted is not supported by evidence in the EVV system;
- Requiring ODM, the Department, a Medicaid MCO, or other entity authorized to pay a Medicaid claim to offer the Medicaid provider the opportunity to review and correct such a claim and data in the EVV system;
- Prohibiting ODM, the Department, a Medicaid MCO, or other entity from denying a claim that is not supported by information in the EVV system;
- Allowing ODM, the Department, a Medicaid MCO, or other entity authorized to conduct a post-payment audit or review to consider information in the EVV system as part of its audit or review protocol;
- Prohibiting ODM, the Department, a Medicaid MCO, or other entity to conduct a post-payment audit or review based solely on information in the EVV system.

Reports, notifications, and audits

Audit and corrective action plan for Medicaid ABD group

(Section 751.170)

The act requires the Auditor of State to conduct an audit of the Medicaid program to determine whether any individuals enrolled in the program on the basis of being members of the ABD eligibility group are ineligible to participate in Medicaid. The audit must specifically examine if ABD members have countable assets that exceed the Medicaid asset limits prescribed under federal law (generally $2,000 for an individual and $3,000 for an individual and spouse).[115]

After the audit, ODM must initiate a corrective action plan to reduce Medicaid spending for individuals in the ABD group. The corrective action plan must:

- Address individuals determined by the audit to be ineligible for continued participation in Medicaid;
- Establish and implement an electronic asset verification system for all ABD applicants and enrollees;
- Undertake other initiatives to reduce Medicaid spending for ABD enrollees.

ODM must then submit a copy of the corrective action plan to LSC and the chairpersons of the standing committees in the House and Senate that primarily consider legislation governing Medicaid.

[115] 20 C.F.R. 416.1205.

Quarterly Medicaid statement of expenditures form

(R.C. 5162.14)

The act requires the Medicaid Director to immediately notify (1) the Speaker of the House, (2) the Senate President, (3) the LSC Director, and (4) the chairpersons of the relevant standing committees in the House and Senate if CMS takes certain actions related to the Quarterly Medicaid Statement of Expenditures Form submitted to CMS by ODM to report its Medicaid costs. The Director must provide the notice if CMS does any of the following related to a CMS-64 Form submitted by ODM:

- Determines that the form has a variance of expenditures of 8% or greater;
- Asks any questions related to the form;
- Refuses to certify the information provided on the form;
- Refuses to release any funds to the state.

When providing the notice, the Director must include any letter or information provided to ODM by CMS related to its questioning or decision not to certify a CMS-64 Form. Additionally, the Director must include any correspondence from ODM to CMS as part of the notice provided.

Medicaid reports regarding fraud, waste, and abuse

(R.C. 5162.132 (primary) and 5101.98)

Continuing law requires ODM to prepare and submit a report regarding its efforts to minimize fraud, waste, and abuse in the Medicaid program. The act adds that the report must be prepared and submitted by December 31 of each year, and include the following information for the most recently concluded state fiscal year:

- Improper Medicaid payments and expenditures, including the individual and total dollar amounts for claims that were determined to be the result of fraud, waste, and abuse;
- Federal and state recovered funds, including the dollar amount per claim and the total dollar amounts concerning Medicaid fraud, waste, and abuse;
- Aggregate data concerning improper payments and ineligible Medicaid recipients who received Medicaid services as a percentage of the claims investigated or reviewed;
- The number of payments made in error, the dollar amount of those payments within Medicaid, and the number of confirmed cases of intentional program violation and fraud (instead of JFS as under prior law).

In addition to making this report available on ODM's website as required under continuing law, the act requires ODM to also provide copies of the report to the chairpersons and ranking members of the House and Senate committees with jurisdiction over Medicaid and to LSC. The act removes the requirement that the report be submitted to the Governor, the General Assembly generally, and to the public upon request.

Presumptive eligibility error rate quarterly report

(R.C. 5163.104)

The act requires ODM to submit a quarterly report to the General Assembly regarding the presumptive eligibility error rate for presumptive eligibility determinations made during the previous quarter. Continuing law unchanged by the act defines the "presumptive eligibility error rate" as the rate at which a qualified entity or qualified provider deems an individual presumptively eligible for Medicaid, when the individual is not eligible to participate in Medicaid.

Legislative notice of amendments and waivers

(R.C. 5162.08 and 5166.03)

The act prohibits ODM from seeking to implement an amendment to the Medicaid state plan or an 1115 or 1915 Medicaid waiver that would (1) expand Medicaid coverage to any additional individuals or class of individuals or (2) increase any net costs to the state, unless ODM first provides notice to LSC and the standing committees of the House and Senate with jurisdiction over Medicaid. The act further requires ODM to provide updates to those committees regarding the status of any amendment or waiver submitted.

Continuing law requires the ODM Director to provide written notice to the Speaker of the House and Senate President at least ten days before submitting a request for an 1115 Medicaid waiver. The act requires that this notice also include confirmation that ODM has informed the committees as described above, if doing so is required for the proposed waiver.

Audit of Next Generation

(Section 751.70)

The act requires the Auditor of State to conduct a performance and fiscal audit of ODM's Next Generation system and submit copies of the audit report to the standing committees of the House and the Senate that oversee Medicaid and to LSC by December 31, 2027. In conducting the audit, the Auditor may examine:

- The Provider Network Management;
- The Ohio Medicaid Enterprise System;
- The Ohio Resilience Through Integrated Systems and Excellent (OhioRISE) program;
- The Electronic Data Interchange;
- The Medicaid single state pharmacy benefit manager;
- Centralized provider credentialing;
- Prior authorization requirements;
- Issues with late payments to Medicaid providers;

Any other aspects of the system the Auditor considers relevant.