
DEPARTMENT OF MEDICAID

Medicaid waiver component definition

- Specifies that the definition of a “Medicaid waiver component” does not include services delivered under a prepaid inpatient health plan.

Medicaid rates for community behavioral health services

- Permits the Department of Medicaid to establish Medicaid rates for community behavioral health services provided during FYs 2022 and 2023 that exceed the Medicare rates paid for the services.

Duties of area agencies on aging

- Requires the Department, if it adds to the Medicaid managed care system during FYs 2022 and 2023 more Medicaid recipients who are aged, blind, disabled, or also enrolled in Medicare, to take certain actions regarding the duties of area agencies on aging relative to home and community-based waiver services.

Hospital Care Assurance Program, franchise permit fee

- Continues, for two additional years, the Hospital Care Assurance Program and the franchise permit fee imposed on hospitals under Medicaid.

Voluntary community engagement program

- Requires the Medicaid Director to establish a voluntary community engagement program for medical assistance recipients.
- Requires the program to encourage work among able-bodied medical assistance recipients of working age, including providing information about the benefits of work on physical and mental health.
- Provides that the program is in effect through FY 2022 and FY 2023, or until Ohio is able to implement the waiver component establishing work requirements and community engagement as a condition of enrolling in the Medicaid expansion eligibility group (also known as “Group VIII”).

Nursing facilities

Critical access nursing facilities

- For calculating the occupancy and utilization rates to determine if a nursing facility is a critical access nursing facility, provides that “as of the last day of the calendar year” refers to the rates for the entire cost reporting period for which the nursing facility participated in the Medicaid program during the applicable calendar year.

Medicaid payment rate formula

- Removes provisions that require the Department, when determining a nursing facility’s occupancy rate, to include any beds that the facility removes from its Medicaid certified capacity, unless also removed from its licensed capacity.

Resident assessment data

- Requires rules relating to the resident assessment data that nursing facilities must compile quarterly for each resident to specify any resident assessment data that is excluded from the facility's case mix score calculated quarterly by the Department.

Special Focus Facility Program

- Modifies the nursing facility Special Focus Facility (SFF) Program, which requires the Department to terminate a nursing facility's Medicaid participation if the facility is placed on the SFF list and fails to make improvements or graduate from the program within certain periods of time.
- As part of the modifications, requires nursing facilities to take all necessary steps to improve its quality of care to avoid having its license terminated under the SFF program, and permits appeals relating to the amount of time a facility has been on an SFF list.

Quality incentive and quality improvement payments

- Repeals the quality payments and quality incentive payments that are added to nursing facilities' Medicaid payment rates, and replaces them with similar, temporary payments.
- Establishes a quality incentive payment for FY 2022 that uses a payment calculation methodology substantially similar to the repealed quality incentive payment.
- By January 1, 2022, requires the Department, in consultation with the Departments of Aging and Health, to develop and establish quality improvement criteria that will be used to calculate a quality improvement payment for eligible nursing facilities.
- Provides that the criteria replace the FY 2022 quality incentive payment if implemented in that fiscal year, and, if developed after FY 2022, no quality improvement payments are to be made until the criteria are established.
- Requires nursing facilities to operate a location in this state with key program staff to be eligible for the quality improvement payments.

Lump sum payment for low Medicaid utilization

- Requires the Department to issue a lump sum payment to nursing facilities that have a Medicaid utilization rate for 2022 that is less than 90% of the aggregate Medicaid utilization for calendar year 2019, with certain exceptions.
- Caps the total lump sum payments to the lesser of \$50 million or an amount equal to the aggregate utilization shortfall across all nursing facilities during that time period.

Temporary expansion of rebasing

- Delays the Department's next nursing facility rebasing until July 1, 2023.

Medicaid waiver component definition

(R.C. 5166.01)

The bill specifies that the current law definition of a “Medicaid waiver component” does not include services that are delivered under a prepaid inpatient health plan.⁴⁹ Medicaid waiver component means a component of the Medicaid program authorized by a waiver granted by the U.S. Department of Health and Human Services and does not include the care management system.

Medicaid rates for community behavioral health services

(Section 333.160)

The bill permits the Department of Medicaid to establish Medicaid payment rates for community behavioral health services provided during FY 2022 and FY 2023 that exceed the authorized rates paid for the services under the Medicare Program. This does not apply, however, to services provided by hospitals on an inpatient basis, nursing facilities, or ICF/IIDs.

Duties of area agencies on aging

(Section 333.170)

The bill requires the Department, if it expands the inclusion of the aged, blind, and disabled Medicaid eligibility group or Medicaid recipients who are also eligible for Medicare (dual-eligible individuals) in the Medicaid managed care system during the FY 2022-FY 2023 biennium, to do both of the following for the remainder of the biennium:

1. Require area agencies on aging to be the coordinators of home and community-based waiver services they receive and permit Medicaid MCOs to delegate to the agencies full-care coordination functions for those and other health care services; and

2. In selecting Medicaid MCOs, give preference to organizations that will enter into subcapitation arrangements with area agencies on aging under which the agencies perform, in addition to other functions, network management and payment functions for services that those recipients receive.

Hospital Care Assurance Program, franchise permit fee

(Sections 601.20 and 601.21, amending Sections 125.10 and 125.11 of H.B. 59 of the 130th General Assembly)

The bill continues the Hospital Care Assurance Program (HCAP) for two additional years. The program is scheduled to end October 16, 2021. The bill extends it to October 16, 2023. 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

⁴⁹ Federal law defines a “prepaid inpatient health plan” as an entity that provides limited services to Medicaid enrollees through a limited-benefit risk-based plan. (42 Code of Federal Regulations (C.F.R.) 438.2.)

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, 2023, rather than October 1, 2021. 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.

Voluntary community engagement program

(Section 333.210; R.C. 5166.37, not in the bill)

As a result of the COVID-19 public health emergency, the bill requires the Medicaid Director to establish and implement a voluntary community engagement program not later than January 1, 2022. The program must be voluntary and available to all medical assistance recipients (individuals enrolled or enrolling in Medicaid, CHIP, the refugee medical assistance program, or other medical assistance program the Department administers). The program must:

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

As part of the program, the Director must explore partnerships with education and training providers to increase training opportunities for Medicaid recipients. The program is to continue through state fiscal years 2022 and 2023, or until the Department is able to implement the Work Requirement and Community Engagement Section 1115 Demonstration waiver, whichever is sooner.

Continuing law requires the Director to establish a Medicaid waiver component under which an individual eligible for Medicaid on the basis of being included in the expansion eligibility group (also known as “Group VIII”) – adults under age 65 with no dependents and incomes at or below 138% of the federal poverty level – must meet one of a list of enumerated criteria to enroll in Medicaid. The criteria include (1) being at least age 55, (2) being employed, (3) being enrolled in a school or occupational training program, (4) participating in an alcohol and drug addiction treatment program, or (5) having intensive physical health care needs or serious mental illness.⁵⁰ Pursuant to this requirement, the Department submitted a waiver request to the U.S. Centers for Medicare and Medicaid Services (CMS) to implement a Work Requirement and Community Engagement Section 1115 Demonstration waiver program. CMS approved the waiver on March 15, 2019; however, the program was never implemented because the federal Coronavirus Aid,

⁵⁰ R.C. 5166.37, not in the bill.

Relief, and Economic Security (CARES) Act prohibits state Medicaid programs from imposing additional eligibility criteria on Medicaid enrollees during the COVID-19 public health emergency.

Nursing facilities

Critical access nursing facilities

(R.C. 5165.01)

The bill clarifies terminology relating to the critical access incentive payment received by nursing facilities that qualify as critical access nursing facilities. Under current law, to qualify as a critical access nursing facility, the nursing facility must meet certain occupancy and Medicaid utilization rate metrics. For purposes of calculating the occupancy and utilization rates, the bill clarifies that “as of the last day of the calendar year” refers to the rates for the entire cost reporting period for which the nursing facility participated in the Medicaid Program during the calendar year and identified in its annual cost report filed with the Department.

Medicaid payment rate formula

(R.C. 5165.01, 5165.15, and 5165.17)

In definitions, the bill provides that inpatient days include all days during which a resident, regardless of payment source, occupies a licensed bed in a nursing facility, instead of a bed in a nursing facility that is included in the facility’s Medicaid certified capacity. It also provides that a nursing facility’s occupancy rate refers to the percentage of licensed beds that, regardless of the payer source, are either reserved for use or are actually being used.

The bill also removes provisions of law, under the ancillary and support costs and capital cost center components of the nursing facility payment rate, that require the Department, when determining a nursing facility’s occupancy rate, to include any beds that the facility removes from its Medicaid certified capacity, unless the facility also removes them from its licensed capacity.

Resident assessment data

(R.C. 5165.191)

Relating to the resident assessment data nursing facilities must compile quarterly for each resident, the bill requires the associated rules to specify any resident assessment data that is excluded from the facility’s case mix score calculated quarterly by the Department for each nursing facility.

Special Focus Facility Program

(R.C. 5165.771)

The bill modifies the Special Focus Facility (SFF) Program, which requires the Department to terminate a nursing facility’s Medicaid participation if the facility is placed on the federal SFF list and fails to make improvements or graduate from the SFF Program within certain periods of time. The SFF list is part of the SFF Program that federal law requires the U.S. Department of

Health and Human Services to create for nursing facilities identified as having substantially failed to meet federal requirements.⁵¹

SFF tables

The SFF has different tables. Table A identifies nursing facilities that are newly added to the list. Table B identifies nursing facilities that have not improved. Table C identifies nursing facilities that have shown improvement. Table D identifies nursing facilities that have recently graduated from the SFF Program.

The bill makes nonsubstantive changes to current law regarding the SFF tables, which requires the Department to terminate a nursing facility's Medicaid participation if:

1. The nursing facility was listed in Table A or Table B on September 29, 2013, and failed to be placed on Table C by September 29, 2014 (12 months after the provision's effective date);
2. The nursing facility was listed in Table A, Table B, or Table C on September 29, 2013, and failed to be placed on Table D by September 29, 2015 (24 months after the provision's effective date);
3. The nursing facility is placed on Table A after September 29, 2013, and fails to be placed in Table C not later than 12 months after the placement in Table A;
4. The nursing facility is placed in Table A after September 29, 2013, and fails to be placed in Table D not later than 24 months after the placement in Table A.

The bill removes the effective date references. Instead, under the bill, the Department must terminate a nursing facility's Medicaid participation if:

1. The nursing facility is placed in Table A or Table B and fails to be placed in Table C not later than 12 months after being placed in Table A or Table B;
2. The nursing facility is placed in Table A, Table B, or Table C and fails to be placed in Table D not later than 24 months after being placed in Table A, Table B, or Table C;
3. The nursing facility is placed in Table A and fails to be placed in Table C not later than 12 months after being placed in Table A;
4. The nursing facility is placed in Table A and fails to be placed in Table D not later than 24 months after the nursing facility is placed in Table A.⁵²

The bill requires a nursing facility to take all necessary steps to avoid having its Medicaid participation terminated. As part of that requirement, the bill provides that technical assistance and quality improvement initiatives to help a nursing facility avoid having its Medicaid participation terminated are available through the Nursing Home Quality Initiative (NHQI) and through a quality improvement organization under the NHQI. Current law requires the

⁵¹ 42 U.S.C. 1396r(f)(10).

⁵² Under the bill, numbers (3) and (4) appear to be included in (1) and (2).

Department of Aging to provide assistance through the NHQI at least four months before ODM would be required to terminate the facility's Medicaid participation.

The bill permits nursing facilities to appeal, under the Administrative Procedure Act, the length of time a facility is listed on a SFF table. The Director may adopt rules to provide for an expedited appeal process for those appeals, notwithstanding the Administrative Procedure Act's time limits. Under current law, an order terminating a nursing facility's Medicaid participation is not subject to appeal under the Administrative Procedure Act.

Quality incentive and quality improvement payments

(Section 333.220; R.C. 5165.15 and 5165.151; R.C. 5165.25 and 5165.26, repealed)

The bill repeals the quality payments and quality incentive payments that are added to nursing facilities' Medicaid payment rates, based on the score the facility receives for meeting certain quality metrics regarding its residents who have resided in the nursing facility for at least 100 days (i.e., long-stay residents), and replaces them with similar, temporary payments.

FY 2022 quality incentive payment

Under the bill, for FY 2022, nursing facilities receive a quality incentive payment added to their Medicaid payment rates. The calculation methodology for the payment is substantially similar to the quality incentive payment under current law that is repealed by the bill. The total amount to be spent on the quality incentive payments for FY 2022 is the sum of:

1. The amount that is 5.2% of the nursing facility's base rate for nursing facility services provided on the first day of FY 2022 plus \$1.79;
2. Multiply the amount determined under (1) by the number of the nursing facility's Medicaid days for the calendar year preceding FY 2022;
3. Determine the sum of (2) for all nursing facilities for which the product was determined for FY 2022;
4. To the sum determined under (3), add \$50 million.

If a nursing facility undergoes a change of operator in FY 2022, the quality incentive payment rate to be paid to the entering operator is the same rate that was in effect on the day immediately preceding the effective date of the change of operator and paid to the exiting operator.

Quality improvement payment

By January 1, 2022, the bill requires the Department, in consultation with the Departments of Aging and Health, to develop and establish quality improvement criteria that will be used to calculate a quality improvement payment for eligible nursing facilities. If the criteria are established in FY 2022, they replace the FY 2022 quality incentive payment. The quality incentive payment ends after FY 2022, or after the establishment of the quality improvement payment, whichever is sooner. After the quality incentive payment expires, no quality improvement payments are to be made until the quality improvement payment criteria are implemented.

The quality improvement standards must be used to determine a quality improvement payment to be made to nursing facilities, and the Departments above must include stakeholder input as part of the process of developing the standards.

Key program staff

In addition to the quality improvement standards, to be eligible for the quality improvement payment, a nursing facility must operate a location in Ohio with key program staff who are Ohio residents and who include a different individual for each of the following categories:

- An administrator who works 40 hours a week during regular business hours to oversee the entire operation of the nursing facility. The administrator must devote sufficient time to facility operations to ensure adherence to program requirements and timely responses to the Department.
- A medical director who is a physician holding a current, unencumbered license to practice medicine and surgery or osteopathic medicine and surgery with at least three years of training in a medical specialty. The medical director must devote at least 32 hours a week to the nursing facility's operations to ensure timely medical decisions, including after-hours consultation as needed and must be actively involved in all major clinical and quality management components of the facility.
- A director of nursing who holds a current, unencumbered registered nurse license. The nursing director must serve 40 hours a week during regular business hours to ensure appropriate care to facility residents and be actively involved in all clinical and quality management components of the facility.
- A quality improvement director who has experience in quality management and quality improvement and oversees all quality initiatives in the facility. The quality improvement director must be a physician, registered nurse, or physician assistant, holding a current, unencumbered license.

Currently, the Revised Code does not use or define the term "unencumbered license" for professional regulation. Rather, it describes licenses as "current, valid licenses," while unencumbered is used to reference funds or real estate. It is unclear how "unencumbered" may be interpreted in a licensing context.

Rules

The Director may adopt rules to implement these requirements, including establishing quality improvement standards and minimum responsibilities for the key program staff.

Lump sum payment for low Medicaid utilization

(Section 333.230)

The bill establishes a lump sum payment for nursing facilities that experience low Medicaid utilization during state fiscal year 2022. The Department must determine the aggregate Medicaid utilization for all nursing facilities during state fiscal year 2022. If the Department determines that, for all nursing facilities, the aggregate Medicaid utilization for all of state fiscal

year 2022 is less than 90% of the aggregate Medicaid utilization for all nursing facilities for all of calendar year 2019, the Department can issue a lump sum payment to individual nursing facilities that had Medicaid utilization below 90% of utilization for all of fiscal year 2022. The total expenditures for the lump sum payments must be the lesser of \$50 million, or an amount equal to the aggregate calculated shortfall below 90% across all nursing facilities during that period.

The following nursing facilities are not eligible to receive a lump sum payment:

- Nursing facilities with a Medicaid utilization rate for all of state fiscal year 2022 that exceeds 90% of its Medicaid utilization for all of calendar year 2019;
- Nursing facilities that are new in state fiscal year 2022;
- Nursing facilities that have undergone a change of operator during state fiscal year 2022; and
- Nursing facilities that closed during state fiscal year 2022.

The Department may adopt rules, in accordance with the Administrative Procedure Act, to establish eligibility criteria, the distribution formula, and the procedures by which a nursing facility can request a lump sum payment.

Temporary expansion of rebasing

(Section 333.240)

The bill delays the Department's next nursing facility rebasing until July 1, 2023 (FY 2024), notwithstanding the law that requires the Department to conduct a rebasing at least once every five state fiscal years. The Department conducted its last rebasing in FY 2017. A rebasing is a redetermination of the four cost components used to calculate a nursing facility's per Medicaid day payment rate.⁵³

⁵³ 42 U.S.C. 1396r(f)(10).