DEPARTMENT OF JOB AND FAMILY SERVICES (JFS)

I. General

- Authorizes the Ohio Department of Job and Family Services (ODJFS), a county department of job and family services (CDJFS), and a child support enforcement agency (CSEA) to conduct audits (in addition to investigations) as necessary in furtherance of their duties.

- Specifies that until an audit report is formally released by ODJFS, the audit report and any related documents or records are not public records.

- Specifies that an audit conference conducted by the audit staff of ODJFS with the officials of the public office that is the subject of the audit is not a public meeting for the purpose of the Open Meetings Law.

- Authorizes a board of county commissioners to transfer money from the Public Assistance Fund to the Children Services Fund or Child Support Enforcement Administrative Fund, as long as the money may be spent for the purposes of the receiving fund.

- Reduces to 105% (from 110%) the maximum amount that a county may be required to pay, in comparison to the amount paid in the preceding fiscal year, for its share of public assistance expenditures.

- Expands to CSEAs the authority to recover costs of services provided to persons who secured them through fraud or misrepresentation or who intentionally diverted services to ineligible persons.

- Permits county family services agencies to recover (1) costs of benefits (rather than only services) secured through fraud or misrepresentation or that were intentionally diverted to ineligible persons and (2) any other costs of benefits and services provided by the agencies if recovery is required or permitted by federal law.

- Permits ODJFS to take either or both of the following actions to collect excess amounts from a county entity performing family services duties: (1) enter into an agreement with the county entity for repayment of the excess amount plus, at ODJFS's discretion, interest and (2) certify a claim to the Attorney General for collection.

- Replaces the 14% limit on the amount of a local agency's Title XX (the federal Social Services Block Grant) appropriation that may be used for administrative costs with a

requirement that the maximum percentage be established by state agency rules that comply with federal law.

- Requires the Governor to appoint an executive director for the Ohio Commission on Fatherhood.

- Requires the Commission to include with its annual report a description, prepared in collaboration with the ODJFS Director, of (1) its expectations for the outcomes of fatherhood-related programs and initiatives and (2) its methods for annually measuring those outcomes.

- Authorizes the ODJFS Director to refer to the Supplemental Nutrition Assistance Program as the Food Stamp Program or Food Assistance Program in ODJFS rules and documents.

II. Child Care

- Eliminates provisions under which CDJFSs could contract with and reimburse providers of publicly funded child care, and provides instead that purchases of such care are made pursuant to contracts between providers and ODJFS.

- Permits the ODJFS Director to adopt rules specifying exceptions to the eligibility requirements for a family that previously received publicly funded child care but whose eligibility was terminated and is seeking reinstatement.

- Permits ODJFS, when it determines that expenditures for publicly funded child care will exceed available federal and state funds, to change the schedule of fees to be paid by eligible caretaker parents and the rate of payment to child care providers.

- Requires the ODJFS Director to establish enhanced reimbursement ceilings for child care centers that participate in the Step Up to Quality Program and maintain quality ratings and to weigh any reduction in reimbursement ceilings more heavily against centers that do not participate or do not maintain quality ratings.

- Prohibits an eligible caretaker parent from receiving full-time publicly funded child care from more than one provider per child.

- Provides, if ODJFS implements a swipe card program for tracking attendance and submitting invoices for publicly funded child care, that misuse of the program by child care providers or parents may result in license or certification revocation or loss of eligibility for publicly funded child care.

- Eliminates the requirement to renew every two years a license for a child day-care center or type A family day-care home.

- Requires a child care center or type A home for which a license was revoked to wait five years (rather than two) before applying for another license.

- Increases to one year (from six months) the period during which a provisional license is valid.

- Eliminates the requirement that ODJFS notify a child day-care center or type A family day-care home that it is out of compliance with the laws governing centers and homes.

- Eliminates, except for purposes of issuing a provisional license, the requirement that the ODJFS Director consider the number of available child-care staff members when determining the license capacity of a child day-care center or type A family day-care home.

- Increases to 2 (from 1.5) the number of hours during a 24-hour day that the number of napping toddlers or preschool children per child-care staff member may be twice the number of children per staff member otherwise allowed.

- Permits a person seeking to be a child day-care center administrator to meet educational requirements by showing the ODJFS Director evidence that the administrator holds a designation as an "early childhood professional level three" under the Step Up to Quality Program.

- Exempts students who are being home schooled during their last year of instruction or who have graduated from a charter school from the educational requirements for employment at a child day-care center.

- Eliminates the requirements that the ODJFS Director adopt rules to be used for checking the references of child day-care center and type A family day-care home license applicants and potential employees.

- Permits a child day-care center to have on the center premises and readily available a separate staff member who has completed a course in prevention, recognition, and management of communicable diseases approved by the Department of Health.

- Specifies that, when adopting rules establishing procedures for screening children and employees of child day-care centers, the ODJFS Director is permitted, rather than required, to include requirements for physical examinations and immunizations.

- Permits the ODJFS Director, when providing copies of child care licensing requirements and rules to license applicants, to provide the copies in either paper or electronic form.

- Permits ODJFS to publish a guide on certification of type B family day-care homes either electronically or otherwise, and eliminates the requirement to distribute the guide to CDJFSs.

- Eliminates the requirement that each child day-care center administrator prepare and distribute an annual roster and telephone contact list of the parents, guardians, or custodians of the children attending the center.

- Replaces a provision that requires the ODJFS Director to recommend standards to the Governor and General Assembly regarding sanctions to be imposed on persons violating the law governing child care with a provision that permits the Director to adopt rules regarding the sanctions and specifies when the Director is to impose the sanctions.

- Requires the ODJFS Director to make a dispute resolution process available for implementing sanctions.

III. Child Support

- Requires ODJFS's Office of Child Support to administer a fund for the deposit of support payments it receives.

- Prohibits a CSEA from sending a notice to an occupational or professional licensing board, the Bureau of Motor Vehicles (BMV), or the Division of Wildlife regarding a child support default unless: (1) at least 90 days have elapsed since the final and enforceable determination of default, and (2) the obligor has not paid at least 50% of the monthly obligation due for that period by means other than state or federal tax intercept.

- Alters the requirements concerning when a CSEA is required to reinstate a license that has been suspended due to child support default.

- Requires a CSEA to remove license restrictions if the obligor demonstrates an inability to work due to circumstances beyond the obligor's control.

- Permits a CSEA to direct the Registrar of Motor Vehicles to eliminate from the abstract maintained by the BMV any reference to the suspension of an individual's license due to child support default.

IV. Child Welfare and Adoption

- Requires each public children services agency (PCSA) to prepare and maintain a case plan or family service plan for any child receiving in-home services from the agency pursuant to an alternative response.

- Requires ODJFS to include in its rules requiring PCSAs to maintain case plans or family service case plans for children and their families who are receiving services in their homes requirements for case plans or family service plans for such children and families receiving services from PCSAs pursuant to an alternative response.

- Requires that the differential response approach pursued by a PCSA include the traditional response pathway and the alternative response pathway.

- Details when PCSAs must use the traditional response.

- Requires ODJFS, in accordance with the evaluation of the Ohio Alternative Response Pilot Program, to plan the statewide expansion of the pilot program on a county-by-county basis, through a schedule ODJFS is to determine.

- Provides that the act's provisions regarding differential response, traditional response, and alternative response are to become effective for a county in accordance with ODJFS's schedule.

- Authorizes the Children's Trust Fund Board to solicit gifts, money, and other donations from any public or private source and to develop public-private partnerships.

- Permits the Children's Trust Fund Board to request that ODJFS adopt rules the Board considers necessary to carry out its responsibilities, and permits ODJFS to adopt the requested rules or any other rules.

V. Health Programs (Including Medicaid)

- Creates the Health Care Special Activities Fund, requires ODJFS to deposit all funds it receives pursuant to the administration of the Medicaid program into the Fund, and requires ODJFS to use the money in the Fund to pay for Medicaid-related expenses.

- Permits ODJFS to enter into agreements with other state agencies, local government entities, or political subdivisions to accept applications and make eligibility determinations on ODJFS's behalf for Medicaid and the Children's Health Insurance Program.

- Provides that an institutionalized individual may be granted a waiver of the Medicaid penalty imposed when assets are transferred for less than fair market value if the ineligibility would cause an undue hardship for the individual.

- Requires that a waiver of the penalty be granted if a nursing facility has notified an institutionalized individual of a proposed transfer or discharge from the facility due to failure to pay, the individual or the individual's sponsor requests a hearing, and the proposed transfer or discharge is upheld on final appeal.

- Requires the ODJFS Director to adopt rules establishing additional reasons for which waivers of the penalty may be granted.

- Requires the ODJFS Director to retain in the Medicaid state plan a federal option under which medical assistance is made available to children during presumptive eligibility periods.

- Requires the ODJFS Director to amend the Medicaid state plan to implement a federal option under which ambulatory prenatal care is made available to pregnant women during presumptive eligibility periods.

- Requires the ODJFS Director to provide for children's hospitals, federally qualified health centers, and federally qualified health center look-alikes, if they are eligible under federal law and request to serve as qualified providers or entities that make presumptive eligibility determinations, to serve as such for purposes of the presumptive eligibility for children and pregnant women options.

- Permits the ODJFS Director to provide for other types of providers and entities, if they are eligible under federal law and request to serve as qualified providers and entities that make presumptive eligibility determinations, to serve as such for purposes of the presumptive eligibility for children and pregnant women options.

- Specifies that a provision of law governing how a trust must be treated for purposes of determining Medicaid eligibility may be used only for an initial Medicaid eligibility determination or an appeal of an initial Medicaid eligibility determination, and prohibits a court from using the provision to determine a trust's effect on an individual's initial Medicaid eligibility determination.

- Replaces the terms "countable resource" and "countable income" for purposes of the law governing how a trust must be treated in making Medicaid eligibility determinations.

- Except as otherwise authorized by the U.S. Secretary of Health and Human Services, requires ODJFS to comply with the federal maintenance of effort requirement

regarding Medicaid eligibility standards, methodologies, and procedures while the requirement is in effect.

- Requires ODJFS, on receipt of any necessary federal approval, to reduce the complexity of the Medicaid eligibility determination processes caused by the different income and resource standards for the numerous Medicaid eligibility categories.

- Repeals provisions that required the State Auditor to determine whether overpayments were made on behalf of every medical assistance recipient and, in place of those provisions, authorizes the State Auditor to conduct an audit of an individual medical assistance recipient on the request of the ODJFS Director.

- Requires the State Auditor to enter into an interagency agreement with ODJFS governing the confidentiality of information the Auditor receives from ODJFS pursuant to an audit of a medical assistance recipient.

- Revises the laws governing disclosure of information about medical assistance recipients.

- Eliminates the authority of ODJFS or a CDJFS to request from a law enforcement agency information that can be used to determine whether a medical assistance recipient or a member of the recipient's assistance group is a fugitive felon or is violating a condition of probation, a community control sanction, parole, or a post-release control sanction.

- Extends from three to six years after the date of service the period during which a third party (1) must respond to an inquiry by ODJFS regarding a Medicaid claim, and (2) cannot deny a Medicaid claim solely on the basis of the date of submission of the claim, type or format of the claim form, or failure by the Medicaid recipient to present proper documentation at the time of service.

- Prohibits a third party from charging ODJFS a fee for determining whether a Medicaid claim should be paid or for processing a Medicaid claim if the claim was submitted not later than six years after the date of service.

- Requires ODJFS and the Ohio Department of Health (ODH) to work together on the issue of achieving efficiencies in the delivery of medical assistance provided under Medicaid to families and children.

- Requires ODJFS and ODH to develop a proposal for coordinating medical assistance provided to families and children under Medicaid while they wait to be enrolled in Medicaid managed care.

- Permits ODJFS to seek federal approval to authorize payment for Medicaid-reimbursable targeted case management services provided in connection with ODH's Help Me Grow Program and for services provided under the Program.

- Provides, for fiscal years 2012 and 2013, that a Medicaid recipient under 21 years of age automatically satisfies all requirements for any prior authorization process for community mental health services provided under a Medicaid component administered by the Ohio Department of Mental Health if the child meets certain requirements related to being an abused, neglected, dependent, unruly, or delinquent child.

- Authorizes implementation of the federal Medicaid option of providing coordinated care through "health homes" to Medicaid recipients with chronic conditions.

- Authorizes the Health Care Compliance Fund to be used for expenses incurred in implementing or operating health home programs and for the creation, modification, or replacement of federally funded Medicaid health-care systems in fiscal years 2012 and 2013.

- Permits, rather than requires, implementation of a program under which Medicaid recipients are enrolled in group health plans when doing so is cost-effective.

- Authorizes ODJFS to include in the Medicaid managed care system aged, blind, or disabled Medicaid recipients who are under age 21, nursing facility residents, recipients of Medicaid waiver home and community-based services, or dually eligible for Medicaid and Medicare.

- Prohibits ODJFS from including in the Medicaid managed care system, in fiscal years 2012 and 2013, any additional individuals who have cystic fibrosis, hemophilia, or cancer and are receiving services through the program for medically handicapped children operated by the Ohio Department of Health.

- Requires ODJFS to establish a pediatric accountable care organization recognition system not later than July 1, 2012, and requires standards of recognition to be the same as or not conflict with those adopted under the federal health care reform law.

- Requires, rather than permits, that Medicaid managed care coverage of prescription drugs be provided by the health insuring corporations participating in ODJFS's care management system.

- Prohibits the participating health insuring corporations from imposing prior authorization requirements for antidepressants and antipsychotics, if these mental health drugs meet specified criteria.

- Establishes, for persons who are being treated with prescription drugs when coverage by the Medicaid managed care system begins, a period of 30, 90, or 120 days (depending on the type of drug involved) during which a participating health insuring corporation may not impose certain utilization or management techniques.

- Specifies that ODJFS or its actuary is to base the hospital inpatient capital payment portion of the payment made to Medicaid managed care organizations on data for services provided to all Medicaid recipients enrolled in the organization as reported by hospitals.

- Requires ODJFS to establish a Medicaid Managed Care Performance Payment Program to make payments to managed care organizations that meet performance standards established by ODJFS and, for purposes of making the payments, requires ODJFS to withhold a percentage amount from each premium payment made to a managed care organization.

- Exempts actions taken by ODJFS regarding the Medicaid managed care system, including entering into or refusing to enter into a provider agreement, or suspending, terminating, renewing, or refusing to renew an existing provider agreement, from the requirement that the action be taken pursuant to an administrative hearing.

- Requires the ODJFS Director to implement, for fiscal years 2012 and 2013, purchasing strategies and rate reductions that result in payment rates for hospital and other Medicaid-covered services, as selected by the Director, being at least 2% less than the payment rates for fiscal year 2011.

- Excludes nursing facility and intermediate care facility for the mentally retarded (ICF/MR) services from the requirement regarding purchasing strategies and rate reductions.

- Permits ODJFS, the Ohio Department of Health, and the Ohio Department of Mental Health, in conjunction with the Governor's Office of Health Transformation, to seek assistance from and work with the Best Evidence for Advancing Child Health in Ohio! (BEACON) Council and hospital and other provider groups to identify specific targets and initiatives to reduce the cost and improve the quality of medical assistance provided under Medicaid to children.

- Prohibits ODJFS from knowingly making a Medicaid payment for a provider-preventable condition for which federal financial participation is prohibited.

- Authorizes ODJFS to establish an incentive payment program, as authorized by federal law, to encourage the use of electronic health record technology by certain Medicaid providers.

- Requires certain Medicaid providers, no later than January 13, 2013, to submit Medicaid reimbursement claims through an electronic claims submission process and to arrange for receipt of Medicaid reimbursement by electronic funds transfer, but excludes the following from these requirements: nursing facilities, ICFs/MR, Medicaid managed care organizations, and other providers designated by the ODJFS Director.

- Permits ODJFS, if it chooses to outsource the performance of pediatric Medicaid claims review and analysis, quality assurance functions associated with pediatric Medicaid claims, or both, to enter into a contract with any qualified person, including the Ohio Children's Hospital Solutions for Patient Safety, to perform the service or services.

- Requires the ODJFS Director to apply for approval to claim federal Medicaid funds for administrative costs that the Ohio Department of Health and the Arthur G. James and Richard J. Solove Research Institute of The Ohio State University incur in analyzing and evaluating certain data under the Ohio Cancer Incidence Surveillance System.

- Authorizes the ODJFS Director to implement a system under which payments for services provided under the Medicaid program are made to an organization on behalf of the providers.

- Permits ODJFS to recover a Medicaid overpayment to a hospital within one year after receiving from the U.S. Centers for Medicare and Medicaid Services a completed, audited, Medicare cost report.

- Requires ODJFS to charge an application fee to a provider seeking to enter into or renew a Medicaid provider agreement unless the provider is exempt from the fee under federal regulations.

- Provides for the application fee to be set by ODJFS rules, but prohibits the fee from exceeding the amount necessary to pay for implementing provider screening requirements established by federal regulations.

- Requires generally, that ODJFS suspend a Medicaid provider agreement and terminate the provider's Medicaid reimbursement, without a hearing but subject to a notice containing certain information, on determining that a creditable allegation of fraud against the provider exists, as those allegations are specified in federal law.

- Authorizes a Medicaid provider affected by a suspension to request reconsideration of the suspension and associated termination of reimbursement.

- Authorizes ODJFS to take any of several disciplinary actions, without a hearing, against a Medicaid provider agreement or an application for a provider agreement when the action is based on a disciplinary action taken by another state's Medicaid agency or for other reasons specified under federal law.

- Requires ODJFS, by July 1, 2012, to establish a process by which a physician assistant may enter into a Medicaid provider agreement and engage in direct billing.

- Authorizes a Medicaid claim for a physician assistant's services to be submitted either by (1) the physician assistant with a provider agreement, or (2) the physician, group practice, clinic, or other health care facility that employs or contracts with the physician assistant.

- Provides that Medicaid reimbursement rates for physician assistant services provided during fiscal year 2013 cannot be greater than the rates on June 30, 2012.

- Requires the ODJFS Director, as necessary to comply with federal law, to give public notice in the Register of Ohio of any change to a method or standard used to determine the Medicaid reimbursement rate for a service.

- Prohibits, except as required by federal law, Medicaid reimbursement rates from exceeding (1) limits established in federal Medicaid regulations in the case of hospital, nursing facility, and ICF/MR services and (2) the authorized Medicare reimbursement limits for services in the case of all other providers.

- Requires ODJFS, for fiscal year 2012, to pay Medicaid providers the Medicare copayment amounts that apply to dialysis services for persons eligible for both Medicaid and Medicare, as those copayments were made by ODJFS prior to the act.

- Permits ODJFS, in fiscal year 2013, to adjust Medicaid payments for dialysis services by an amount sufficient to achieve $9 million in savings.

- Requires ODJFS, effective October 1, 2011, to (1) reduce the first-hour-unit price Medicaid pays for aid services to 97% of the price paid on June 30, 2011, and for nursing services to 95% of the price paid on June 30, 2011, and (2) pay independent providers of aide and nursing services 80% of the price paid providers that are not independent providers.

- Requires that ODJFS, not sooner than July 1, 2012, adjust the Medicaid reimbursement rates for aide services and nursing services in a manner that reflects,

at a minimum, labor market data, education and licensure status, home health agency and independent provider status, and length of service visit.

- Prohibits the Medicaid payment for a drug that is subject to a federal upper reimbursement limit from exceeding, in the aggregate, the federal limit for the drug.

- Sets the Medicaid dispensing fee for noncompounded drugs at $1.80 for the period beginning July 1, 2011, and ending on the effective date of a rule changing the amount of the fee.

- Requires the ODJFS Director to maintain, for fiscal years 2012 and 2013, the Medicaid reimbursement rates in effect on June 30, 2011, for Medicaid-covered hospital inpatient and outpatient services that are paid under a prospective payment system.

- Requires the ODJFS Director to make, for fiscal years 2012 and 2013, additional Medicaid payments to children's hospitals for inpatient services under a program modeled on the program that was created for fiscal years 2006 and 2007 and subsequently continued.

- Continues the Hospital Care Assurance Program (HCAP) for two additional years.

- Provides for the assessments imposed on hospitals for the purpose of the Medicaid program to be imposed for two additional years.

- Requires ODJFS to establish the hospital assessment rate in rules.

- Permits the assessment rate to vary for different hospitals if ODJFS obtains any necessary federal waiver.

- Provides for ODJFS to impose a 10% penalty on overdue hospital assessments.

- Permits ODJFS to offset the amount of a hospital's unpaid penalty imposed under HCAP or the law governing hospital assessments from one or more payments due the hospital under the Medicaid program.

- Permits ODJFS to continue and modify the existing Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program to provide supplemental Medicaid payments to hospitals for providing Medicaid-covered inpatient and outpatient services to Medicaid recipients.

- Requires ODJFS to apply for federal approval of a Medicaid Managed Care Hospital Incentive Payment Program under which Medicaid managed care organizations are

provided funds to increase payments to hospitals under contract with the organizations.

- Prohibits ODJFS from implementing the Medicaid Managed Care Hospital Incentive Payment Program in a manner that reduces either (1) the amounts Medicaid managed care organizations would have otherwise received or (2) the amounts hospitals would have otherwise received from the Hospital Assessment Fund.

- Requires Medicaid managed care organizations and hospitals, if the Medicaid Managed Care Hospital Incentive Payment Program does not result in $22 million in state savings, to pay the state the difference between the amount saved and $22 million.

- Sets the base rate for the franchise permit fee to be paid by nursing homes and hospital long-term care units at $11.47 for fiscal year 2012 and $11.67 for fiscal year 2013 and thereafter.

- Provides for the percentage that is used in determining whether the franchise permit fee must be reduced in order for the fee to comply with federal restrictions to change in accordance with the federal restrictions.

- Requires ODJFS annually to redetermine each nursing home's and hospital long-term care unit's franchise permit fee for the second half of a fiscal year if, during a certain period of time, any nursing home or hospital surrendered one or more beds.

- Provides that the exiting and entering operator of a nursing home or hospital long-term care unit undergoing a change of operator have proportional responsibility for the nursing home's or hospital long-term care unit's franchise permit fee.

- Abolishes the Home- and Community-Based Services for the Aged Fund.

- Renames the Nursing Facility Stabilization Fund the Nursing Home Franchise Permit Fee Fund.

- Provides for all money raised by the franchise permit fee and associated penalties to be deposited into the Nursing Home Franchise Permit Fee Fund, provides for the money to be used to make Medicaid payments to providers of home and community-based services as well as providers of nursing facility services, and permits the money to also be used for the Residential State Supplement program.

- Abolishes the PASSPORT Fund.

- Provides for the money raised by horse-racing-related taxes that previously was deposited into the PASSPORT Fund to be deposited into the Nursing Home Franchise Permit Fee Fund and continues to require that the money be used for the PASSPORT Program.

- For purposes of calculating nursing facilities' Medicaid reimbursement rates for direct care costs, (1) includes the costs of behavioral and mental health services among the costs included in nursing facilities' direct care costs, (2) alters the methodology for determining a peer group's cost per case-mix unit, and (3) changes, beginning in fiscal year 2013, the residents for whom data from a resident assessment instrument is used in determining semiannual case-mix scores.

- For purposes of calculating nursing facilities' Medicaid reimbursement rates for ancillary and support costs, eliminates the 3% adjustment applied to such costs of the nursing facility in each peer group that is at the 25th percentile of the rate for such costs.

- For purposes of calculating nursing facilities' Medicaid reimbursement rates for capital costs, (1) provides that a peer group's rate for capital costs is to be the capital costs for the nursing facility in the peer group that is at the 25th percentile of the rate for capital costs rather than the peer group's median rate, (2) eliminates a requirement that ODJFS use information about construction costs obtained from the Dodge Building Cost Indexes when calculating adjustments used in determining the rate for capital costs, and (3) prohibits ODJFS from redetermining a peer group's rate for capital costs based on additional information that it receives after the rate is determined and provides for ODJFS to make a redetermination only if it made an error in determining the rate based on information available at the time of the original determination.

- Eliminates the franchise permit fee price center, effective July 1, 2012.

- For purposes of calculating nursing facilities' quality incentive payments under the Medicaid program, (1) modifies how points are to be awarded in fiscal year 2012 under pre-existing accountability measures, (2) requires ODJFS to cease using the pre-existing accountability measures beginning in fiscal year 2013, and (3) provides for ODJFS, beginning in fiscal year 2013, to award each nursing facility points for meeting accountability measures in accordance with amendments to be made, not later than December 31, 2011, to state law governing quality incentive payments.

- For the purpose of determining a nursing facility's fiscal year 2012 Medicaid rate for direct care costs, provides for the nursing facility's semiannual case-mix score for the period beginning July 1, 2011, and ending January 1, 2012, to be the same as the

semiannual case-mix score used in calculating the nursing facility's June 30, 2011, rate for direct care costs.

- In determining nursing facilities' Medicaid reimbursement rates for fiscal year 2012, requires ODJFS to increase the cost per case-mix unit, rate for ancillary and support costs, rate for tax costs, and rate for capital costs by 5.08%.

- Provides for the per resident per day Medicaid rate paid for the franchise permit fee in fiscal year 2012 to be $11.47.

- In determining nursing facilities' quality incentive payments for fiscal year 2012, requires ODJFS to provide for the mean payment to be $3.03 per Medicaid day.

- For a nursing facility whose preliminary fiscal year 2012 rate is less than 90% of its fiscal year 2011 rate, establishes a stop loss mechanism that provides for the amount of the reduction to be less than what it otherwise would be.

- In determining nursing facilities' Medicaid reimbursement rates for fiscal year 2013, requires ODJFS to increase the cost per case-mix unit, rate for ancillary and support costs, rate for tax costs, and rate for capital costs by 5.08%.

- In determining nursing facilities' quality incentive payments for fiscal year 2013, provides for the maximum quality incentive payment to be $16.44 per Medicaid day.

- Sets the fiscal year 2013 Medicaid rate for nursing facility services provided to low resource utilization residents at $130 per Medicaid day.

- Specifies that a nursing facility is not to be paid more than 100%, rather than 109%, of the nursing facility's Medicaid per diem rate for services provided on or after January 1, 2012, to a dual eligible individual (i.e., an individual eligible for Medicaid and Medicare) who is eligible for nursing facility services under the Medicaid program and post-hospital extended care services under Medicare Part A.

- Permits the ODJFS Director to seek federal approval to create the Centers of Excellence program, the purpose of which is to increase the efficiency and quality of nursing facility services provided to Medicaid recipients with complex nursing facility service needs.

- Provides that the Medicaid reimbursement rate to reserve a bed in a nursing facility, for a day in calendar 2011, is not to exceed 50% of the nursing facility's regular per diem rate for that day and, for a day in calendar year 2012 and thereafter, is not to exceed (a) 50% of the nursing facility's regular per diem rate for that day if nursing facility had an occupancy rate of more than 90% in the preceding calendar year or

(b) 18% of the nursing facility's regular per diem rate for that day if nursing facility had an occupancy rate of 90% or less in the preceding calendar year.

- Repeals a provision that required ODJFS to prepare an annual report containing recommendations on the methodology that should be used to transition paying nursing facilities the Medicaid reimbursement rate for one fiscal year to the next.

- Permits ODJFS, if it determines that a nursing facility is experiencing or is likely to experience a serious financial loss or failure that jeopardizes or is likely to jeopardize the health, safety, and welfare of its residents, to appoint, subject to the provider's consent, a temporary resident safety assurance manager.

- Sets the rate for the franchise permit fee charged ICFs/MR at $17.99 for fiscal year 2012 and $18.32 for fiscal year 2013 and thereafter.

- Provides for the percentage that is used in determining whether the ICF/MR franchise permit fee must be reduced in order for the fee to comply with federal restrictions to change in accordance with the federal restrictions.

- Specifies that 81.77% of the money raised by the ICF/MR franchise permit fee and associated penalties for fiscal year 2012, and 82.2% of such money raised for fiscal year 2013 and thereafter, is to be deposited into the Home and Community-Based Services for the Mentally Retarded and Developmentally Disabled Fund.

- Continues to provide for the money raised by the ICF/MR franchise permit fee and associated penalties that is not deposited into the Home and Community-Based Services for the Mentally Retarded and Developmentally Disabled Fund to be deposited into the Department of Developmental Disabilities Operating and Services Fund.

- Provides for ODJFS, when determining inflation rates used in calculating Medicaid reimbursement rates for the direct care, indirect care, and other protected costs of ICFs/MR, to use a successor index if the index specified in statute ceases to be published.

- Eliminates a requirement that an ICF/MR refund to ODJFS the amount of excess depreciation paid to the ICF/MR under Medicaid if the ICF/MR is sold.

- For fiscal year 2012, requires ODJFS to determine modified rates and capped rates for existing ICFs/MR and provides for an existing ICF/MR to be paid a rate that is the average of its modified and capped rates unless the mean of such rates for all existing ICFs/MR is other than $282.59, in which case the ICF/MR's rate is to be

adjusted by a percentage that equals the percentage by which the mean rate is greater or less than $282.59.

- For fiscal year 2013, requires ODJFS to determine modified and capped rates for existing ICFs/MR and provides for an existing ICF/MR to be paid a rate that is the average of its modified and capped rates unless the mean of such rates for all existing ICFs/MR is other than $282.92, in which case the ICF/MR's rate is to be adjusted by a percentage that equals the percentage by which the mean rate is greater or less than $282.92.

- Requires ODJFS and the Ohio Department of Developmental Disabilities (ODODD) to conduct a study regarding Medicaid reimbursement rates for ICF/MR services and, at the same time they conduct the study, work with the Governor's Office of Health Transformation and persons interested in the issue of ICF/MR services to develop recommendations regarding various ICF/MR issues.

- Requires ODJFS to contract with ODODD for ODODD to assume ODJFS's powers and duties regarding the Medicaid program's coverage of ICF/MR services.

- Prohibits a nursing facility or ICF/MR from amending a Medicaid cost report if ODJFS has notified the facility or ICF/MR that an audit of the cost report or a cost report for a subsequent cost reporting period is to be conducted, but permits the facility or ICF/MR to provide ODJFS information that affects the costs included in the cost report.

- Provides that ODJFS is permitted, rather than required, to base a determination of whether to conduct an audit of the Medicaid cost report of a nursing facility or ICF/MR on the facility's or ICF/MR's prior performance.

- Requires ODJFS to revise certain requirements included in its manual for field audits.

- Requires ODJFS to fine a nursing facility if an audit report regarding a Medicaid cost report includes (1) adverse findings that exceed 3% of the total amount of Medicaid-reimbursable costs reported in the cost report or (2) adverse findings that exceed 20% of Medicaid-reimbursable costs for a particular cost center reported in the cost report.

- Specifies, for purposes of the law governing the collection of the Medicaid debts of nursing facilities and ICFs/MR, that a facility closure occurs when the building, or part of the building, that houses a nursing facility or ICF/MR converts to a different use, if any necessary license or other approval needed for that use is obtained and

one or more of the facility's residents remain in the facility to receive services under the new use.

- Requires nursing facilities and ICFs/MR that undergo a change of operator, close, or voluntarily cease to participate in Medicaid to use a method ODJFS specifies in rules when submitting certain notices, forms, and documents.

- Revises the list of information that a written notice of a change of operator must include.

- Revises the criteria used to determine when a Medicaid provider agreement with an entering operator following a change of operator goes into effect.

- Applies the Medicaid debt-collection process to nursing facilities and ICFs/MR that undergo an involuntary termination from Medicaid.

- Permits Medicaid payments to be made for nursing facility and ICF/MR services for up to 30 days after the effective date of an involuntary termination of the facility that provides the services if they are provided to a Medicaid recipient who is eligible for the services and resided in the facility before the effective date of the involuntary termination.

- Requires ODJFS, the Ohio Department of Aging (ODA), and ODODD to strive to have, by June 30, 2013, non-institutionally based long-term service used by (1) at least 50% of Medicaid recipients who are age 60 or older and need long-term services and (2) at least 60% of Medicaid recipients who are under age 60 and have cognitive or physical disabilities for which long-term services are needed.

- Permits ODJFS to apply to participate in the federal Balancing Incentive Payments Program and requires that any funds Ohio receives be deposited into the Balancing Incentive Payments Program Fund.

- Eliminates the Ohio Access Success Project eligibility requirement under which an applicant for Project benefits must need a nursing facility level of care.

- Specifies that an applicant must be able to remain in the community as a result of receiving the Project's benefits when it is being administered as a non-Medicaid program.

- Requires the ODJFS Director to assess an applicant's eligibility for participation in the Project regardless of how long the applicant has been a recipient of Medicaid-funded nursing facility services.

- Creates state-funded, non-Medicaid components of the PASSPORT and Assisted Living programs.

- Provides for individuals who have applications pending for the Medicaid-funded components of the PASSPORT and Assisted Living programs and meet other requirements to qualify for the state-funded components for up to three months.

- Provides that certain other individuals qualify for the state-funded component of the PASSPORT program for an unlimited number of months.

- Provides that the Home First processes for the PASSPORT and Assisted Living programs apply only to the Medicaid components of those programs.

- Eliminates the eligibility requirement for the Medicaid-funded component of the Assisted Living program under which an applicant had to be a nursing facility resident, residential care facility resident, or participant of the PASSPORT program, the Choices program, or an ODJFS-administered Medicaid waiver program.

- Provides for ODA to administer the Assisted Living program without the condition that the Director of the Office of Budget and Management (OBM) approve the contract between ODA and ODJFS regarding ODA's administration of the program.

- Provides that a requirement for ODA to establish a unified waiting list for the PASSPORT, Choices, Assisted Living, and PACE programs applies if ODA determines that there are insufficient funds to enroll all individuals who have applied and been determined eligible for the programs.

- Requires the ODA Director to contract with Miami University's Scripps Gerontology Center for an evaluation of the PACE program.

- Permits the ODA Director, in consultation with the ODJFS Director, to expand the PACE program to new regions of Ohio under certain circumstances.

- Codifies the Ohio Home Care and Ohio Transitions II Aging Carve-Out programs.

- Modifies the ODJFS Director's rulemaking authority regarding prioritizing and approving enrollment in Medicaid waivers for home and community-based services.

- Eliminates a requirement that ODJFS seek federal approval to obtain a federal Medicaid waiver to consolidate the PASSPORT, Choices, and Assisted Living programs into one Medicaid waiver program.

- Requires ODJFS, working with ODA, to seek federal approval for a unified long-term services and support Medicaid waiver program to provide home and

community-based services to eligible individuals of any age who require the level of care provided by nursing facilities.

- Requires ODJFS and ODA to work together to determine, on an individual program basis, whether the PASSPORT, Choices, Assisted Living, Ohio Home Care, and Ohio Transitions II Aging Carve-Out programs should continue to operate as separate Medicaid waiver programs or be terminated if the unified long-term services and support Medicaid waiver program is created.

- Eliminates a requirement that an individual be on ODA's unified waiting list to qualify for the PASSPORT, Assisted Living, or PACE program through the Home First process.

- Eliminates a requirement for ODA to make quarterly certifications to the OBM Director regarding the estimated increase in the costs of the PASSPORT, Assisted Living, and PACE programs resulting from enrollment of individuals through the Home First process.

- Establishes Home First processes for the Ohio Home Care Program and unified long-term services and support Medicaid waiver program.

- Repeals the requirement for ODJFS to create a pilot program under which up to 200 Medicaid recipients were to be given spending authority to pay for the cost of home and community-based services.

- Requires ODJFS to adopt rules establishing the amount of reimbursement or methods by which reimbursement is to be determined, in place of the previous statewide fee schedules, for home and community-based services provided to individuals with mental retardation and developmental disabilities through ODODD-administered Medicaid waiver programs.

- Permits an operator of an ICF/MR to convert some of the beds in the facility from providing ICF/MR services to providing home and community-based services under an ODODD-administered Medicaid waiver program, rather than requiring that all of the beds be converted.

- Permits ODJFS to seek federal approval for up to 200 (rather than 100) slots for home and community-based services provided and ODODD-administered Medicaid waiver programs for the purpose of the beds that convert from providing ICF/MR services to home and community-based services.

- Requires ODJFS to contract with ODODD for ODODD to administer the Transitions Developmental Disabilities Medicaid Waiver.

- Maintains the Money Follows the Person Enhanced Reimbursement Fund into which the OBM Director is to deposit the federal grant Ohio receives under the Money Follows the Person Demonstration Program.

- Permits the ODJFS Director to seek federal approval to implement a demonstration project to test and evaluate the integration of the care that dual eligible individuals receive under the Medicare and Medicaid programs.

- Creates the Integrated Care Delivery Systems Fund in the state treasury to receive amounts that the demonstration project saves the Medicare program if the terms of the project provide for Ohio to receive such amounts.

- Requires ODJFS to use the money in the Integrated Care Delivery Systems Fund to further develop integrated delivery systems and improved care coordination for dual eligible individuals.

- Creates the Joint Legislative Committee for Unified Long-Term Services and Supports.

- Permits the Committee to examine (1) implementing the dual eligible integrated care demonstration project, (2) implementing a unified long-term services and support Medicaid waiver component, (3) providing consumers choices regarding a continuum of services that meet their health-care needs, promote autonomy and independence, and improve quality of life, (4) ensuring that long-term care services and supports are delivered in a cost effective and quality manner, (5) subjecting county homes, county nursing homes, and district homes to the nursing home franchise permit fee, and (6) other issues of interest to the Committee.

- Abolishes the Children's Buy-In Program and establishes the following timeframes for concluding its affairs: (1) suspends new enrollments immediately, (2) repeals the applicable statutes on October 1, 2011, and (3) permits persons enrolled in the program when it is repealed to continue receiving services through December 31, 2011.

- Makes an individual injured while in active service as a member of the armed forces of the United States while serving in Operation New Dawn eligible for Military Injury Relief Fund grants.

VI. Unemployment Compensation

- Prohibits, effective October 30, 2011, an individual who performs services that significantly consist of seasonal employment from being paid unemployment compensation benefits for services performed in seasonal employment during the

period between two successive seasonal periods if there is reasonable assurance that the individual will be employed in the later of the seasonal periods.

- Eliminates the authority of the Unemployment Compensation Council with respect to the Unemployment Compensation Special Administrative Fund.

I. General

Audit authority and confidentiality of audit reports

(R.C. 5101.37)

The act authorizes the Ohio Department of Job and Family Services (ODJFS), a county department of job and family services (CDJFS), and a child support enforcement agency (CSEA) to conduct audits as necessary in furtherance of their duties. Associated with this authority, the act requires ODJFS and each CDJFS to keep a record of their audits. Under continuing law, ODJFS, a CDJFS, and a CSEA may make necessary investigations.

The act specifies that until an audit report is formally released by ODJFS, the report or any working paper or other document or record prepared by ODJFS and related to the audit that is the subject of the report is not a public record. This means that ODJFS must not make the audit report available for inspection or copying until it is formally released.

The act authorizes the ODJFS Director to adopt rules as necessary to implement the act's provisions discussed above. The rules must be adopted in accordance with R.C. 111.15 as if they were internal management rules. Internal management rules are not filed with the Joint Committee on Agency Rule Review (JCARR); therefore, they are not subject to a public hearing.[120]

Audit conferences

(R.C. 121.22)

The act adds to the list of exceptions from the Open Meetings (Sunshine) Law. An audit conference conducted by the audit staff of ODJFS with officials of the public office that is the subject of the audit is not required to be conducted in an open meeting.

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[120] Joint Committee on Agency Rule Review, *Procedures Manual* (revised Feb. 2011), available at <https://www.jcarr.state.oh.us/images/stories/manual.pdf>.

The Open Meetings Law generally requires public officials to take official action and to conduct deliberations upon official business only in open meetings. However, continuing law establishes various exceptions to the Open Meetings Law, which permit certain meetings, such as meetings of a grand jury or audit conferences conducted by the Auditor of State, to be closed to the public.

Transfer of money from Public Assistance Fund

(R.C. 5101.144 (not in the act), 5101.161 (not in the act), and 5705.14)

Continuing law prohibits the transfer of money from one county fund to another county fund except in specified circumstances. The Public Assistance Fund consists of funds appropriated by a board of county commissioners and money received from ODJFS for the state and federal share of the county's public assistance expenditures. The Children Services Fund consists of appropriations made by the board of county commissioners or any other source for the purpose of providing children services. Rules adopted by ODJFS authorize each county to establish a Child Support Enforcement Administrative Fund in the county treasury.

The act permits the transfer of money from the Public Assistance Fund to the Children Services Fund or the Child Support Enforcement Administrative Fund, as long as the money to be transferred may be spent for the purposes of the receiving fund.

County share of public assistance expenditures

(R.C. 5101.16)

Continuing law requires that each board of county commissioners pay each fiscal year a percentage of the costs of certain public assistance programs, including Ohio Works First and Medicaid. The act reduces to 105% (from 110%) the maximum amount that a county is required to pay, in comparison to the amount paid in the preceding fiscal year, for its share of public assistance expenditures.

Recovery of costs by county family service agencies

(R.C. 5101.183)

Under continuing law, the ODJFS Director may adopt rules requiring CDJFSs and public children services agencies (PCSAs) to take action to recover the costs of services provided to (1) persons who were not eligible to receive the services but who secured them through fraud or misrepresentation and (2) persons who were eligible for the services but intentionally diverted them to other persons ineligible to receive them.

The act extends to all county family services agencies ODJFS's authority adopt rules requiring that agencies take action to recover the cost of services provided to persons who secured them through fraud or misrepresentation or intentionally diverted services to ineligible persons. This means that CSEAs, in addition to CDJFSs and PCSAs, are subject to those rules.

The act expands ODJFS's rulemaking authority to recovering the cost of benefits, in addition to services, that are secured through fraud or misrepresentation or that were intentionally diverted. ODJFS also may adopt rules requiring a county family services agency to take action to recover the cost of any benefits or services provided by the agency if recovery is required or permitted by federal law. Any money recovered must be used to meet a family services duty (rather than the provision of social services), unless federal law requires ODJFS to return a portion of the money to the federal government.

Continuing law authorizes a CDJFS or PCSA to bring a civil action against a recipient to recover costs. The act extends to a CSEA the authority to bring such an action.

Recovering excess payments to counties

(R.C. 5101.244)

The act expands the actions ODJFS may take if it determines that a grant awarded to a county grantee in a grant agreement, an allocation, advance, or reimbursement ODJFS makes to a county family services agency, or a cash draw a county family services agency makes exceeds the allowable amount. Under continuing law, ODJFS may adjust, offset, withhold, or reduce an allocation, cash draw, advance, reimbursement, or other financial assistance to the county grantee or county family services agency as necessary to recover the excess amount.

In addition to or instead of the actions permitted under continuing law, the act permits ODJFS to take either or both of the following actions to collect the excess amount: (1) enter into an agreement with the county entity for the entity to repay the amount of the excess plus, at ODJFS's discretion, interest and (2) certify a claim to the Attorney General for collection.

Use of Title XX funds for local administrative costs

(R.C. 5101.46)

Under continuing law, ODJFS, the Ohio Department of Mental Health, and the Ohio Department of Developmental Disabilities, with their respective local agencies,

provide social services funded by Title XX of the Social Security Act, also known as the Social Services Block Grant. The act replaces the 14% limit on the amount of a local agency's Title XX funds that may be used for administrative costs with a requirement that each state department adopt rules establishing the maximum percentage. The percentage established by rule must comply with federal law. The rules are to be adopted in the manner provided for internal management rules (R.C. 111.15).

Ohio Commission on Fatherhood executive director and annual report

(R.C. 5101.341 and 5101.342)

Continuing law establishes the Ohio Commission on Fatherhood in ODJFS. The act requires the Governor to appoint the Commission's executive director. The executive director is to serve at the pleasure of the Governor and report to the ODJFS Director or the Director's designee. The act requires the Governor to set the executive director's salary, and the executive director is to be in the unclassified civil service.

The act requires the Commission to collaborate with the ODJFS Director in describing (1) its expectations for the outcomes of fatherhood-related programs and initiatives and (2) its methods for conducting annual measures of those outcomes. The Commission is to include this information its annual report.

Name of Food Stamp Program

(Section 309.40.20)

Under federal law, the name of the Food Stamp Program was changed to the Supplemental Nutrition Assistance Program (SNAP).[121] Am. Sub. H.B. 1 of the 128th General Assembly, the general appropriations act, made corresponding changes in state law.

Similar to H.B. 1's provisions regarding the SNAP name change, the act authorizes the ODJFS Director to refer to the program as the Food Stamp Program or the Food Assistance Program in ODJFS rules and documents. The act specifies that the Director is not required to amend rules regarding the Food Stamp Program to change the name of the program.

[121] The Food, Conservation, and Energy Act of 2008 (Pub. Law 110-246).

II. Child Care

Payment for publicly funded child care

State contracts in place of county contracts

(R.C. 5104.32 (primary), 5104.34, 5104.341, 5104.35, 5104.37, 5104.38, 5104.39, 5104.42, and 5104.43)

Under prior law, all purchases of publicly funded child care were to be made under contracts between the child care provider and the CDJFS. A contract had to specify that the provider agreed to be paid at the lowest of the rate customarily charged for children enrolled for child care, the reimbursement ceiling established by ODJFS by rule, or a rate the CDJFS negotiated with the provider.

The act eliminates provisions under which CDJFSs could contract with and reimburse providers of publicly funded child care and all provisions related to CDJFSs performing that function. In place of these provisions, the act provides that purchases of publicly funded child care are made pursuant to contracts between the provider and ODJFS. A contract must specify that the provider agrees to be paid at the lower of the rate customarily charged for children enrolled for child care or the reimbursement ceiling ODJFS establishes by rule.

Reinstatement of publicly funded child care

(R.C. 5104.38(A))

The act permits the ODJFS Director to adopt rules specifying exceptions to ongoing rules that detail procedures and criteria to be used when making certain eligibility determinations for publicly funded child care. The new rules may specify exceptions to the eligibility requirements in the case of a family that previously received publicly funded child care and is seeking to have the child care reinstated after the family's eligibility was terminated.

Child care during pre-work activities

(R.C. 5104.35 and 5104.38(M))

To the extent permitted by federal law, the act requires that ODJFS adopt a rule under which ODJFS, rather than a CDJFS, may pay for child care for up to 30 days for a child whose parent is seeking employment, participating in orientation activities, or taking part in other activities in anticipation of enrollment or attendance in an education or training program.

Rates for special needs children

(R.C. 5104.35 and 5104.38(L))

Under the act, if the ODJFS Director establishes a different reimbursement ceiling for child care provided to special needs children, ODJFS must adopt rules establishing standards and procedures for determining the amount of the higher payment. This is in place of a CDJFS's authority under prior law to request a waiver of the reimbursement ceiling in the case of a special needs child.

Monitoring child care expenditures

(R.C. 5104.39)

Under continuing law, the ODJFS Director is required to establish a procedure for monitoring expenditures to ensure that they do not exceed the available federal and state funds for publicly funded child care. When ODJFS determines that anticipated future expenditures will exceed available funds, it must issue an administrative order that specifies priorities for spending the remaining funds and instructions and procedures to be used by the CDJFS. The order may also suspend enrollment, limit enrollment, or disenroll existing participants.

The act retains these procedures in the context of ODJFS's administration of the program. In addition, it provides that the administrative order may change (1) the schedule of fees paid by eligible caretaker parents and (2) the rate of payment to providers.

Prohibition on obtaining child care from multiple providers

(R.C. 5104.34 and 5104.38)

Prior law contained no restrictions regarding the number of child care providers from whom an eligible caretaker parent may receive publicly funded child care. The act prohibits a caretaker parent from receiving full-time publicly funded child care from more than one provider per child.

Step Up to Quality incentives

(R.C. 5104.30)

ODJFS is required by continuing law to establish a voluntary child day-care center quality-rating program. ODJFS has implemented this requirement by establishing the Step Up to Quality Program. The act requires that, in establishing reimbursement ceilings for publicly funded child care, ODJFS must establish enhanced

reimbursement ceilings for child day-care centers that participate in the Program and maintain quality ratings under the Program. The act requires ODJFS to weigh any reduction in reimbursement ceilings more heavily against child day-care providers that do not participate in Step Up to Quality or do not maintain quality ratings.

Swipe card pilot program

(Section 309.40.70)

ODJFS has entered into a contract for the development and implementation of Ohio Electronic Child Care (ECC). According to ODJFS, ECC will allow child care providers to track the attendance of publicly funded children in their care by requiring caretakers to record attendance using a swipe card to check children in and out of care.

The act provides that, if ODJFS implements a program that uses a swipe card system and point-of-service device to track attendance and submit invoices for payment for publicly funded child care, (1) misuse of the system by a provider participating in the program is a reason for which the provider's license or certification may be subject to revocation and (2) misuse of the system by a caretaker parent participating in the program is a reason for which the parent may lose eligibility for publicly funded child care.

Child care licensing

Continuous licensure of child day-care centers and type A homes

(R.C. 5104.04 (primary), 5104.011, 5104.012, 5104.013, 5104.03, 5104.05, and 5104.99)

Prior law required that a child care center or type A family day-care home license be renewed every two years. The act eliminates this requirement. It also eliminates corresponding provisions related to the renewal process.

If a license is revoked, prior law required the center or type A home to wait two years before applying for another license. The act extends the waiting period to five years. It also prohibits the ODJFS Director from issuing a license if the owner's application for a license has been denied within five years.

Under continuing law, a center or type A home is initially issued a provisional license. The act increases to one year (from six months) the period during which a provisional license is valid.

Licensure enforcement

(R.C. 5104.04)

The act eliminates the requirements that ODJFS (1) notify a child day-care center or type A family day-care home that it has determined, pursuant to an inspection or investigation, is out of compliance with the laws governing centers and homes, and (2) provide the notice in writing and describe the nature of the violation, what must be done to correct the violation, and by what date the correction must be made. The act eliminates a related provision that expressly authorized ODJFS to commence a license revocation action if the correction has not been made.

License capacity in relation to staff

(R.C. 5104.01(AA) and 5104.03)

The act eliminates the requirement that the ODJFS Director consider the number of available child-care staff members when determining "license capacity" for the licensure of child day-care centers or type A family day-care homes. However, the act retains this requirement for when the Director issues the initial provisional day-care license to a center or home.

Staff ratios while toddlers or preschool children are napping

(R.C. 5104.011(E)(2))

The act increases to 2 (from 1.5) the number of hours during a 24-hour day that the number of napping toddlers or preschool children per child-care center staff member may be twice the number of children per staff member otherwise allowed. The center must still meet the following requirements: (1) have at least one staff member present in the room, (2) have sufficient staff on the center's premises, and (3) have naptime preparations complete and all napping children resting or sleeping on cots.

Child day-care center administrator qualifications

(R.C. 5104.011(B)(4))

The act establishes a method by which a person seeking to be a child day-care center administrator may meet educational requirements by showing the ODJFS Director evidence that the person holds a high school diploma and a designation as an "early childhood professional level three" under the Step Up to Quality Program's career pathways model.[122] The career pathways model is defined by the act as an

[122] The Step Up to Quality Program is established by rule (O.A.C. Chapter 5101:2-17).

alternative pathway to meeting the requirements for a child care staff member or administrator that uses one framework to integrate the pathways of formal education, training, experience, and specialized credentials, and certifications, and that allows the member or administrator to achieve a designation as an early childhood professional level one, two, three, four, five, or six.

Under the act's method of meeting educational requirements, any administrator employed or designated as such on or after September 29, 2011 (the act's 90-day effective date) must show evidence of at least one of the following not later than one year after the date of employment or designation:

(1) Two years of experience working as a child-care staff member in a center and at least four courses in child development or early childhood education from an accredited college, university, or technical college, except that a person who has two years of experience working as a child-care staff member in a particular center and who has been promoted to or designated as administrator of that center may have one year from the time the person was promoted to or designated as administrator to complete the required four courses;

(2) Two years of training, including at least four courses in child development or early childhood education from an accredited college, university, or technical college;

(3) A child development associate credential issued by the National Child Development Associate Credentialing Commission;

(4) An associate or higher degree in child development or early childhood education from an accredited college, technical college, or university, or a license designated for teaching in an associate teaching position in a preschool setting issued by the State Board of Education;

(5) An administrator's credential as approved by ODJFS.

The act permits any administrator employed or designated as such *prior* to September 29, 2011, to show evidence of an administrator's credential as approved by ODJFS in lieu of, or in addition to, the educational requirements that otherwise apply under continuing law. The evidence of an administrator's credential must be shown to the ODJFS Director no later than one year after the date of employment or designation.

Educational requirements for child day-care staff

(R.C. 5104.011(B)(5)(b))

With limited exceptions, all child-care staff members of a child day-care center are required to have (1) graduated from high school, (2) a certification of high school equivalency, or (3) completed a training program approved by ODJFS or the State Board of Education. The act exempts from those educational requirements staff members who are receiving or have completed the final year of instruction at home or who have graduated from a charter school.

Reference checks of license applicants and employees

(R.C. 5104.011(A)(16) and (F)(16))

The act eliminates the requirements that the ODJFS Director adopt rules to be used for checking the references of child day-care center and type A family day-care home license applicants and potential employees.

Course requirements for child day-care center staff members

(R.C. 5104.011(C)(1))

The act permits a child day-care center to have on the center premises and readily available a separate staff member who has completed a course in prevention, recognition, and management of communicable diseases approved by the Department of Health, rather than a staff member who has completed both this course *and* a course in first aid. (The center must still have a staff member who has completed a course in first aid).

Physical examinations and immunizations

(R.C. 5104.011(A)(5))

With regard to the ongoing requirement that the ODJFS Director adopt rules establishing procedures for screening children and employees of child day-care centers, the act specifies that the rules may, rather than must, include requirements for physical examinations and immunizations.

Copy of child care licensure requirements

(R.C. 5104.03)

Continuing law requires the ODJFS Director to provide each applicant for a child day-care center or type A family day-care home license a copy of the licensure

requirements and rules governing child care. The act permits the Director to provide the copy in paper or electronic form.

Publication of type B family day-care homes guide

(R.C. 5104.13)

The act permits, rather than requires, that ODJFS publish a guide describing the laws governing the certification of type B family day-care homes. ODJFS may publish the guide electronically or otherwise. ODJFS must do so in such a manner that the guide is accessible to the public, including type B home providers. The act eliminates the requirement that ODJFS distribute the guide to CDJFSs in sufficient number that a copy is available to each type B home provider.

Child day-care center rosters and contact lists

(R.C. 5104.011(B)(7))

The act eliminates the requirement that each child day-care center administrator prepare and distribute at least annually a roster of the names and telephone numbers of parents, custodians, or guardians of each group of children attending the center. On request, the administrator was required to furnish the roster for each group to the parents, custodians, or guardians of the children in that group. Similarly, the act eliminates the authority of an administrator to prepare a roster of names and telephone numbers of *all* the parents, custodians, or guardians. The act eliminates the related prohibitions against (1) including in any roster the name or telephone number of any parent, custodian, or guardian who requested not to be included and (2) furnishing any roster to any person other than a parent, custodian, or guardian of a child attending the center.

Sanctions for violating laws governing child care

(R.C. 5104.011(J)(5) (primary) and 5104.01(OO))

The act permits the ODJFS Director to adopt rules in accordance with the Administrative Procedure Act regarding sanctions to be imposed on persons or entities violating the laws governing child care. This replaces a requirement that the Director recommend standards for imposing sanctions and provide copies of the recommendations to the Governor and General Assembly regarding sanctions.

The sanctions adopted pursuant to rule may be imposed only for a serious risk noncompliance violation of licensure or certification standards. A serious risk noncompliance violation means a licensure or certification standard violation that leads

to the greatest risk of permanent harm to, or death of, a child and is observable, not inferable.

The act requires the ODJFS Director to make a dispute resolution process available for the implementation of sanctions. The process may include an opportunity for appeal under the Administrative Procedure Act.

Incentives for substantial compliance with licensure or certification standards

(R.C. 5104.011(J)(6))

The act requires the ODJFS Director to adopt rules establishing incentives for persons and entities that are licensed or certified to provide child care and have a history of substantial compliance with licensure or certification standards. The incentives must at least include less frequent or focused licensure or certification visits, participation in the Step Up to Quality rating program, and scholarships for training.

III. Child Support

Child Support Custodial Fund

(R.C. 3121.48, 3121.03 (not in the act), and 3121.19 (not in the act))

Payors and financial institutions that withhold or deduct money pursuant to a child support order are required to forward that money to the Office of Child Support in ODJFS within seven business days. Prior law required the Office of Child Support to maintain a separate account for the deposit of support payments it received as trustee for persons entitled to receive the support payments. The act requires instead that the Office of Child Support administer a fund for the deposit of those payments. The Treasurer of State is the custodian of the fund, but the fund is not to be part of the state treasury.

License suspension procedures for defaulting child support obligors

(R.C. 3123.44, 3123.45, 3123.55, 3123.56, 3123.58, 3123.59, 3123.591, 3123.63, 4506.071, 4507.111, 4705.021, 3123.52 (repealed), 3123.61 (repealed), 3123.612 (repealed), 3123.613 (repealed), and 3123.614 (repealed))

Ohio and federal law require the occupational, professional, motor vehicle, or recreational license or permit of an obligor found in default under a child support order to be denied or suspended, or not be issued or renewed, at the request of a child support enforcement agency (CSEA). "Default" means any failure to pay an amount equal to or greater than the amount payable for one month under a child support order. When a CSEA identifies a default, it investigates and then sends a default notice

containing information on the arrearage and the administrative and court action that will take place if the obligor contests the information in the default notice. When the obligor exhausts the ability to contest the information in the default notice, the default becomes final and enforceable. These licenses also may not be issued or renewed and may be suspended or revoked if the obligor fails to comply with a subpoena or warrant issued by the court or a CSEA with respect to a proceeding to enforce a child support order. The license may not be issued or renewed and must remain suspended or revoked until the obligor complies with the child support order, subpoena, or warrant.

The act prohibits a CSEA from notifying an occupational or professional licensing board, the Bureau of Motor Vehicles (BMV), or the Division of Wildlife that an obligor is in default unless at least 90 days have elapsed since the final and enforceable determination of default, and, in the preceding 90 days, the obligor has failed to pay at least 50% of the total monthly obligation due for that period by means other than federal or state tax refund intercept. It requires ODJFS to adopt rules establishing a uniform pre-suspension notice form to be used by CSEAs that send notice to occupational or professional licensing boards, the BMV, or the Division of Wildlife. The rules must require the contents of the notice to include information about the effect of a license suspension and appropriate steps that an obligor can take to avoid license suspension.

Under continuing law, a CSEA that notifies an occupational or professional licensing board, the BMV, or the Division of Wildlife that an obligor is in default must send another notice that the obligor is not in default within seven days of certain specified events. Under prior law, the notice was required to be sent if (a) the obligor made full payment of the arrearage, (b) an appropriate withholding or deduction notice or other order was issued to collect current support and the arrearage and the obligor was complying with the notice or order, or (c) a new child support order was issued or the order that was in default was modified to collect current support and the arrearage.

The act alters the circumstances under which the notice must be sent. Under the act, the CSEA must send the notice if one of the following occurs:

(1) The obligor makes full payment of the arrearage as of the date the payment is made;

(2) If (1) is not possible, the obligor has presented the CSEA sufficient evidence of current employment or of an account in a financial institution, confirmed by the CSEA, and a withholding or deduction notice has been issued to collect current support and any arrearage (the ODJFS Director must adopt rules establishing standards for confirming the obligor's employment or the existence of the account);

(3) If (1) and (2) are not possible, the obligor presents evidence to the CSEA sufficient to establish that the obligor is unable to work due to circumstances beyond the obligor's control;

(4) If (1), (2), and (3) are not possible, the obligor enters into and complies with a written agreement with the CSEA requiring the obligor to comply with a family support program administered or approved by the CSEA or a program to establish compliance with a seek work order issued; or

(5) If (1), (2), (3), and (4) are not possible, the obligor pays the balance of the total monthly obligation due for the 90-day period preceding the date the agency sent notice to the occupational or professional licensing board, BMV, or Division of Wildlife that the obligor is in default.

The act also permits a CSEA, pursuant to rules adopted by the ODJFS Director, to direct the Registrar of Motor Vehicles to eliminate from the abstract maintained by the BMV any reference to the suspension of an obligor's license due to default.

IV. Child Welfare and Adoption

Case plan or family service plan for child receiving in-home services from a PCSA

(R.C. 2151.011(B)(4) and 2151.412(B) and (C)(2))

The act requires each public children services agency (PCSA) to prepare and maintain a case plan or a family service plan for any child receiving in-home services from the agency pursuant to an alternative response. An "alternative response" is a PCSA's response to a report of child abuse or neglect that engages the family in a comprehensive evaluation of child safety, risk of subsequent harm, and family strengths and needs. It does not include a determination as to whether child abuse or neglect has occurred. The act also requires that the rules adopted pursuant to R.C. Chapter 119. requiring PCSAs to maintain case plans for children and their families who are receiving services in their homes from the agencies and for whom case plans are not otherwise required (continuing law) must include the requirements for case plans or family service plans maintained for children and their families who are receiving services in their homes from PCSAs pursuant to an alternative response. PCSAs must maintain case plans and family service plans as required by those rules; however, the case plans and family service plans are not subject to any other provision of the law regarding case plans except as specifically required by the rules.

Use of the investigative assessment response and the family assessment response

(R.C. 2151.011(B)(16) and (56) and 2151.429)

Under the act, the differential response approach pursued by a PCSA must include two pathways, the traditional response pathway and the alternative assessment response pathway. The ODJFS Director must adopt rules pursuant to R.C. Ch. 119. setting forth the procedures and criteria for PCSAs to assign and reassign response pathways.

The PCSA must use the traditional response for the following types of accepted reports: (1) physical abuse resulting in serious injury or that creates a serious and immediate risk to a child's health and safety, (2) sexual abuse, (3) child fatality, (4) reports requiring a specialized assessment as identified by rule adopted by ODJFS, and (5) reports requiring a third party investigative procedure as identified by rule adopted by ODJFS.

For all other child abuse and neglect reports, an alternative response is the preferred response, whenever appropriate and in accordance with rules adopted by ODJFS.

"Differential response approach" means an approach that a PCSA may use to respond to accepted reports of child abuse or neglect with either an alternative response or a traditional response. "Traditional response" means a PCSA response to a report of child abuse or neglect that encourages engagement of the family in a comprehensive evaluation of the child's current and future safety needs and a fact-finding process to determine whether child abuse or neglect occurred and the circumstances surrounding the alleged harm or risk of harm.

Investigations by a PCSA

(R.C. 2151.421(O); cross-reference changes in 2151.424 and 2152.72)

Continuing law generally requires a PCSA to investigate, within 24 hours, each report of child abuse or child neglect that is known or reasonably suspected or believed to have occurred and of a threat of child abuse or child neglect that is known or reasonably suspected or believed to exist that is referred to in R.C. 2151.421 to determine the circumstances surrounding the injuries, abuse, or neglect, the cause of the injuries, abuse, neglect, or threat, and the person or persons responsible. The investigation is made in cooperation with the law enforcement agency and in accordance with the prepared memorandum of understanding. The act defines

"investigation" as the PCSA's response to an accepted report of child abuse or neglect through either an alternative response or a traditional response.

Statewide expansion of the Ohio Alternative Response Pilot Program

(Section 309.50.10)

The biennial budget act of the 128th General Assembly, Am. Sub. H.B. 1, required ODJFS to implement a pilot program in not more than ten counties based on an "alternative response" approach to reports of child abuse, neglect, and dependency. ODJFS was required to assure that the pilot program be independently evaluated and was permitted, if the evaluation recommended statewide implementation of an alternative response approach to child protection, to expand the approach statewide.

The act requires that ODJFS, in accordance with the evaluation of the Ohio Alternative Response Pilot Program, plan the statewide expansion of the pilot program on a county by county basis, through a schedule ODJFS is to determine. The program is to be known as the differential response approach. The act's provisions regarding differential response, traditional response, and alternative response are to become effective for a county in accordance with ODJFS's schedule. ODJFS is permitted to adopt rules in accordance with the Administrative Procedure Act (R.C. Chapter 119.) before the statewide implementation as necessary to carry out its duties regarding the expansion.

Children's Trust Fund Board

(R.C. 3109.16)

Continuing law generally requires certain additional fees collected (1) for copies of birth records, birth certificates, and death certificates, and (2) upon filing a divorce decree to be forwarded to the Children's Trust Fund, a fund in the state treasury. This money is used by the Children's Trust Fund Board to develop and carry out a biennial state plan for comprehensive child abuse and child neglect prevention. The Board is authorized to obtain other funds, which also are deposited into the Children's Trust Fund. For example, the Board may accept gifts and donations from any source and may apply for and accept federal and other funds for the purpose of funding child abuse and child neglect prevention programs.

The act authorizes the Board to not only accept gifts and donations, but also solicit them. In addition, the act permits the Board to solicit and accept money. The act specifies that the Board may solicit and accept the gifts, money, and other donations from any public or private source.

The act authorizes the Board to develop private-public partnerships. The partnerships are to be developed to support the mission of the Children's Trust Fund.

Consistent with continuing law pertaining to the acceptance and use of federal funds, the act specifies that the Board's acceptance or use of any other funds does not entail any commitment or pledge of state funds, nor obligate the General Assembly to continue the programs or activities for which the funds are made available.

Continuing law authorizes ODJFS to adopt administrative rules for the purpose of providing budgetary, procurement, accounting, and other related management functions for the Board. The act permits the Board to request that ODJFS adopt rules the Board considers necessary for the purpose of carrying out the Board's responsibilities. It also authorizes ODJFS to adopt any other rules to assist the Board in carrying out its responsibilities.

V. Health Programs (Including Medicaid)

Health Care Special Activities Fund

(R.C. 5111.945)

The act creates in the state treasury the Health Care Special Activities Fund. ODJFS is required to deposit all funds it receives pursuant to the administration of the Medicaid program into the Fund, other than any funds that are required by law to be deposited into another fund. ODJFS must use the money in the Fund to pay for expenses related to services provided under, and the administration of, the Medicaid program.

Eligibility determinations for Medicaid and CHIP

(R.C. 5101.47 and 5111.012)

Continuing law generally authorizes ODJFS to accept applications and determine eligibility for Medicaid and the Children's Health Insurance Program (CHIP).[123] The act permits ODJFS, to the extent permitted by federal law, to enter into agreements with one or more other state agencies, local government entities, or political subdivisions to

[123] CHIP is a health-care program for uninsured, low-income children under age 19. It is funded with federal, state, and county funds and was established by Congress in 1997 as Title XXI of the Social Security Act. ODJFS has chosen to implement CHIP as part of the Medicaid program. State law provides for CHIP to have three parts. Part I covers children with family incomes not exceeding 150% of the federal poverty guidelines. Part II covers children with family incomes above 150% but not exceeding 200% of the federal poverty guidelines. Part III, which has not been implemented, is to cover children with family incomes above 200% but not exceeding 300% of the federal poverty guidelines.

accept applications, determine and redetermine eligibility, and perform related administrative functions regarding Medicaid and CHIP.

If ODJFS enters into such an agreement with a county department of job and family services (CDJFS), the CDJFS is permitted to establish Medicaid eligibility only if authorized under the agreement. Prior law required each CDJFS to establish Medicaid for persons living in the county.

Waiver for transferring assets for less than fair market value

(R.C. 5111.0116 (primary) and 5111.011)

The act revises the law governing exceptions to the requirement that an institutionalized individual temporarily be denied Medicaid eligibility for nursing facility services, nursing facility equivalent services, and home and community-based services if the individual or individual's spouse disposes of assets for less than fair market value on or after a date known as the "look-back date." Under continuing law, the look-back date is the date that is a number of months (as specified in ODJFS rules) immediately before (1) the date an individual becomes an institutionalized individual if the individual is eligible for Medicaid on that date or (2) the date an individual applies for Medicaid while an institutionalized individual. An institutionalized individual is a resident of a nursing facility, an inpatient in a medical institution for whom a payment is made based on a level of care provided in a nursing facility, or an individual receiving home and community-based services under a federal Medicaid waiver.

Prior to the act, exceptions to the temporary ineligibility that otherwise occurs when assets are transferred for less than fair market value on or after the look-back date were not included in statute. Instead, prior law required ODJFS to adopt rules establishing exceptions. The act specifies the following two exceptions in statute:

--**Undue hardship**: An institutionalized individual may be granted a waiver of all or part of the temporary ineligibility if the ineligibility would cause an undue hardship for the individual. "Undue hardship" is defined as being deprived of (1) medical care such that an individual's health or life is endangered or (2) food, clothing, shelter, or other necessities of life.

--**Transfer or discharge for failure to pay**: An individual must be granted a waiver of all or a part of the temporary ineligibility if the administrator of the nursing facility in which the individual resides has notified the individual of a proposed transfer or discharge from the facility due to failure to pay for the care the facility has provided to the individual, the individual or the individual's sponsor requests a hearing on the proposed transfer or discharge, and the transfer or discharge is upheld by a final determination that is not subject to further appeal.

The ODJFS Director is to adopt rules establishing procedures for granting the waivers described above. The act also requires the Director to adopt rules establishing additional reasons for which waivers of the temporary ineligibility may be granted.

Presumptive eligibility for children and pregnant women

(R.C. 5111.0124 (primary), 5111.013, and 5111.0125)

Federal law permits states to implement options regarding presumptive Medicaid eligibility for children and pregnant women. Under the options, a state may make certain Medicaid services available to a child or pregnant woman during a presumptive eligibility period. This period begins on the date a qualified entity or provider determines, based on preliminary information, that the family income of the child or pregnant woman does not exceed the state's applicable eligibility limit and ends on the earlier of (1) the day a Medicaid eligibility determination is made or (2) the last day of the month following the month the eligibility determination is made if a Medicaid application is not filed by that day.

Prior to the act, the ODJFS Director adopted a rule to implement the presumptive eligibility for children option but not the presumptive eligibility for pregnant women option. The rule as in effect July 1, 2011, provides that only CDJFS may serve as qualified entities.[124]

The act requires the ODJFS Director to retain the presumptive eligibility for children option that was included in the Medicaid state plan prior to the act and to submit a Medicaid state plan amendment to the U.S. Secretary of Health and Human Services to implement the presumptive eligibility for pregnant women option.

The act eliminates a requirement that the ODJFS Director do either of the following:

(1) To the extent that federal funds are provided, adopt a plan for granting presumptive eligibility for pregnant women applying for the Healthy Start component of Medicaid;

(2) To the extent permitted by federal Medicaid regulations, adopt a plan for making same day eligibility determinations for pregnant women applying for Healthy Start.

[124] O.A.C. 5101:1-38-40.

Eligibility determinations by qualified providers and entities

The act requires the ODJFS Director to provide for children's hospitals, federally qualified health centers, and federally qualified health center look-alikes, if they are eligible to be qualified providers or entities under federal law and request to serve in that capacity, to serve as qualified providers and entities for purposes of the presumptive eligibility for children and pregnant women options. The act permits the ODJFS Director to provide for other types of providers and entities to be qualified providers and entities if they are eligible and request to serve. Under federal law, qualified providers and entities may make presumptive eligibility determinations.

Implementation date

The ODJFS Director is to begin implementing the presumptive eligibility for pregnant women option and the provisions regarding qualified providers and entities on the later of April 1, 2012, or a date that is not later than 90 days after the effective date of the federal approval needed to implement the option and provisions.

Treatment of trusts for Medicaid eligibility determinations

When the statute may be applied

(R.C. 5111.151(A))

Regarding a provision of law governing how a trust must be treated for purposes of determining Medicaid eligibility, the act specifies that the provision may be used only for either of the following: (1) an initial eligibility determination for Medicaid made by ODJFS or a CDJFS, or (2) an appeal from an initial eligibility determination made by ODJFS or a CDJFS. The act expressly prohibits a court from using the provision to determine the effect of a trust on an individual's initial eligibility for Medicaid, but specifies that this prohibition does not apply when the court considers an appeal from an initial eligibility determination.

Resources and income available under a trust

(R.C. 5111.151(C); conforming changes in R.C. 5111.151(D), (F), and (G))

When a Medicaid applicant or recipient is a recipient of a trust, continuing law requires a CDJFS to determine what type of trust it is and to treat the trust in accordance with the provision, described above, governing how trusts must be treated for purposes of determining Medicaid eligibility. Relative to this responsibility, the act requires the CDJFS to determine that the trust or a portion of it (1) is a resource available to the applicant or recipient, (2) contains income available to the applicant or recipient, (3) constitutes both a resource available to the applicant or recipient or

contains income available to the applicant or recipient, or (4) neither is a resource available to the applicant or recipient nor contains income available to the applicant or recipient. Prior law referred to a resource available to the applicant or recipient as a "countable resource" and a trust that contained income available to the applicant or recipient as "countable income."

The act expressly requires that a trust or a portion of a trust that is a resource available to the applicant or recipient or that contains income available to the applicant or recipient must be counted for purposes of determining Medicaid eligibility. This requirement does not, however, apply to principal or income from a special needs trust, qualifying income trust, pooled trust, or supplemental services trust.[125]

Compliance with federal maintenance of effort requirement

(R.C. 5111.0122)

Except to the extent, if any, otherwise authorized by the U.S. Secretary of Health and Human Services, ODJFS is required by the act to comply with the federal maintenance of effort (MOE) requirement regarding Medicaid eligibility standards, methodologies, and procedures while the requirement is in effect. The MOE requirement is part of the Patient Protection and Affordable Care Act (federal health care reform).[126] Generally, a state violates the MOE requirement if it has eligibility standards, methodologies, or procedures under its Medicaid state plan or a Medicaid waiver that are more restrictive than those in effect on March 23, 2010. The MOE requirement for adults continues until the U.S. Secretary determines that the state's American Health Benefit Exchange is fully operational.[127] January 1, 2014, is the deadline for states to establish such exchanges. The MOE requirement for children continues until October 1, 2019. A state that violates the MOE requirement is to lose all

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[125] A special needs trust is a trust to benefit an individual with a mental or physical disability who has not reached the age of 65. A qualifying income trust is a trust that is composed only of pension, social security, and other income to the beneficiary. A pooled trust is a special arrangement with a nonprofit organization that serves as the trustee to manage assets belonging to many disabled individuals (with investments being pooled), but with separate trust "accounts" being maintained for each disabled individual. A supplemental services trust is a trust to benefit individuals with a mental or physical disability who are eligible to receive services through the Ohio Department of Developmental Disabilities, a county board of developmental disabilities, the Ohio Department of Mental Health, or a board of alcohol, drug addiction, and mental health services.

[126] Section 2001(b) of the Patient Protection and Affordable Care Act (Public Law 111-148).

[127] An American Health Benefit Exchange is to be a governmental agency or nonprofit entity established by a state to make qualified health plans available to individuals and employers (Section 1311 of the Patient Protection and Affordable Care Act).

federal funds for the state's Medicaid program for the duration of the MOE requirement.

Reduction of complexity in Medicaid eligibility determination processes

(R.C. 5111.0123)

The act requires the ODJFS Director to adopt rules to reduce the complexity of the eligibility determination processes for the Medicaid program caused by the different income and resource standards for the numerous Medicaid eligibility categories. Before implementing a revision to an eligibility determination process, the ODJFS Director must obtain, to the extent necessary, the approval of the U.S. Secretary of Health and Human Services in the form of a federal Medicaid waiver, Medicaid state plan amendment, or demonstration grant. In implementing any revisions, ODJFS must comply with the act's requirement regarding the federal maintenance of effort requirement.

Audits of medical assistance recipients

(R.C. 5101.181 and 5101.28; conforming changes in R.C. 145.27, 742.41, 3307.20, 3309.22, 4123.27, and 5505.04)

The act repeals provisions that required the State Auditor to determine whether overpayments were made on behalf of every medical assistance recipient. In place of those provisions, the act authorizes the Auditor, on the request of the ODJFS Director, to conduct an audit of an individual who receives medical assistance.[128] If the Auditor decides to conduct an audit, the act requires the Auditor to enter into an interagency agreement with ODJFS that specifies that the Auditor agrees to comply with the act's provisions governing the confidentiality of medical assistance recipient information (see "**Disclosure of information regarding medical assistance recipients**," below).

Determining other public assistance overpayments

The act does not similarly authorize the Auditor to conduct an audit of an individual public assistance recipient[129] on the ODJFS Director's request. Rather, law largely retained by the act requires the Auditor to determine overpayments to public

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[128] The act defines "medical assistance" as medical assistance provided pursuant to, or under programs established by, the Refugee Act of 1980, the Children's Health Insurance Program, the Medicaid program, or any other provision of Ohio law (R.C. 5101.181(A)(2)).

[129] The act defines "public assistance" as Ohio Works First; Prevention, Retention, and Contingency; disability financial assistance; and general assistance provided before the program was abolished July 17, 1995.

assistance recipients. The only change relative to investigating overpayments to public assistance recipients is that the act authorizes (rather than requires) the ODJFS Director to (1) furnish quarterly the name and social security number of each public assistance recipient to the Director of Administrative Services, the Administrator of the Bureau of Workers' Compensation, and each of the state's retirement boards, and (2) furnish semiannually the name and social security number of each public assistant recipient to the Tax Commissioner.

Disclosure of information regarding medical assistance recipients

When disclosure is prohibited or permitted

(R.C. 5101.26, new 5101.271, and 5101.273)

The act repeals provisions governing ODJFS's or a CDJFS's use or disclosure of information about a medical assistance recipient and replaces them with new provisions. Under the act, ODJFS or a CDJFS is generally prohibited from using or disclosing information regarding a medical assistance recipient for any purpose not directly connected with the administration of the medical assistance program (this provision is substantially similar to one in former law). The act specifies that both of the following *are* considered to be purposes directly connected with the administration of the medical assistance program: (1) treatment, payment, or other operations or activities authorized by federal regulations, and (2) any administrative function or duty ODJFS performs alone or jointly with a federal government entity, another state government entity, or a local government entity implementing a provision of federal law.

The act provides for exceptions to the general prohibition on the use and disclosure of medical assistance recipient information. First, ODJFS may disclose information regarding a medical assistance recipient to any of the following persons:

(1) The recipient or the recipient's authorized representative;

(2) The recipient's legal guardian;

(3) The recipient's attorney, if ODJFS or a CDJFS has obtained authorization from the recipient, the recipient's authorized representative, or the recipient's legal guardian that meets all requirements of the Health Insurance Portability and Accountability Act (HIPAA), regulations promulgated to implement HIPAA, the act's requirements governing authorization, and rules the act requires the ODJFS Director to adopt;

(4) A health information or health records management entity, if the entity has executed with ODJFS a business associate agreement required by a provision of the HIPAA Privacy Rule[130] and has been authorized by the recipient, the recipient's authorized representative, or the recipient's legal guardian to receive the recipient's electronic health records in accordance with rules the act requires the ODJFS Director to adopt;

(5) A court, if pursuant to a written order of the court.

Second, ODJFS may disclose information regarding a medical assistance recipient for any of the following purposes:

(1) To the extent necessary to participate as an active member in the Public Assistance Reporting Information System (PARIS), a computer system operated under the auspices of the Administration for Children and Families in the U.S. Department of Health and Human Services that matches public recipients' social security numbers against various federal databases and participating states' databases;

(2) When permitted by rules the act requires the ODJFS Director to adopt;

(3) When required by federal law.

Authorization form

(new R.C. 5101.272)

The written authorization that a medical assistance recipient, the recipient's authorized representative, or the recipient's legal guardian must make to give the recipient's attorney access to the recipient's information is to be on a form that contains the same components required under former law governing authorization for the release of public assistance recipient information. The form may also include a provision specifically authorizing the release of the recipient's electronic health records, if any, to the recipient's attorney in accordance with rules the ODJFS Director must adopt under the act.

Requesting information from law enforcement agencies; reports regarding children

(R.C. 5101.28)

The act eliminates the authority of ODJFS or a CDJFS to request from a law enforcement agency information regarding a medical assistance recipient that ODJFS or

[130] The provision is codified in 45 C.F.R. 164.502(e)(2).

the CDJFS can use to determine whether a recipient or a member of the recipient's assistance group is (1) a fugitive felon, or (2) violating a condition of probation, a community control sanction, parole, or a post-release control sanction imposed under state or federal law.

The act also eliminates a provision that expressly authorized ODJFS, CDJFSs, and employees of those departments to report to a public children services agency (PCSA) or other appropriate agency information, to the extent permitted by federal law, on known or suspected physical or mental injury, sexual abuse or exploitation, or negligent treatment or maltreatment of a child receiving medical assistance.[131]

Rules

(R.C. 5101.30)

The act authorizes the ODJFS Director to adopt rules in accordance with the Administrative Procedure Act (R.C. Chapter 119.) implementing provisions governing the disclosure (in addition to custody, use, and preservation) of information generated or received by ODJFS, CDJFSs, other state and county entities, contractors, grantees, private entities, or officials participating in the administration of public assistance and medical assistance programs.

The rules the ODJFS Director is authorized to adopt, for the purposes described above, may define the "authorized representatives" who (1) must be given access to information regarding a public assistance recipient and (2) may be given access to information regarding a medical assistance recipient in accordance with the act's provisions.

Medicaid right of recovery against liable third parties

(R.C. 5101.573)

Federal regulations require states to have plans to identify Medicaid recipients' other sources of health coverage, determine the extent of the liability of third parties, and avoid payment of third party claims.[132] To enhance states' ability to identify and obtain payments from liable third parties, the Deficit Reduction Act of 2005 made

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[131] Although this provision is eliminated, under continuing law governing who has a duty to report child abuse or neglect (R.C. 2151.421), an ODJFS or CDJFS employee who is a person specified in that law (*e.g.*, an attorney, health care professional, etc.) remains obligated to report to a PCSA a known or suspected case of child abuse or neglect regarding a child receiving medical assistance.

[132] 42 C.F.R. Part 433, subpart D.

several changes to these federal provisions.[133] One change was a requirement that third parties provide states with the coverage, eligibility, and claims data they need to identify potentially liable third parties.[134] Consistent with this requirement, Am. Sub. H.B. 119 (the main appropriations act of the 127th General Assembly) included provisions that did both of the following: (1) required a third party to respond to an inquiry by ODJFS regarding a Medicaid claim not later than three years after the date of service, and (2) prohibited a third party from denying a claim solely on the basis of the date of submission, type or format of the claim form, or failure by the Medicaid recipient to present proper documentation at the time of service if the claim was submitted to ODJFS not later than three years after the date of service.[135]

The act extends the time periods described above from three to six years. The act does not modify a provision specifying that the time periods apply only to submissions of claims to, and payments of claims by, a health insurer that the Deficit Reduction Act requires be subjected to the requirements. These include self-insured plans, group health plans, service benefit plans, managed care organizations, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

With respect to a Medicaid claim submitted within the six-year time period, the act prohibits a third party from charging ODJFS a fee for determining whether the claim should be paid or for processing the claim.

Medicaid care coordination for families and children

(Section 309.30.50)

The act requires ODJFS and the Ohio Department of Health (ODH) to work together on the issue of achieving efficiencies in the delivery of medical assistance provided under Medicaid to families and children.

Proposal for care coordination prior to managed care

As part of their work, ODJFS and ODH must develop a proposal for coordinating medical assistance provided to families and children under Medicaid

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[133] Letter from Dennis G. Smith, Director, Center for Medicaid and State Operations, Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services, to State Medicaid Directors (SMD #06-026) (dated Dec. 15, 2006), available at <http://www.cms.hhs.gov/smdl/downloads/SMD121506.pdf>.

[134] 42 U.S.C. 1396a(a)(25).

[135] R.C. 5101.573(A)(2) and (4)(a).

while they wait to be enrolled in Medicaid managed care. The Departments may do the following:

(1) Conduct research on the status of families and children waiting to be enrolled, including research on the reasons for the wait and the utilization of medical assistance during the waiting period;

(2) Conduct a review of ways to help families and children receive medical assistance in the most appropriate setting while they wait to be enrolled;

(3) Develop recommendations for a coordinated, cost-effective system of helping the families and children find the medical assistance they need during the waiting period;

(4) Develop recommendations for improving the enrollment processes.

Help Me Grow services

As part of its work with ODH, ODJFS may seek federal approval to authorize payment for Medicaid-reimbursable targeted case management services provided in connection with the ODH's Help Me Grow Program and for services provided under the Program. The federal approval must be sought as a Medicaid state plan amendment. On a quarterly basis during fiscal years 2012 and 2013 following federal approval of the state plan amendment, ODJFS must certify to the Director of Budget and Management the state and federal shares of the amount ODJFS expended that quarter for services. On receipt of each quarterly certification, the Medicaid appropriation is increased by an amount equal to the state and federal share of the certified expenditures and the Help Me Grow appropriation is correspondingly reduced.

Prior authorization for community mental health services

(Section 309.30.55)

For fiscal years 2012 and 2013, the act provides that a Medicaid recipient under 21 years of age automatically satisfies all requirements for any prior authorization process for community mental health services provided under a component of the Medicaid program administered by the Ohio Department of Mental Health if the recipient (1) is in the temporary or permanent custody of a public children services agency or private child placing agency, (2) is in a planned permanent living arrangement, (3) has been placed in protective supervision by a juvenile court, (4) has been committed to the Ohio Department of Youth Services, or (5) is an alleged or

adjudicated delinquent or unruly child receiving services under the Felony Delinquent Care and Custody Program.

Health homes for Medicaid recipients

(R.C. 5111.14)

The act authorizes the ODJFS Director to implement within the Medicaid program a system under which Medicaid recipients with chronic conditions are provided with coordinated care through health homes. Federal approval of a Medicaid state plan amendment must be obtained. The ODJFS Director may adopt rules to implement the system.

"Health homes" are authorized under the federal Patient Protection and Affordable Care Act. An eligible Medicaid recipient may select a designated health care provider, a team of health care professionals, or a health team as the recipient's health home relative to chronic conditions. Chronic conditions include (1) a mental health condition, (2) a substance abuse problem, (3) asthma, (4) diabetes, (5) heart disease, and (6) being overweight (as evidenced by having a body mass index over 25). Health home services include care management, care coordination, health promotion, transitional care, patient and family support, and, if appropriate, referral to support services and the use of health information technology.[136]

Health Care Compliance Fund

(Section 309.35.73)

The act permits money in the Health Care Compliance Fund to be used for expenses incurred in implementing or operating health home programs and for the creation, modification, or replacement of federally funded Medicaid health-care systems in fiscal years 2012 and 2013. Otherwise, money in that fund could be used solely (1) to reimburse a Medicaid managed care organization that, after paying a fine for failing to meet a performance standard or other requirement, has come into compliance and (2) to provide financial incentive awards to Medicaid managed care organizations.

Enrollment of Medicaid recipients in group health plans

(R.C. 5111.13)

The act permits implementation of a program under which Medicaid recipients are enrolled in group health plans when the ODJFS determines that it is cost-effective.

[136] 42 U.S.C. 1396w-4.

Under prior law, implementation of such a program was required. The act eliminates all provisions of prior law specifying how ODJFS must operate the program.

The act authorizes ODJFS to submit a Medicaid state plan amendment to the U.S. Secretary of Health and Human Services for the purpose of implementing the program. The act authorizes the ODJFS Director to adopt rules as necessary to implement the program.

Medicaid managed care for the aged, blind, or disabled

(R.C. 5111.16)

The act expands the group of individuals who may be required or permitted to participate in the Medicaid care management system. The expansion applies to individuals who are included in the Medicaid coverage group known as the "aged, blind, and disabled," or "ABD."

In implementing the care management system, ODJFS is required by continuing law to designate the Medicaid recipient who may or must participate. Generally, ABD Medicaid recipients must be designated as participants, but several exclusions apply.

The act modifies the ABD exclusions by permitting ODJFS, if any necessary waiver of federal Medicaid requirements is granted, to designate any of the following ABD Medicaid recipients as individuals who are permitted or required to participate in the care management system:

(1) Individuals under age 21;

(2) Individuals who reside in a nursing facility;

(3) Individuals who, as an alternative to receiving nursing facility services, are participating in a home and community-based Medicaid waiver program;

(4) Individuals who are dually eligible for Medicaid and Medicare.

Exclusion of BCMH participants

(Section 309.30.53)

In fiscal years 2012 and 2013, the act prohibits ODJFS from including in the Medicaid care management system certain individuals receiving services through the program for medically handicapped children, also known as the Bureau for Children with Medical Handicaps (BCMH), operated by the Ohio Department of Health. The

individuals excluded are BCMH participants who have one or more of the following: (1) cystic fibrosis, (2) hemophilia, or (3) cancer.

The act provides that the exclusion does not apply to a BCMH participant who was already enrolled in the Medicaid managed care system. Otherwise, the exclusion applies regardless of other laws governing Medicaid managed care, including the act's provisions authorizing the system to be expanded to additional ABD individuals.

Pediatric accountable care organizations

(R.C. 5111.161)

If ODJFS receives any necessary federal Medicaid waiver to include ABD individuals under age 21 in the Medicaid care management system, the act requires ODJFS to develop a system to recognize entities as pediatric accountable care organizations for the purpose of meeting the complex medical and behavioral needs of disabled children through new approaches to care coordination. An entity recognized by ODJFS is authorized to develop innovative partnerships between relevant groups and contract directly or subcontract with the state to provide services to ABD Medicaid recipients who are individuals under age 21. The act requires the recognition system to be implemented no later than July 1, 2012.

An entity is required to meet any standards established by ODJFS to be recognized by ODJFS as a pediatric accountable care organization. Unless required by the federal health care reform law[137] or Ohio law, ODJFS is prohibited from adopting a standard that requires an entity to be a health insuring corporation as a condition of receiving ODJFS's recognition. If the standards are met, any of the following may be recognized by ODJFS as a pediatric accountable care organization:

(1) A children's care network, which the act defines as a children's hospital, a group of children's hospitals, or a group of pediatric physicians;

(2) A children's care network that may include one or more other entities, including, but not limited to, health insuring corporations or other managed care organizations;

(3) Any other entity ODJFS determines is qualified to be recognized as a pediatric accountable care organization.

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[137] The Patient Protection and Affordable Care Act established a demonstration project under which pediatric accountable care organizations that meet certain criteria could be provided with performance payments. The project is to be conducted from January 1, 2012 to December 31, 2016. (Public Law 111-148, Title II, Subtitle I, §2706.)

ODJFS is required to adopt rules to implement the recognition system. When adopting the rules, ODJFS is required to consult with the Superintendent of Insurance, children's hospitals, Medicaid managed care organizations, and any other relevant entity ODJFS determines has an interest in pediatric accountable care organizations. ODJFS is to do all of the following in adopting the rules:

(1) Establish application procedures to be followed by an entity seeking recognition as a pediatric accountable care organization;

(2) Ensure that the standards of recognition are the same as and do not conflict with standards adopted pursuant to the federal health care reform law;

(3) Establish requirements regarding the access to pediatric specialty care provided through or by a pediatric accountable care organization;

(4) Establish accountability and financial requirements for an entity recognized as a pediatric accountable care organization;

(5) Establish quality improvement initiatives consistent with any state Medicaid quality plan established by ODJFS;

(6) Establish transparency and consumer protection requirements;

(7) Establish a process for sharing data.

The act declares that nothing in the recognition process limits the authority of the Department of Insurance to regulate the business of insurance.

Medicaid managed care coverage of prescription drugs

(R.C. 5111.172; Section 309.37.50)

Under the act, ODJFS must require that Medicaid coverage of prescription drugs be provided by the health insuring corporations (HICs) under contract with ODJFS for purposes of the Medicaid care management system. To implement this coverage requirement, the act requires ODJFS to enter into new contracts or amend existing contracts with HICs not later than October 1, 2011.

Under prior law, ODJFS was permitted to require HICs to provide prescription drug coverage. During the 2011-2012 biennium, ODJFS did not implement this authority; instead, prescription drugs coverage was provided through the Medicaid fee-for-service system.

Mental health drugs excluded from prior authorization

For drugs that are antidepressants or antipsychotics, the act establishes limitations on the use of prior authorization requirements by HICs. Under the act, ODJFS cannot permit any HIC to impose such a requirement if all of the following apply to the mental health drug:

(1) The drug is administered or dispensed in a standard tablet or capsule form or, if the drug is an antipsychotic, in a long-acting injectable form;

(2) The drug is prescribed by (a) a physician credentialed by the HIC to provide care as a psychiatrist or (b) a psychiatrist practicing at a community mental health agency certified by the Ohio Department of Mental Health;

(3) The drug is prescribed for a use that is indicated on the drug's labeling, as approved by the U.S. Food and Drug Administration.

Continuity period

The act establishes the following limitations that apply during a specified period after ODJFS first implements the act's requirement for coverage of prescription drugs through Medicaid-participating HICs:

(1) If, immediately before the HIC's coverage becomes effective, a Medicaid recipient enrolled in the HIC was being treated with a drug prescribed by a physician, the HIC must provide coverage of the drug without using drug utilization or management techniques that are more stringent than the utilization or management techniques, if any, the person was subject to before the transfer of drug coverage. These requirements apply for a 30-day period after the coverage is effective if the drug was a controlled substance and a 90-day period after the coverage is effective for other drugs.

(2) With respect to mental health drugs, both of the following apply for a 120-day period after the coverage is effective:

--If, immediately before the HIC's coverage becomes effective, a Medicaid recipient enrolled in the HIC was being treating with an antidepressant or antipsychotic in the form specified in the act, the HIC must provide coverage without a prior authorization requirement.

--The HIC must permit the health professional who was prescribing the drug to continue prescribing the drug for the Medicaid recipient, regardless of whether the prescriber is a psychiatrist credentialed by the HIC or practicing at a certified community mental health agency.

Medicaid managed care capital payments

(R.C. 5111.17)

The act requires ODJFS or its actuary to base the hospital inpatient capital payment portion of the payment made to Medicaid managed care organizations on data for services provided to all recipients enrolled in managed care organizations under contract with ODJFS. The hospital inpatient capital payment portion is one part of the calculation used by ODJFS to determine the payments to Medicaid managed care organization. Data reported by hospitals on relevant cost reports is to be used in determining the payment.

Medicaid Managed Care Performance Payment Program

(R.C. 5111.1711; Section 309.30.40)

The act requires ODJFS to establish a Managed Care Performance Payment Program under which ODJFS is permitted to provide payments to managed care organizations that meet performance standards established by ODJFS. The act permits ODJFS to specify in its contract with the managed care organization the standards that must be met to receive the payments.

In establishing the performance standards, ODJFS is permitted to use the most recent Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a tool developed by the National Committee for Quality Assurance to measure a health plan's performance on specified dimensions of care and service.[138] ODJFS may also use any quality measures developed under the federal Pediatric Quality Measures Program or core set of adult health quality measures for Medicaid eligible adults used for the federal Quality Measurement Program.[139]

When a managed care organization meets the performance standards, ODJFS must make payments to the organization. The amount of the payments, number of payments, and schedule of making payments are to be established by ODJFS. The payments must be discontinued if the organization no longer meets the performance standards. The act prohibits ODJFS from making or discontinuing payments based on any performance standard that has been in effect as part of an organization's contract for less than six months.

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[138] National Committee for Quality Assurance, *What is HEDIS?* (last visited August 17, 2011), available at <http://www.ncqa.org/tabid/187/Default.aspx>.

[139] The federal Patient Protection and Affordable Care Act required the development of health quality measures for public and privately sponsored health care arrangements (42 U.S.C. 1320b-9a and 1320b-9b).

ODJFS is to establish a percentage amount that is to be withheld from each premium payment made to a Medicaid managed care organization. The amount is to be the same for each organization and the organization must agree to the withholding as a condition of receiving or maintaining its Medicaid provider agreement with ODJFS. The amounts withheld and deposited into the Managed Care Performance Payment Fund, created by the act, are to be used for purposes of the program. The sum of all withholdings cannot exceed 1% of the total of all premium payments made by ODJFS to all Medicaid managed care organizations.

Medicaid managed care exemption from administrative hearings

(R.C. 5111.06)

The act exempts actions ODJFS takes for certain purposes regarding the Medicaid managed care program from a requirement that the action be taken pursuant to a hearing conducted in accordance with the Administrative Procedure Act (R.C. Chapter 119.). The act also eliminates the provider's right to appeal an adverse administrative decision in court. Actions exempted by the act include entering into or refusing to enter into Medicaid managed care provider agreements, and suspending, terminating, renewing, or refusing to renew Medicaid managed care provider agreements.[140]

Reduction in Medicaid payment rates for fiscal years 2012 and 2013

(Section 309.30.30)

The act requires the ODJFS Director to implement, for fiscal years 2012 and 2013, purchasing strategies and rate reductions that result in payment rates for hospital and other Medicaid-covered services, as selected by the Director, being at least 2% less than the respective payment rates for fiscal year 2011. The requirement does not apply to nursing facility and intermediate care facility for the mentally retarded (ICF/MR) services.

When implementing the purchasing strategies and rate reductions, the ODJFS Director must do both of the following:

(1) Notwithstanding the act's provision regarding hospitals' Medicaid rates for fiscal years 2012 and 2013 (see "**Fiscal years 2012 and 2013 hospital Medicaid rates**,"

[140] According to an ODJFS representative, Medicaid managed care provider agreements are awarded through a competitive bidding process. This process authorizes a person to challenge an adverse decision by filing a written protest with ODJFS's Office of Legal Services. (Electronic correspondence from ODJFS (June 27, 2011).)

below), modernize hospital inpatient and outpatient reimbursement methodologies by (a) modifying the inpatient hospital capital reimbursement methodology, (b) establishing new diagnosis-related groups in a cost-neutral manner, (c) modifying, for hospital discharges that occur during the period beginning October 1, 2011, and ending January 1, 2012, the measures used to determine whether claims for hospital inpatient services qualify for cost outlier payments (i.e., charge high trim points) other than exceptional cost outliers, as in effect on January 1, 2011, by a factor of 13.6%, (d) modifying, for hospital discharges that occur during the period beginning January 1, 2012, and ending on the effective date of the first of the new diagnosis-related groups, charge high trim points (excluding charge high trim points for exceptional cost outliers), as in effect on October 1, 2011, by a factor of 9.72%, and (e) implementing other changes the Director considers appropriate;

(2) Establishing selective contracting and prior authorization requirements for types of medical assistance identified by the Director.

The ODJFS Director must adopt rules under the Administrative Procedure Act as necessary to implement the act's requirements regarding purchasing strategies and rate reductions.

BEACON quality improvement initiatives for children

(Section 309.33.40)

The act permits ODJFS, the Ohio Department of Health, and the Ohio Department of Mental Health, in conjunction with the Governor's Office of Health Transformation, to seek assistance from and work with the Best Evidence for Advancing Child Health in Ohio NOW! (BEACON) Council[141] and hospital and other provider groups to identify specific targets and initiatives to reduce the cost and improve the quality of medical assistance provided under Medicaid to children. The targets and initiatives must focus on reducing (1) avoidable hospitalizations, (2) inappropriate emergency room utilization, (3) use of multiple medications when not medically indicated, (4) Ohio's rate of premature births, and (5) Ohio's rate of elective, preterm births.

[141] The BEACON Council is a public/private partnership whose mission is to improve the quality of care leading to improved health outcomes of care and reduced cost with a special emphasis on Medicaid-eligible children, youth, and their families (ODH, *BEACON Council* (last visited August 6, 2011), available at <http://www.odh.ohio.gov/ASSETS/78F0EAB110274D50A18E0B21B7F96171/BEACON%20Council%20Projects.pdf>).

If the Departments identify initiatives as described above, they must make the initiatives available on their web sites, along with a list of hospitals and other provider groups involved in the initiatives.

No Medicaid payments for provider-preventable conditions

(R.C. 5111.0214)

The act prohibits ODJFS from knowingly making a Medicaid payment for a provider-preventable condition for which federal financial participation is prohibited under the Patient Protection and Affordable Care Act (federal health care reform).[142] The ODJFS Director is required to adopt rules as necessary to implement this provision.

Medicaid electronic health record incentive payment program

(R.C. 5111.0215)

The act authorizes ODJFS to establish an incentive payment program to encourage the use of electronic health record technology by Medicaid providers who are physicians, dentists, nurse practitioners, nurse-midwives, and physician assistants. This incentive program is authorized by the Health Information Technology and Economic Clinical Health Act.[143] ODJFS may adopt rules under the Administrative Procedure Act to implement the program.

The act requires ODJFS to notify a provider of ODJFS's determination regarding the amount or denial of an incentive payment. Not later than 15 days after receiving the notice, the provider may request in writing that ODJFS reconsider its determination. After receiving the request, ODJFS must reconsider its determination and may uphold, reverse, or modify its original determination. By certified mail, ODJFS must send a written notice of the reconsideration decision. Not later than 15 days after the decision is mailed, the provider may appeal the reconsideration decision to the Court of Common Pleas of Franklin County.

Electronic claims submission process

(R.C. 5111.052)

The act requires certain Medicaid providers to use only an electronic claims submission process to submit Medicaid reimbursement claims to ODJFS. The providers are also required to arrange to receive Medicaid reimbursement from ODJFS by means

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[142] 42 U.S.C. 1396b-1.

[143] 42 U.S.C. 1396b(a)(3)(F) and 1396b(t).

of electronic funds transfer. The act permits the ODJFS Director to adopt rules under the Administrative Procedure Act to implement the process.

Providers must comply not later than January 1, 2013. The act prohibits ODJFS from processing a Medicaid claim submitted on or after January 1, 2013, unless the claim is submitted through an electronic claims submission process.

The electronic claims submission process and the requirement to be reimbursed by means of electronic funds transfer do not apply to the following: (1) nursing facilities, (2) ICFs/MR, (3) Medicaid managed care organizations, or (4) any other provider or type of provider designated by the ODJFS Director.

Outsourcing of pediatric claims review and quality assurance functions

(R.C. 5111.054 (primary), 127.16, and 5101.10 (not in the act))

The act expressly authorizes ODJFS, if it chooses to outsource either or both of the following services, to contract with any qualified person, including the Ohio Children's Hospital Solutions for Patient Safety (OCHSPS), to perform the services on ODJFS's behalf:

(1) The review and analysis of pediatric Medicaid claims in accordance with all state and federal laws governing the confidentiality of patient-identifying information;

(2) The performance of quality assurance and quality review functions, other than those described in (1), above, related to the provision of medical care to Medicaid recipients who are children. These may include functions recommended by the Best Evidence for Advancing Child Health in Ohio NOW! (BEACON) Council.[144] The act specifies that such a contract is exempt from the competitive bidding requirement that typically applies to contracts involving purchases of $50,000 or more.

The act defines OCHSPS as a private, not-for-profit corporation which was formed for the purpose of improving pediatric patient care in Ohio, which performs functions that are included within the functions of a peer review committee, and which consists of all of the following members: Akron Children's Hospital, Cincinnati Children's Hospital Medical Center, Cleveland Clinic Children's Hospital, Dayton Children's Medical Center, Mercy Children's Hospital, Nationwide Children's Hospital, Rainbow Babies & Children's Hospital, and Toledo Children's Hospital.

If ODJFS enters into a contract with OCHSPS to perform either or both of the services described above, the act specifies that OCHSPS is considered to be a "public

[144] See "**BEACON quality improvement initiatives for children**," above.

entity" for purposes of a provision of continuing law relating to ODJFS's operations. That provision authorizes a public entity that performs a function on behalf of ODJFS to request ODJFS to seek federal financial participation[145] for the costs incurred by the entity.

Ohio Cancer Incidence Surveillance System administrative claiming

(R.C. 5111.83 (primary); R.C. 3701.261 and 3701.262 (not in the act))

The act requires the ODJFS Director to apply, no later than January 1, 2012, for approval of a Medicaid administrative claiming program under which federal financial participation (i.e., federal Medicaid matching funds) is received as reimbursement for the administrative costs incurred by the Ohio Department of Health and the Arthur G. James and Richard J. Solove Research Institute of The Ohio State University in analyzing and evaluating (1) cancer reports under the Ohio Cancer Incidence Surveillance System and (2) the incidence, prevalence, costs, and medical consequences of cancer on Medicaid recipients and other low-income populations. In seeking approval to claim federal financial participation, the act requires the ODJFS Director to consult with the Director of Health. The Directors must cooperate in seeking the approval to the extent they find the approval necessary for the effective and efficient administration of the Medicaid program.

The Ohio Cancer Incidence Surveillance System is a population-based cancer registry established under continuing law. The Arthur G. James and Richard J. Solove Research Institute provides analysis and evaluation services relative to the System.

Medicaid payments to organizations on behalf of providers

(R.C. 5111.051)

The act authorizes the ODJFS Director to submit a state plan amendment or to request a waiver of federal requirements to implement, at the ODJFS Director's discretion, a system under which payments for Medicaid services are made to an organization on behalf of the providers of the services. The system is prohibited from providing to an organization an amount that exceeds, in aggregate, the amount ODJFS would have paid directly to the providers for providing the services.

[145] "Federal financial participation" is the federal government's share of expenditures made by an entity implementing the Medicaid program (R.C. 5111.054(A)(1)).

Recovery of Medicaid overpayments to hospitals

(R.C. 5111.061)

Continuing law authorizes ODJFS to recover a Medicaid payment or portion of a payment made to a provider to which the provider is not entitled. The recovery may occur at any time during the five-year period following the end of the state fiscal year in which the overpayment is made.

With regard to hospital providers only, the act permits ODJFS, if it determines as a result of a Medicare or Medicaid cost report settlement that the provider received a Medicaid overpayment, to recover the overpayment if ODJFS notifies the provider during either (1) the five-year period following the end of the state fiscal year in which the overpayment is made or (2) the one-year period immediately following the date ODJFS receives from the U.S. Centers for Medicare and Medicaid Services a completed, audited Medicare cost report for the provider that applies to the state fiscal year in which the overpayment was made.

Application fees for Medicaid provider agreements

(R.C. 5111.063 (primary), 5111.06, and 5111.94; Section 309.37.10)

To participate in the Medicaid program, a health care provider must enter into a contract with ODJFS known as a "provider agreement." By signing the agreement, the provider agrees to comply with the terms of the agreement and all applicable state and federal laws. Medicaid reimbursement for providing health care services is contingent on a valid provider agreement being in effect when the services are provided.[146]

Federal regulations require each state to implement a Medicaid provider screening program for the purpose of increasing the program's integrity.[147] States must assess an application fee for a provider agreement, unless the applicant is (1) an individual physician or other practitioner, (2) a provider who is enrolled in Medicare or another state's Medicaid program or Children's Health Insurance Program, or (3) a provider who has paid the application fee to a Medicare contractor or another state.[148]

The act requires the ODJFS Director to charge an application fee to a provider seeking to enter into or renew a Medicaid provider agreement who is not exempt from

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[146] O.A.C. 5101:3-1-17 and 5101:3-1-172.

[147] 42 C.F.R. 455.450.

[148] 42 C.F.R. 455.460.

the fee under federal regulations. The fees are to be deposited into the Health Care Services Administration Fund.

The amount of the fee is to be set by the ODJFS Director in rules adopted under the Administrative Procedure Act. The fee amount cannot be more than necessary to pay for the expenses of implementing the provider screening requirements established by federal regulations.

Automatic suspension of Medicaid provider agreements

(R.C. 5111.035 (primary), 5111.031, and 5111.06)

Overview

The act generally requires ODJFS to do both of the following when ODJFS determines there is a creditable allegation of fraud[149] against a Medicaid provider[150] for which an investigation is pending under the Medicaid program: (1) suspend the provider's Medicaid provider agreement and (2) terminate reimbursement to the provider for services rendered to Medicaid recipients.

The act also authorizes ODJFS to take any of several types of disciplinary action, without a hearing, against a Medicaid provider agreement or an application for a provider agreement when the action is based on a disciplinary action taken by another state's Medicaid agency or for reasons specified in regulations promulgated under the federal Patient Protection and Affordable Care Act.

The act's provisions governing suspension of Medicaid provider agreements, as summarized above, are consistent with federal regulations governing state Medicaid fraud detection and investigation programs.[151]

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[149] The act generally defines "creditable allegation of fraud" consistent with the definition of this term in a federal regulation. Under that definition, modified to conform to Ohio law, a creditable allegation of fraud may be an allegation, which has been verified by ODJFS, from any source, including but not limited to, fraud hotline complaints, claims data mining, and patterns identified through provider audits, false claims cases, and law enforcement investigations. The federal regulation specifies that allegations are considered to be credible when they have indicia of reliability and ODJFS has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. (42 C.F.R. 455.2.)

[150] A "provider" is any person, institution, or entity that has a Medicaid provider agreement with ODJFS (R.C. 5111.035(A)(2)).

[151] *See* 42 C.F.R. Part 455.

Suspensions based on creditable allegations of fraud

(R.C. 5111.035(B))

In general, the act requires ODJFS, on determining there is a creditable allegation of fraud for which an investigation is pending under the Medicaid program against a Medicaid provider, to do both of the following: (1) suspend the provider agreement held by the provider, and (2) terminate reimbursement to the provider for services rendered to Medicaid recipients.

Exceptions – when suspension does not occur

(R.C. 5111.035(C))

Under the act, ODJFS is prohibited from suspending a Medicaid provider agreement or terminating Medicaid reimbursement based on a creditable allegation of fraud when prescribed by rules adopted by ODJFS or when the provider or owner can demonstrate through the submission of written evidence that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee that resulted in the creditable allegation of fraud.

Duration of suspension

(R.C. 5111.035(B)(2))

The act requires the suspension of a Medicaid provider agreement based on a creditable allegation of fraud to continue in effect until any of the following, as applicable, is the case:

(1) ODJFS or a prosecuting authority determines there is insufficient evidence of fraud by the provider.

(2) The proceedings in any related criminal case are completed through dismissal of the indictment or through conviction, entry of a guilty plea, or finding of not guilty.

(3) ODJFS concludes the process to terminate the provider's agreement, if ODJFS has commenced a process to terminate the suspended agreement.

Prohibition on services relative to other Medicaid providers or risk contractors

(R.C. 5111.035(B)(4))

When a Medicaid provider is subject to a suspension based on a creditable allegation of fraud, a provider, owner,[152] officer, authorized agent, associate, manager, or employee of the provider is prohibited from doing any of the following:

(1) Owning or providing services to any other Medicaid provider or risk contractor;

(2) Arranging for, rendering, or ordering services to any other Medicaid provider or risk contractor;

(3) Arranging for, rendering, or ordering services for Medicaid recipients during the period of suspension;

(4) Receiving reimbursement in the form of direct payments from ODJFS or indirect payments of Medicaid funds in the form of salary, shared fees, contracts, kickbacks, or rebates from or through any participating provider or risk contractor.

Termination of reimbursement

(R.C. 5111.035(D))

The act specifies that termination of Medicaid reimbursement based on a creditable allegation of fraud applies only to payments for Medicaid services rendered by a provider subsequent to the date on which a notice required by the act is sent. Claims for reimbursement of services rendered by the provider prior to issuance of the notice may be subject to prepayment review procedures whereby ODJFS reviews claims to determine whether they are supported by sufficient documentation, are in compliance with state and federal statutes and rules, and are otherwise complete.

Notice

(R.C. 5111.035(E) to (G))

After suspending a provider agreement based on a creditable allegation of fraud, the act requires ODJFS, consistent with federal regulations governing state Medicaid

[152] An "owner" is any person having at least 5% ownership in a noninstitutional Medicaid provider (R.C. 5111.035(A)(3)).

fraud detection and investigation programs,[153] to send notice of the suspension to the affected provider or owner in accordance with the following:

(1) Not later than five days after the suspension, unless a law enforcement agency makes a written request to temporarily delay the notice;

(2) Not later than 30 days after the suspension, if a law enforcement agency makes a written request to temporarily delay the notice. However, the written request may be renewed in writing by a law enforcement agency not more than two times. Under no circumstances may the notice be issued more than 90 days after the suspension occurs.

The notice regarding a suspended provider agreement must do all of the following:

(1) State that payments are being suspended based on creditable allegations of fraud and the federal regulation governing such suspensions;[154]

(2) Set forth the general allegations related to the nature of the conduct leading to suspension, except that it is not necessary for the notice to disclose any specific information concerning an ongoing investigation;

(3) State that the suspension continues to be in effect until either of the following is the case: (a) ODJFS or a prosecuting authority determines there is insufficient evidence of fraud by the provider, or (b) the proceedings in any related criminal case are completed through dismissal of the indictment or through conviction, entry of a guilty plea, or finding of not guilty and, if ODJFS commences a process to terminate the suspended provider agreement, until the termination process is concluded;

(4) Specify, if applicable, the type or types of Medicaid claims or business units of the provider that are affected by the suspension;

(5) Inform the provider or owner of the opportunity to submit to ODJFS, not later than 30 days after receiving the notice, a request for reconsideration of the suspension.

[153] Specifically, 42 C.F.R. 455.23(b).

[154] 42 C.F.R. 455.23.

Reconsideration process

(R.C. 5111.035(H) and (I))

The act authorizes a provider or owner subject to a suspension based on a creditable allegation of fraud to request a reconsideration of the suspension. The request must be made not later than 30 days after receipt of the notice required by the act. The reconsideration is not subject to a hearing conducted in accordance with the Administrative Procedure Act.

In requesting reconsideration of a suspension, the affected provider or owner must submit written information and documents to ODJFS. The information and documents may pertain to any of the following issues:

(1) Whether the determination to suspend the provider agreement was based on a mistake of fact, other than the validity of an indictment in a related criminal case;

(2) If there has been an indictment in a related criminal case, whether any offense charged in the indictment resulted from an act that would be a felony or misdemeanor under Ohio law and the act relates to or results from (a) furnishing or billing for medical care, services, or supplies under the Medicaid program, or (b) participating in the performance of related management or administrative services;

(3) Whether the affected provider or owner can demonstrate that the provider or owner did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee that resulted in the suspension for a creditable allegation of fraud or an indictment in a related criminal case.

The act requires ODJFS to review the information and documents submitted by the affected provider or owner. After the review, the suspension may be affirmed, reversed, or modified, in whole or in part. ODJFS is required to notify the affected provider or owner of the results of the review. The review and notification of its results must be completed not later than 45 days after receiving information and documents submitted in a reconsideration request.

Rules

(R.C. 5111.035(J))

The act authorizes ODJFS to adopt rules in accordance with the Administrative Procedure Act to implement the act's provisions regarding automatic suspension of a Medicaid provider agreement based on a creditable allegation of fraud. The rules may specify circumstances under which ODJFS would not suspend a provider agreement based on such an allegation.

Disciplinary actions based on other states' actions

(R.C. 5111.06(D)(5))

Without conducting a hearing, ODJFS is authorized under the act to deny, terminate, or not renew a Medicaid provider agreement when ODJFS's action is based on the provider's termination, suspension, or exclusion from another state's Medicaid program. In such cases, the out-of-state termination, suspension, or exclusion is binding on the provider's participation in Ohio's Medicaid program.

Disciplinary actions for reasons specified by other federal provisions

(R.C. 5111.06(D)(12))

Without conducting a hearing, ODJFS is authorized under the act to suspend or terminate a provider agreement or deny an application for enrollment or re-enrollment for any of the following reasons authorized or required by regulations promulgated pursuant to the federal Patient Protection and Affordable Care Act:

- The provider did not fully and accurately make a disclosure of information on owners or agents convicted of offenses related to involvement with programs established under Medicaid, Medicare, or the federal Title XX Social Services Block Grant.[155]

- A creditable allegation of fraud has been determined, an investigation is pending under the Medicaid program, and ODJFS does not have good cause to not suspend the provider's payments.[156]

- A person with a 5% or greater direct or indirect ownership interest in the provider:

  --Did not submit timely and accurate information and cooperate with any screening methods required by federal regulations;[157]

  --Has been convicted of a criminal offense related to that person's involvement with Medicare, Medicaid, or the Children's Health Insurance Program (CHIP) in the last ten years, unless ODJFS determined that denial or termination of enrollment was not in the

[155] 42 C.F.R. 455.106(c).

[156] 42 C.F.R. 455.23

[157] 42 C.F.R. 416(a).

best interests of the Medicaid program and documented that determination in writing.[158]

- The provider's agreement to participate in Medicare or in another state's Medicaid program or CHIP was terminated on or after January 1, 2011.[159]

- The provider or a person with an ownership or control interest or who is an agent or managing employee of the provider failed to submit timely or accurate information, unless ODJFS determined that termination or denial of enrollment was not in the best interests of the Medicaid program and documented that determination in writing.[160]

- The provider or a person with a 5% or greater direct or indirect ownership interest in the provider failed to submit sets of fingerprints in the form and manner determined by ODJFS within 30 days of a U.S. Centers for Medicare and Medicaid Services (CMS) or ODJFS request, unless ODJFS determined that termination or denial of enrollment was not in the best interests of the Medicaid program and documented that determination in writing.[161]

- The provider failed to permit access to provider locations for any site visits required by federal regulations,[162] unless ODJFS determined that termination or denial of enrollment was not in the best interests of the Medicaid program and documented that determination in writing.[163]

- CMS or ODJFS (1) determined that the provider falsified any information provided on the application, or (2) cannot verify the identity of an applicant.[164]

- Failure to submit to a criminal background check as a condition of enrolling to be a Medicaid provider, as specified in federal regulations.[165]

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[158] 42 C.F.R. 416(b).

[159] 42 C.F.R. 455.416(c).

[160] 42 C.F.R. 455.416(d).

[161] 42 C.F.R. 455.416(e).

[162] 42 C.F.R. 455.432.

[163] 42 C.F.R. 455.416(f).

[164] 42 C.F.R. 455.416(g).

- Failure to meet screening requirements for Medicaid providers specified in federal regulations.[166]

Physician assistants as Medicaid providers

Claims submissions

(R.C. 5111.053; Section 309.37.53(A))

The act requires ODJFS to establish a process by which a physician assistant may enter into a Medicaid provider agreement. The process must be implemented when the ODJFS Director determines that the computer system improvements necessary to implement the process are in place. The Director must ensure that the improvements are in place not later than July 1, 2012.

As a result of having a Medicaid provider agreement, a physician assistant may submit a claim for, and receive, reimbursement directly from ODJFS (*i.e.*, engage in "direct billing"). This is in contrast to the previous reimbursement system under which Medicaid reimbursement services provided by a physician assistant could be paid only to (1) the physician, physician group practice, or clinic employing the physician assistant, or (2) a hospital (as part of the facility payment).[167]

Although the act requires ODJFS to establish a process by which a physician assistant may enter into a Medicaid provider agreement, the act does not require a physician assistant to enter into an agreement. Under the act, there are two options for submitting a physician assistant's Medicaid claim: either (1) the physician assistant who provided the service, or (2) the physician, group practice, clinic, or other health care facility that employs or contracts with the physician assistant may submit the claim.

If a physician assistant chooses to submit the claim, the physician assistant must have a valid Medicaid provider agreement. When submitting the claim, the physician assistant must use the Medicaid provider number ODJFS has assigned to the physician assistant.

The act authorizes the ODJFS Director to adopt rules to implement the provisions described above.

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[165] 42 C.F.R. 455.434.

[166] 42 C.F.R. 455.450.

[167] O.A.C. 5101:3-4-039(C)(1) and (8); telephone interview with ODJFS representative (April 22, 2011).

Reimbursement rates

(Section 309.37.53(B))

Under the act, the Medicaid reimbursement rates for services provided by physician assistants during fiscal year 2013 cannot be greater than the Medicaid reimbursement rates for physician assistant services provided on June 30, 2012.

Public notice of proposed changes to Medicaid rates

(R.C. 5111.0212)

As necessary to comply with federal law, the act requires the ODJFS Director to give public notice in the Register of Ohio of any change to a method or standard used to determine the Medicaid reimbursement rate for Medicaid providers. Federal law requires that the public notice provide information on the methodologies underlining the rates and an opportunity for the public to review and comment on the proposed rates.[168]

Maximum Medicaid reimbursement rate

General rule

(R.C. 5111.021)

Prior law provided that, in reimbursing any Medicaid provider, ODJFS, except as permitted by federal law and at the discretion of ODJFS, was to reimburse the provider no more than the amount authorized for the same service under the Medicare program. The act instead prohibits Medicaid reimbursement rates for hospital, nursing facility, and ICF/MR services from exceeding the limits established in federal regulations. For all other services, the rates cannot exceed the authorized Medicare reimbursement limit for the same services. These prohibitions, however, do not apply when federal law requires otherwise.

Fiscal years 2012 and 2013 rate for dialysis services

(Sections 309.30.31 and 309.30.32)

For a dialysis service provided during fiscal year 2012 to an individual dually eligible for Medicare and Medicaid, the act requires ODJFS to pay an amount equal to the Medicare copayment amount that applies to the service, as that amount was paid by ODJFS immediately prior to June 30, 2011 (the act's immediate effective date). The

[168] 42 U.S.C. 1396(a)(13)(A).

payment is to be made notwithstanding the act's restriction on Medicaid payments or other state laws.

In fiscal year 2013, ODJFS is permitted to adjust the Medicaid rates that are paid for dialysis services by an amount sufficient to achieve aggregate savings of not more than $9 million in state share expenditures under the Medicaid program. The aggregate savings are to include any savings that may be achieved through measures taken with regard to dialysis services under the act's provision that requires ODJFS to implement, for fiscal years 2012 and 2013, purchasing strategies and rate reductions for Medicaid services. (See "**Reduction in Medicaid payment rates for fiscal years 2012 and 2013**" above.)

Medicaid rates for aide and nursing services

(R.C. 5111.0213)

The act requires ODJFS to reduce the Medicaid program's first-hour-unit price for aide and nursing services provided as home care.[169] The Medicaid program's first-hour-unit price for aide services is to be reduced to 97% of the price paid on June 30, 2011. The Medicaid program's first-hour-unit price for nursing services is to be reduced to 95% of the price paid on June 30, 2011. Additionally, ODJFS is to pay for a service that is an aide service or nursing service provided by an independent provider[170] 80% of the price ODJFS pays for the same service provided by a provider that is not an independent provider. These reductions are effective October 1, 2011.

Not sooner than July 1, 2012, ODJFS must adjust the Medicaid reimbursement rates for aide services and nursing services in a manner that reflects, at a minimum, labor market data, education and licensure status, home health agency and independent provider status, and length of service visit. ODJFS is required to strive to have this adjustment go into effect on July 1, 2012. The reductions that are effective October 1, 2011, are to remain in effect until the adjustment is made.

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[169] For purposes of the act, "aide services" are home health aide services available under the federal Medicaid home health services benefit and home care attendant and personal care aide services under a home and community-based services Medicaid waiver component. "Nursing services" are nursing services available under the federal Medicaid home health services benefit, private duty nursing services, and nursing services available under a home and community-based services Medicaid waiver component. (R.C. 5111.0213(A)(1) and (4).)

[170] The act defines "independent provider" as an individual who personally provides aide services or nursing services and is not employed by, under contract with, or affiliated with another entity that provides those services (R.C. 5111.0213(A)(3)).

The ODJFS Director must adopt rules under the Administrative Procedure Act (R.C. Chapter 119.) as necessary to implement these reductions and adjustments.

Federal upper limit for drugs

(R.C. 5111.086)

The act prohibits ODJFS from making a Medicaid payment for a drug subject to a federal upper reimbursement limit that exceeds, in the aggregate, the federal upper reimbursement limit for the drug.[171] The ODJFS Director is to adopt rules as necessary to implement the act's provision.

Drugs subject to a federal upper limit are those generally referred to as "generic drugs" (*i.e.*, multiple source drugs for which there are three or more therapeutically equivalent drug products).[172] States generally base their Medicaid reimbursements to a retail pharmacy for a covered outpatient drug on the *lowest* of the following:[173]

(1) The state's best estimate of the retail pharmacy's acquisition cost for the drug;

(2) The pharmacy's usual and customary charge for the drug;

(3) The federal upper limit for the drug, if one applies;

(4) The state's maximum allowable cost (MAC) for the drug, if one applies.[174]

The act's prohibition does not affect ODJFS's authority to pay an amount lower than the federal upper limit; it only places a ceiling on the amount of the payment.

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[171] The act defines "federal upper reimbursement limit" as the limit established pursuant to federal law governing payments for outpatient drugs covered by Medicaid (42 U.S.C. 1396r-8(e)).

[172] 42 U.S.C. 1396r-8(e)(4).

[173] Government Accountability Office, *Letter to Joe Barton* (former chairman), U.S. House of Representatives Committee on Energy and Commerce (GAO-07-239R Medicaid Federal Upper Limits) (Dec. 22, 2006).

[174] States that administer a MAC program publish lists of selected multiple source drugs with the maximum price at which the state will reimburse for those drugs. Generally, state MAC lists include more drugs, and establish lower reimbursement prices, than the federal upper limit list.

Medicaid dispensing fee for noncompounded drugs

(Section 309.33.70)

The act sets the Medicaid dispensing fee for each noncompounded drug covered by the Medicaid program at $1.80 for the period beginning July 1, 2011, and ending on the effective date of an ODJFS rule changing the amount of the fee. This is the same amount that was in effect during fiscal years 2010 and 2011.

Fiscal years 2012 and 2013 hospital Medicaid rates

(Section 309.30.35)

The act requires the ODJFS Director to amend rules as necessary to continue, for fiscal years 2012 and 2013, the Medicaid reimbursement rates in effect on June 30, 2011, for Medicaid-covered hospital inpatient and outpatient services that are paid under the prospective payment system established in the rules.

Children's hospitals supplemental funding

(Sections 309.30.38 (primary) and 309.30.33)

The act requires the ODJFS Director to make additional Medicaid payments to children's hospitals for inpatient services. The additional payments are for fiscal years 2012 and 2013 and are to compensate children's hospitals for the high percentage of Medicaid recipients they serve. The payments are to be made under a program modeled on the program ODJFS was required to create for fiscal years 2006 and 2007. The program may be the same as the program the Director used for making payments to children's hospitals for fiscal years 2010 and 2011.

The act provides that nothing in its Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program and the Medicaid Managed Care Hospital Incentive Payment Program (see "**Use of hospital assessments**," below) reduces the additional Medicaid payments to be made to children's hospitals.

Hospital Care Assurance Program

(Sections 690.10 and 690.11)

The act continues the Hospital Care Assurance Program (HCAP) for two additional years. HCAP was scheduled to end October 16, 2011, but under the act will continue until October 16, 2013. Under HCAP, hospitals are annually assessed an amount based on their total facility costs and government hospitals make annual intergovernmental transfers to ODJFS. ODJFS distributes to hospitals money generated

by the assessments and intergovernmental transfers along with federal matching funds generated by the assessments and transfers. A hospital compensated under HCAP 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 guidelines.

Hospital assessments

(R.C. 5112.40, 5112.41, 5112.46, and 5112.99; Sections 620.10 to 620.13 and 812.20)

The act continues the assessments imposed on hospitals for two additional years, ending October 1, 2013, rather than October 1, 2011. The assessments are in addition to HCAP, but like HCAP, they raise money to help pay for the Medicaid program (see "**Use of hospital assessments**," below).

A hospital's assessment is based on its total facility costs. The act requires ODJFS to adopt rules specifying the percentage of hospitals' total facility costs that hospitals are to be assessed. The percentage may vary for different hospitals. However, ODJFS must obtain a federal waiver before establishing varied percentages if varied percentages would cause the assessments to not be imposed uniformly as required by federal law.

A hospital's total facility costs are derived from cost-reporting data submitted to ODJFS for purposes of HCAP. The act provides that a hospital's total facility costs are to be derived from other financial statements that the hospital is to provide ODJFS if the hospital has not submitted the HCAP cost-reporting data. The financial statements are subject to the same type of adjustments made to the HCAP cost-reporting data.

Continuing law establishes a schedule for hospitals to pay their assessments. ODJFS is permitted, however, to establish a different payment schedule in rules. The act provides that the purpose of a different payment schedule is to reduce hospitals' cash flow difficulties.

The act requires ODJFS to impose a penalty of 10% of the amount due on any hospital that fails to pay its assessment by the due date.

Offsets of penalties under HCAP and hospital assessments

(R.C. 5112.991; Section 309.35.90)

The act permits ODJFS to collect unpaid penalties regarding HCAP and the assessment on hospitals in the form of offsets. When doing so, ODJFS may reduce the

amount of one or more payments due a hospital under the Medicaid program by an amount not exceeding the amount of the unpaid penalty.

Use of hospital assessments

(Section 309.30.33)

The act provides for a portion of the hospital assessments discussed above to be used to (1) continue the Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program, (2) create the Medicaid Managed Care Hospital Incentive Payment Program, and (3) continue fiscal years 2010 and 2011 hospital payment rates (see "**Fiscal years 2012 and 2013 hospital Medicaid rates**," above).[175]

Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program

Am. Sub. H.B. 1 of the 128th General Assembly required the ODJFS Director to seek federal approval for a Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program. The Program was approved and provides supplemental payments to hospitals for Medicaid-covered inpatient and outpatient services. The act requires ODJFS to seek federal approval to continue the Program for fiscal years 2012 and 2013.

Medicaid Managed Care Hospital Incentive Payment Program

The act requires ODJFS to seek federal approval of a Medicaid Managed Care Hospital Incentive Payment Program for the purpose of increasing access to hospital services for Medicaid recipients who are enrolled in Medicaid managed care organizations. If approved, the Program is to provide additional funds to Medicaid managed care organizations to be used by the organizations to increase payments to hospitals for providing services to Medicaid recipients who are enrolled in the Medicaid managed care organizations.

Actuarial study

The act requires ODJFS, not later than July 1, 2012, to select an actuary to conduct a study of contracted reimbursement rates between Medicaid managed care organizations and hospitals. Based on the contracted rates, the actuary is to determine

[175] While the act provides specific appropriations, it also permits the OBM Director to authorize additional expenditures from the Health Care Federal, Healthcare/Medicaid, and Medicaid-Hospital line items to implement these programs and the act's provision regarding hospitals' Medicaid rates for fiscal years 2012 and 2013. The act specifies that nothing in the programs is to reduce payments that are appropriated to children's hospitals.

if a reduction in the capitation rates paid to Medicaid managed care organizations in fiscal year 2013 is appropriate.

Repayment if state savings are insufficient

If the actuary determines that any reduction in the capitation rates paid to Medicaid managed care organizations in fiscal year 2013 will not achieve $22 million in state savings in that year, the state is to receive from Medicaid managed care organizations and hospitals the difference between what is saved and $22 million. In consultation with the Ohio Association of Health Plans and the Ohio Hospital Association, ODJFS is to establish a methodology under which the difference is to be paid equally by Medicaid managed care organizations and hospitals.

The act authorizes ODJFS to waive the payment requirement if spending for the Medicaid program in fiscal year 2013 is less than the amount that is budgeted for that fiscal year. If ODJFS receives payments, the amounts are to be deposited into the Health Care Compliance Fund, which under continuing law is used to make financial incentive awards to Medicaid managed care organizations that meet or exceed performance standards.

Conditions on implementation

The act specifies that the Program is to be implemented only under the following conditions:

(1) An actuary certifies that the Program would not violate the actuarial soundness of capitation rates paid to Medicaid managed care organizations;

(2) ODJFS implements the Program in a manner that does not result in a hospital receiving less money from the Hospital Assessment Fund than the hospital would have received if the Program were not implemented;

(3) ODJFS implements the Program in a manner that does not result in a Medicaid managed care organization receiving a lower capitation payment rate solely because funds are made available to the organization under the Program;

(4) The Program is not determined to be an impermissible healthcare-related tax under federal law.

Nursing home and hospital long-term care unit franchise permit fees

(R.C. 3721.50, 3721.51, 3721.511, 3721.512, 3721.513, 3721.52, 3721.53, 3721.531, 3721.532, 3721.533, 3721.55, 3721.56 (repealed), 3721.561 (renumbered 3721.56), 3721.58, 3769.08, 3769.20, and 3769.26; Section 512.80)

The act revises the law governing the franchise permit fee that is imposed on nursing homes and hospital long-term care units. The fee is used to generate revenue to help fund Medicaid, including the PASSPORT program, and the Residential State Supplement program.

Amount of franchise permit fee

The act sets the franchise permit fee's base rate at $11.47 for fiscal year 2012 and $11.67 for each fiscal year thereafter. In doing so, the act eliminates the formula that was used to calculate the base rate for prior fiscal years. The act maintains law that provides for adjustments in the amount of the fee due to a federal waiver that exempts certain nursing homes from the fee.

Under prior law, the amount assessed under the franchise permit fee for a fiscal year could not exceed 5.5% of the actual net patient revenues for all nursing homes and hospital long-term care units for that fiscal year. If the rate used in the assessment resulted in a higher assessment, ODJFS had to recalculate the assessment. This was done to address a restriction in federal Medicaid law. The federal restriction changes on October 1, 2011, in a manner that permits the amount assessed under the fee to be as high as 6% of the actual net patient revenues for all nursing homes and hospital long-term care units for a fiscal year. The act addresses the federal change by providing for ODJFS to recalculate the assessment for a fiscal year if the total amount assessed exceeds the indirect guarantee percentage of the actual net patient revenues for all nursing homes and hospital long-term care units for that fiscal year. The indirect guarantee percentage is the maximum percentage of actual net patient revenues that the federal law permits the fee to assess (i.e., 5.5% until October 1, 2011, and 6% thereafter).

Redeterminations of franchise permit fee to reflect bed surrenders

ODJFS is required by continuing law to determine each nursing home's and hospital long-term care unit's franchise permit fee for a fiscal year not later than each September 15. The act requires ODJFS to redetermine each nursing home's and hospital long-term care unit's franchise permit fee not later than the last day of February of each year if one or more bed surrenders occur during the period beginning on May 1 of the preceding calendar year and ending on January 1 of the calendar year in which the redetermination is made. In the case of a nursing home, a bed surrender occurs when a bed is removed from the nursing home's licensed capacity in a manner that reduces the

total licensed capacity of all nursing homes. In the case of a hospital long-term care unit, a bed surrender occurs when a bed is removed from registration with the Ohio Department of Health as a skilled nursing facility bed or long-term care bed in a manner that reduces the total number of hospital beds so registered with ODH.

In redetermining the franchise permit fees, ODJFS is required to provide for the redetermination to be conducted in a manner consistent with the terms of a federal waiver that authorizes the state to exempt certain nursing homes from the fees. Also, ODJFS must recalculate each nursing home's and hospital long-term care unit's fee in the manner of the original calculation with the following changes:

(1) In the case of a nursing home or hospital long-term care unit for which one or more bed surrenders occurred, the number of beds included in the calculation is to exclude the beds for which bed surrenders occurred;

(2) The number of days used in the calculation is to be the number of days in the first half of the calendar year in which the redetermination is made;

(3) The amount of the fee so redetermined is to reflect adjustments made under continuing law regarding the federal waiver discussed above.

Not later than March 1 each year, ODJFS is required by the act to mail to each nursing home and hospital long-term care unit notice of the amount of its redetermined franchise permit fee. Each nursing home and hospital long-term care unit is to pay its redetermined fee to ODJFS in two installment payments not later than 45 days after March 31 and June 30 of the calendar year in which the redetermination is made.

Under continuing law, ODH is required to report annually to ODJFS information regarding the number of beds in nursing homes and hospital long-term care units that is needed for ODJFS to be able to calculate the franchise permit fee for a fiscal year. The act requires ODH also to report annually to ODJFS, for each nursing home and hospital long-term care unit, the number of beds for which a bed surrender occurred. The report is due not later than each January 15 and is to be used in calculating the franchise permit fee redeterminations.

Paying the franchise permit fee after a change of operator

The act specifies who is responsible for paying the franchise permit fee when a nursing home or hospital long-term care unit undergoes a change of operator during a fiscal year. A change of operator occurs when an entering operator becomes the operator of a nursing home or hospital long-term care unit in the place of the exiting operator. The operator is the person or government entity responsible for the daily operating and management decisions for the nursing home or hospital long-term care

unit. The exiting operator is to be responsible for paying the amount of the fee that is for the part of the fiscal year that ends on the day before the day that the entering operator becomes the operator of the nursing home or hospital long-term care unit. The entering operator is to be responsible for the amount of the fee that is for the part of the fiscal year that begins on the day that the entering operator becomes the operator. ODJFS is not required to mail a notice to the entering operator regarding the amount of that fiscal year's fee for which the entering operator is responsible.

The act provides that the following are examples of actions that constitute a change of operator:

(1) A change in an exiting operator's form of legal organization, including the formation of a partnership or corporation from a sole proprietorship;

(2) A transfer of all the exiting operator's ownership interest in the operation of the nursing home or hospital long-term care unit to the entering operator, regardless of whether ownership of any or all of the real property or personal property associated with the nursing home or hospital long-term care unit is also transferred;

(3) A lease of the nursing home or hospital long-term care unit to the entering operator or the exiting operator's termination of the exiting operator's lease;

(4) If the exiting operator is a partnership, dissolution of the partnership;

(5) If the exiting operator is a partnership, a change in composition of the partnership unless the change does not cause the partnership's dissolution under state law and the partners agree that the change does not constitute a change in operator;

(6) If the operator is a corporation, dissolution of the corporation, a merger of the corporation into another corporation that is the survivor of the merger, or a consolidation of one or more other corporations to form a new corporation.

The act specifies that the following, alone, do not constitute a change of operator:

(1) A contract for an entity to manage a nursing home or hospital long-term care unit as the operator's agent, subject to the operator's approval of daily operating and management decisions;

(2) A change of ownership, lease, or termination of a lease of real property or personal property associated with a nursing home or hospital long-term care unit if an entering operator does not become the operator in place of an exiting operator;

(3) If the operator is a corporation, a change of one or more members of the corporation's governing body or transfer of ownership of one or more shares of the corporation's stock, if the same corporation continues to be the operator.

Use of money raised by the franchise permit fee

The act abolishes one of the two funds into which money raised by the franchise permit fee was deposited. The fund that is abolished is the Home- and Community-Based Services for the Aged Fund. All of the money raised by the franchise permit fee is to be deposited into the remaining fund, the Nursing Facility Stabilization Fund which is renamed the Nursing Home Franchise Permit Fee Fund. Whereas prior law required ODJFS to use money in that fund to make Medicaid payments only to nursing facilities, the act requires ODJFS to use the money to make Medicaid payments to providers of home and community-based services as well as providers of nursing facility services. Additionally, the act permits money in the Nursing Home Franchise Permit Fee Fund to be used for the Residential State Supplement program. Prior law that governed the fund that is abolished, the Home- and Community-Based Services for the Aged Fund, required ODJFS and the Ohio Department of Aging to use money in that fund for the Medicaid program, including the PASSPORT program, and the Residential State Supplement program.

Prior law provided for only the first dollar of the franchise permit fee to be deposited into the Home- and Community-Based Services for the Aged Fund and for the Nursing Facility Stabilization Fund to receive the remainder. Because the act requires all of the money raised by the franchise permit fee to be deposited into the renamed Nursing Facility Stabilization Fund and provides for the money in that fund to be used for home and community-based services and the Residential State Supplement program rather than just nursing facilities, it is possible that more of the money raised by the franchise permit fee will be used for home and community-based services and the Residential State Supplement program than under prior law.

The act abolishes the PASSPORT Fund. Money raised by horse-racing-related taxes that under prior law was deposited into the PASSPORT Fund is required under the act to be deposited into the Nursing Home Franchise Permit Fee Fund. The act continues to require that the money be used for the PASSPORT Program.

Medicaid reimbursement rates for nursing facilities

The act revises the formula used in determining nursing facilities' Medicaid reimbursement rates. The formula is established in the Revised Code and is comprised of various price centers and a quality incentive payment.

Direct care costs

(R.C. 5111.20 and 5111.231)

Direct care costs are one of the price centers used in determining nursing facilities' Medicaid reimbursement rates. The act includes the costs of behavioral and mental health services among the costs included in nursing facilities' direct care costs.

A nursing facility's Medicaid reimbursement rate for direct care costs is based in part on the cost per case-mix unit determined for the nursing facility's peer group. One of the steps in determining a peer group's cost per case-mix unit is to calculate the amount that is a certain percentage above the cost per case-mix unit determined for the nursing facility in the peer group that is at the 25th percentile of the cost per case-mix units. The act changes the percentage used in the calculation to 2% (from 7%). The act adds a last step in calculating a peer group's cost per case-mix unit. After the other steps are completed, ODJFS is to add $1.88 to the cost per case-mix unit. However, ODJFS is to cease to make the $1.88 increase when it first rebases nursing facilities' rates for direct care costs. ODJFS is not required to rebase more than once every ten years. Rebasing is the process under which ODJFS redetermines nursing facilities' rates using information from Medicaid cost reports for a calendar year that is later than the calendar year used for the previous determination.

Once the cost per case-mix unit is determined, that cost is multiplied by a nursing facility's semiannual case-mix score to determine the nursing facility's Medicaid rate for direct care costs. To determine a nursing facility's semiannual case-mix score, ODJFS uses data from a resident assessment instrument for certain residents. The act changes the residents for whom the data is to be used. Beginning in fiscal year 2013, the data is to be used only for a resident who is a Medicaid recipient and not placed in either of the two lowest resource utilization groups, excluding any resource utilization group that is a default group used for residents with incomplete assessment data. In contrast, for fiscal year 2012, the data is used for each resident who is a Medicaid recipient regardless of which resource utilization group a recipient is in.

Ancillary and support costs

(R.C. 5111.24)

Ancillary and support costs are another price center. Nursing facilities' Medicaid reimbursement rates for ancillary and support costs are based on the ancillary and support costs of the nursing facility in a peer group that is at the 25th percentile of the rate for such costs. The act eliminates a 3% adjustment that was applied to that nursing facility's ancillary and support costs when determining the peer group's rate.

Capital costs

(R.C. 5111.25 (primary), 5111.222, and 5111.254)

Another price center is capital costs. Under prior law, a nursing facility's Medicaid reimbursement rate for capital costs was the median rate for capital costs for the nursing facilities in the nursing facility's peer group. Under the act, a peer group's rate for capital costs is to be the rate for capital costs determined for the nursing facility in the peer group that is at the 25th percentile of the rate for capital costs. The act prohibits ODJFS from redetermining a peer group's rate for capital costs based on additional information that it receives after the rate is determined and provides for ODJFS to make a redetermination only if it made an error in determining the rate based on information available to ODJFS at the time of the original determination.

In determining a nursing facility's capital costs, adjustments are sometimes made to certain of the nursing facility's capital costs. Under prior law, an adjustment was based on the lesser of (1) one-half of the change in construction costs as calculated by ODJFS using the Dodge Building Cost Indexes, Northeastern and North Central states, published by Marshall and Swift or (2) one-half of the change in the Consumer Price Index for all items for all urban consumers, as published by the U.S. Bureau of Labor Statistics. The act provides for the adjustment to be based only on one-half of the change in the Consumer Price Index.

Franchise permit fee costs

(R.C. 5111.243 (repealed) and 5111.222)

Effective July 1, 2012, the act eliminates the franchise permit fee rate as one of the price centers that make up a nursing facility's total Medicaid reimbursement rate.

Quality incentive payments

(R.C. 5111.244)

A quality incentive payment is added to a nursing facility's Medicaid reimbursement rate. The amount of a nursing facility's quality incentive payment depends on how many points the nursing facility earns for meeting accountability measures.

The act provides for the pre-existing accountability measures to be used only for one more fiscal year: fiscal year 2012. ODJFS is no longer required to establish in rules the system for awarding points for meeting accountability measures. Instead, while the pre-existing accountability measures are used and with one exception, a nursing facility is to be awarded one point for each of the measures that the nursing facility meets. The

exception is that a nursing facility is to be awarded three points if its Medicaid utilization rate is above the statewide average. Regarding quality incentive points for resident and family satisfaction, a nursing facility is to be awarded points only if a satisfaction survey was conducted for the nursing facility in calendar year 2010.

Beginning in fiscal year 2013, ODJFS is to award each nursing facility points for meeting accountability measures in accordance with amendments to be made to state law governing quality incentive payments not later than December 31, 2011. Under the act, the General Assembly is to provide for all of the following when enacting the amendments:

(1) Meaningful accountability measures of quality of care, quality of life, and nursing facility staffing;

(2) The maximum number of points that a nursing facility may earn for meeting accountability measures;

(3) A methodology for calculating the quality incentive payment that recognizes different business and care models in nursing facilities by providing flexibility in nursing facilities' ability to earn the entire quality incentive payment;

(4) A quality bonus to be paid at the end of a fiscal year in a manner that provides for all funds that the General Assembly intends to be used for the quality incentive payment for that fiscal year to be distributed to nursing facilities.

The act specifies that the amount of funds the General Assembly intends to be used for the quality incentive payment for a fiscal year is to be the product of (a) the number of Medicaid days in the fiscal year and (b) the maximum quality incentive payment the General Assembly has specified in law to be paid to nursing facilities for that fiscal year.

FY 2012 and FY 2013 reimbursement rates

(Sections 309.30.60 and 309.30.70)

As was done for several prior fiscal years, the act requires ODJFS to adjust certain price centers and the quality incentive payment when determining nursing facilities' Medicaid reimbursement rates for fiscal years 2012 and 2013.

FY 2012

ODJFS is to make the following adjustments in calculating a nursing facility's Medicaid rate for fiscal year 2012:

(1) For the purpose of determining the nursing facility's rate for direct care costs, the nursing facility's semiannual case-mix score for the period beginning July 1, 2011, and ending January 1, 2012, is to be the same as the semiannual case-mix score used in calculating the nursing facility's June 30, 2011, rate for direct care costs.

(2) Each of the following are to be increased by 5.08%: the cost per case-mix unit, rate for ancillary and support costs, rate for tax costs, and rate for capital costs.

(3) The per resident per day rate paid for the franchise permit fee is to be $11.47.

(4) The mean payment used in the calculation of the quality incentive payment is to be, weighted by Medicaid days, $3.03 per Medicaid day.

If the rate determined for a nursing facility after these adjustments are made is less than 90% of its June 30, 2011, rate, ODJFS is required to implement a stop loss mechanism under which the amount of the nursing facility's rate reduction becomes less than what it otherwise would be. Under the stop loss mechanism, the nursing facility's fiscal year 2012 rate is to be the percentage determined as follows less than its June 30, 2011, rate:

(1) Determine the percentage difference between the nursing facility's June 30, 2011, rate and the rate determined under the act after the adjustments are made.

(2) Reduce the percentage determined under (1) by ten percentage points;

(3) Divide the percentage determined under (2) by two.

(4) Increase the percentage determined under (3) by ten percentage points.

FY 2013

ODJFS is to make the following adjustments in calculating a nursing facility's Medicaid rate for fiscal year 2013:

(1) Each of the following are to be increased by 5.08%: the cost per case-mix unit, rate for ancillary and support costs, rate for tax costs, and rate for capital costs.

(2) The maximum quality incentive payment is to be $16.44 per Medicaid day.

The rate determined with the above adjustments is not to be paid for nursing facility services provided to low resource utilization residents.[176] Instead, the fiscal year 2013 Medicaid reimbursement rate for those services is to be $130 per Medicaid day.

Franchise permit fee affect on rate

The total Medicaid reimbursement rate determined for nursing facilities for fiscal year 2012 or 2013 is to be reduced if the nursing home franchise permit fee is required to be reduced or eliminated that fiscal year to comply with federal law. The amount of the reduction is to reflect the loss to the state of the revenue and federal financial participation generated from the franchise permit fee.

Maximum payment for nursing facility services to dual eligible individuals

(R.C. 5111.225)

A dual eligible individual is an individual who is eligible for Medicaid and is entitled to, or enrolled in, Medicare Part A (which covers inpatient hospital services and some post-hospital extended care services such as skilled nursing care) or enrolled in Medicare Part B (which covers services such as physician services, outpatient care, and certain other medical services).

The act requires ODJFS to pay a nursing facility the lesser of the following for services provided on or after January 1, 2012, to a dual eligible individual:

(1) The coinsurance amount for the services as provided under federal law governing Medicare Part A;

(2) 100% of the nursing facility's per diem rate for the day of service, less the amount that Medicare Part A pays for the services.

This causes the maximum reimbursement rate to be reduced, effective January 1, 2012, from 109% to 100% of a nursing facility's Medicaid per diem rate because an ODJFS rule adopted prior to the act set the maximum reimbursement rate at 109%.

[176] The act defines a "low resource utilization resident" as a Medicaid recipient residing in a nursing facility who, for purposes of calculating the nursing facility's Medicaid reimbursement rate for direct care costs, is placed in either of the two lowest resource utilization groups, excluding any resource utilization group that is a default group used for residents with incomplete assessment data.

Centers of Excellence

(R.C. 5111.259 (primary) and 5111.258)

The act permits the ODJFS Director to seek federal approval to create a Medicaid program to be known as Centers of Excellence. The purpose of the Centers of Excellence program is to increase the efficiency and quality of nursing facility services provided to Medicaid recipients with complex nursing facility service needs.

If federal approval is obtained, the ODJFS Director may adopt rules governing the program, including rules that establish a method of determining the Medicaid reimbursement rates for nursing facility services provided to Medicaid recipients participating in the program. The rules may specify the extent to which, if any, the program is subject to continuing law governing the rates paid for nursing facility services provided to individuals with diagnoses or special care needs that are considered outliers.

Medicaid payments to reserve beds in nursing facilities

(R.C. 5111.331 (primary), 5111.20, 5111.22, 5111.221, 5111.222, 5111.224, 5111.232, 5111.25, 5111.251, 5111.254, 5111.255, 5111.258, 5111.259, 5111.262, 5111.27, 5111.29, 5111.291, and 5111.33)

The act permits ODJFS to make payments to a nursing facility to reserve a bed for a Medicaid recipient during a temporary absence under conditions prescribed by ODJFS. Under prior law, Medicaid reimbursement to a nursing facility had to include a payment to reserve a bed for a recipient during such a temporary absence. The act does not change the maximum period for which a payment may be made to reserve a bed: 30 days.

The act sets the maximum amounts that ODJFS may pay to reserve a bed in a nursing facility. Prior to the act, the amounts were established in an ODJFS rule. Under the act, the per diem rate for calendar year 2011 is not to exceed 50% of the per diem rate the nursing facility would be paid if the recipient were not absent that day. The per diem rate for calendar year 2012 and thereafter is not to exceed the following:

(1) In the case of a nursing facility that had an occupancy rate of more than 90% in the preceding calendar year, 50% of the per diem rate the facility would be paid if the recipient were not absent that day;

(2) In the case of a nursing facility that had an occupancy rate of 90% or less in the preceding calendar year, 18% of the per diem rate the facility would be paid if the recipient were not absent that day.

Report on nursing facility Medicaid-rate methodology

(R.C. 5111.20 and 5111.34 (repealed))

The act repeals a provision that required ODJFS to prepare an annual report containing recommendations on the methodology that should be used to transition paying nursing facilities the Medicaid reimbursement rate for one fiscal year to the rate for the next fiscal year. The ODJFS Director was required to submit a copy of the report to the Governor, the President and Minority Leader of the Senate, and the Speaker and Minority Leader of the House of Representatives by October 1 each year.

Nursing facility fiscal emergency

(R.C. 5111.511 (primary), 5111.35, 5111.52, 5111.54, and 5111.62)

Temporary resident safety assurance manager

The act authorizes ODJFS, if it determines that a nursing facility is experiencing or is likely to experience a serious financial loss or failure that jeopardizes or is likely to jeopardize the health, safety, and welfare of its residents, to appoint, subject to the provider's consent, a temporary resident safety assurance safety manager in the facility. The manager is to take actions ODJFS determines are appropriate to ensure the health, safety, and welfare of residents.

The act specifies that a provision of continuing law[177] governing the general authority and qualifications of temporary managers of nursing facilities does not apply to temporary resident safety assurance managers. The managers must meet qualifications, if any, established in rules the ODJFS Director adopts under the act.

The act specifies that a temporary resident safety assurance manager is vested with the authority necessary to take actions that ODJFS determines are appropriate to ensure the health, safety, and welfare of the nursing facility's residents. The manager is authorized to use any of the following funds to pay for costs the manager incurs on behalf of the nursing facility:

(1) Medicaid payments made in accordance with the nursing facility's Medicaid provider agreement;

(2) Funds from the Residents Protection Fund that ODJFS provides the manager (see "**Residents Protection Fund**," below);

[177] See R.C. 5111.54.

(3) Other funds ODJFS determines are appropriate if such use of the funds is consistent with the appropriations that authorize the use of the funds and all other state and federal laws governing the use of the funds.

The act specifies that the nursing facility provider is liable to ODJFS for the amount of any payments ODJFS makes to the temporary resident safety assurance manager, other than Medicaid payments made in accordance with the nursing facility's Medicaid provider agreement. ODJFS is authorized to recover the amount the provider owes ODJFS by doing any of the following: (1) offsetting Medicaid payments, (2) placing a lien on any of the provider's real and personal property, or (3) initiating other collection actions.

The act specifies that the actions ODJFS takes regarding a temporary resident safety assurance manager are not subject to appeal under the Administrative Procedure Act (R.C. Chapter 119.).

The ODJFS Director may establish in rules all of the following regarding temporary resident safety assurance managers:

(1) Qualifications persons must meet to be appointed;

(2) Procedures for maintaining a list of qualified appointees;

(3) Procedures consistent with federal law for paying for their services;

(4) Accounting and reporting requirements for the managers;

(5) Other procedures and requirements the Director determines are necessary.

Residents Protection Fund

The act specifies that money in the Residents Protection Fund created by continuing law[178] may be used to make payments to temporary resident safety assurance managers. The Fund consists of proceeds of all fines, including interest, collected pursuant to law governing nursing facility deficiencies. Under prior law, money in the Fund could be used only for the protection of the health or property of residents of nursing facilities in which the Ohio Department of Health found deficiencies.

[178] See R.C. 5111.62.

ICF/MR franchise permit fee

(R.C. 5112.30, 5112.31, 5112.37, 5112.371, and 5112.39)

The act sets the ICF/MR franchise permit fee rate at $17.99 for fiscal year 2012 and $18.32 for fiscal year 2013 and thereafter. The rate for future fiscal years is no longer to be the rate for the immediately preceding fiscal year as adjusted in accordance with a composite inflation factor established in rules.

Under prior law, the amount assessed under the ICF/MR franchise permit fee could not exceed 5.5% of the actual net patient revenues for all ICFs/MR for that fiscal year. If the rate used in the assessment resulted in a higher assessment, ODJFS was required to recalculate the assessment. This was done to address a restriction in federal Medicaid law. The federal restriction changes on October 1, 2011, in a manner that permits the amount assessed under the fee to be as high as 6% of the actual net patient revenues for all ICFs/MR for a fiscal year. The act addresses the federal change by providing for ODJFS to recalculate the assessment for a fiscal year if the total amount assessed exceeds the indirect guarantee percentage of the actual net patient revenues for all ICFs/MR for that fiscal year. The indirect guarantee percentage is the maximum percentage of actual net patient revenues that the federal law permits the fee to assess (i.e., 5.5% until October 1, 2011, and 6% thereafter).

Money raised by the ICF/MR franchise permit fee is deposited into two funds: the Home and Community-Based Services for the Mentally Retarded and Developmentally Disabled Fund and the Department of Developmental Disabilities Operating and Services Fund. The act revises the percentages used to determine how much of the money each fund receives. In fiscal year 2012, 81.77% of the money is to be deposited into the Home and Community-Based Services for the Mentally Retarded and Developmentally Disabled Fund. In fiscal year 2013 and thereafter, that fund is to receive 82.2% of the money. For each fiscal year, the Department of Developmental Disabilities Operating and Services Fund is to receive the remainder of the money. The act does not revise the purposes for which money in the funds must be used.

Medicaid reimbursement rates for ICFs/MR

Index used in calculating inflation factors

(R.C. 5111.23, 5111.235, and 5111.241)

The formulas used to determine the direct care, indirect care, and other protected costs of ICFs/MR include provisions regarding inflation adjustments. The act specifies what is to be done if an index used in calculating an inflation adjustment ceases to be published.

In determining the inflation adjustment for direct care costs, ODJFS has been required to use the Employment Cost Index for Total Compensation, Health Services Component, as published by the U.S. Bureau of Labor Statistics. The act specifies that, if the index ceases to be published, ODJFS is to use the index that is subsequently published by the Bureau and covers nursing facilities' staff costs.

In calculating the inflation adjustments for indirect care costs, ODJFS has been required to use the Consumer Price Index for all items for all urban consumers of the North Central region, as published by the U.S. Bureau of Labor Statistics. Under the act, if that index ceases to be published, a comparable index that the Bureau publishes and that ODJFS determines is appropriate is to be used.

In the case of other protected costs, ODJFS has been required to make the inflation adjustment using the Consumer Price Index for all urban consumers for nonprescription drugs and medical supplies, as published by the U.S. Bureau of Labor Statistics. The act specifies that, if the index ceases to be published, the index that the Bureau subsequently publishes and covers nonprescription drugs and medical supplies is to be used.

Refund of excess depreciation

(R.C. 5111.251)

The act eliminates a requirement that an ICF/MR, after the date on which a transaction of sale is closed, refund to ODJFS the amount of excess depreciation that ODJFS paid to the facility for each year it operated under a Medicaid provider agreement. Prior law specified that the amount of the refund had to be prorated according to the number of Medicaid patient days for which the ICF/MR received payment. "Excess depreciation" was defined as an ICF/MR's depreciated basis, which was the ICF/MR's cost less accumulated depreciation, subtracted from the purchase price but not exceeding the amount paid to the ICF/MR for cost of ownership less any amount paid for interest costs.

FY 2012 reimbursement rates

(Section 309.30.90)

The act provides for an existing ICF/MR's Medicaid reimbursement rate for fiscal year 2012 to be the average of its modified and capped rates unless the mean of such rates for all existing ICFs/MR is other than $282.59, in which case the ICF/MR's rate is to be adjusted by a percentage that equals the percentage by which the mean rate is greater or less than $282.59. An ICF/MR is considered to be an existing ICF/MR if (1) the provider of the ICF/MR has a valid Medicaid provider agreement for the ICF/MR

on June 30, 2011, and a valid Medicaid provider agreement for the ICF/MR during fiscal year 2012 or (2) the ICF/MR undergoes a change of operator that takes effect during fiscal year 2012, the exiting operator has a valid Medicaid provider agreement for the ICF/MR on the day immediately preceding the effective date of the change of operator, and the entering operator has a valid Medicaid provider agreement for the ICF/MR during fiscal year 2012.

An ICF/MR's modified rate is its rate as determined in accordance with Revised Code provisions governing the Medicaid reimbursement rates for ICFs/MR with the following modifications:

(1) In place of the inflation adjustment otherwise made in determining the ICF/MR's rate for other protected costs, its other protected costs, excluding the franchise permit fee component of those costs, from calendar year 2010 is to be multiplied by 1.0123.

(2) In place of the maximum cost per case-mix unit otherwise established for the ICF/MR's peer group, its maximum costs per case-mix unit is to be $108.21 if it has more than eight beds or $102.21 if it has eight or fewer beds.

(3) In place of the inflation adjustment otherwise calculated in determining the ICF/MR's rate for direct care costs, an inflation adjustment of 1.0123 is to be used.

(4) In place of the maximum rate for the indirect care costs of the ICF/MR's peer group, the maximum rate for the indirect care costs for its peer group is to be $68.98 if it has more than eight beds or $59.60 if it has eight or fewer beds.

(5) In place of the inflation adjustment otherwise calculated in determining the ICF/MR's rate for indirect care costs, an inflation adjustment of 1.0123 is to be used.

(6) In place of the efficiency incentive otherwise calculated in determining its rate for indirect care costs, its efficiency incentive for indirect care costs is to be $3.69 if it has more than eight beds or $3.19 if it has eight or fewer beds.

(7) The ICF/MR's efficiency incentive for capital costs is to be reduced by 50%.

An ICF/MR's capped rate is to be its rate as determined in accordance with Revised Code provisions governing the Medicaid reimbursement rates for ICFs/MR reduced by the percentage by which the mean of such rates for all ICFs/MR, weighted by May 2011 Medicaid days and calculated as of July 1, 2011, exceeds $282.59.

ODJFS is required by the act to reduce the amount it pays ICFs/MR for fiscal year 2012 if the U.S. Centers for Medicare and Medicaid Services requires that the ICF/MR

franchise permit fee be reduced or eliminated. The amount of the reduction is to reflect the loss to the state of the revenue and federal financial participation generated from the franchise permit fee.

FY 2013 reimbursement rates

(Section 309.33.10)

The act provides for an existing ICF/MR's Medicaid reimbursement rate for fiscal year 2013 to be the average of its modified and capped rates unless the mean of such rates for all existing ICFs/MR is other than $282.92, in which case the ICF/MR's rate is to be adjusted by a percentage that equals the percentage by which the mean rate is greater or less than $282.92. An ICF/MR is considered to be an existing ICF/MR if (1) the provider of the ICF/MR has a valid Medicaid provider agreement for the ICF/MR on June 30, 2012, and a valid Medicaid provider agreement for the ICF/MR during fiscal year 2013 or (2) the ICF/MR undergoes a change of operator that takes effect during fiscal year 2013, the exiting operator has a valid Medicaid provider agreement for the ICF/MR on the day immediately preceding the effective date of the change of operator, and the entering operator has a valid Medicaid provider agreement for the ICF/MR during fiscal year 2013.

An ICF/MR's modified rate is its rate as determined in accordance with Revised Code provisions governing the Medicaid reimbursement rates for ICFs/MR with the following modifications:

(1) In place of the inflation adjustment otherwise made in determining the ICF/MR's rate for other protected costs, its other protected costs, excluding the franchise permit fee component of those costs, from calendar year 2011 is to be multiplied by 1.0123.

(2) In place of the maximum cost per case-mix unit otherwise established for the ICF/MR's peer group, its maximum costs per case-mix unit is to be $108.21 if it has more than eight beds or $102.21 if it has eight or fewer beds.

(3) In place of the inflation adjustment otherwise calculated in determining the ICF/MR's rate for direct care costs, an inflation adjustment of 1.0123 is to be used.

(4) In place of the maximum rate for the indirect care costs of the ICF/MR's peer group, the maximum rate for the indirect care costs for its peer group is to be $68.98 if it has more than eight beds or $59.60 if it has eight or fewer beds.

(5) In place of the inflation adjustment otherwise calculated in determining the ICF/MR's rate for indirect care costs, an inflation adjustment of 1.0123 is to be used.

(6) In place of the efficiency incentive otherwise calculated in determining its rate for indirect care costs, its efficiency incentive for indirect care costs is to be $3.69 if it has more than eight beds or $3.19 if it has eight or fewer beds.

(7) The ICF/MR's efficiency incentive for capital costs is to be reduced by 50%.

An ICF/MR's capped rate is to be its rate as determined in accordance with Revised Code provisions governing the Medicaid reimbursement rates for ICFs/MR reduced by the percentage by which the mean of such rates for all ICFs/MR, weighted by May 2012 Medicaid days and calculated as of July 1, 2012, exceeds $282.92.

ODJFS is required by the act to reduce the amount it pays ICFs/MR for fiscal year 2013 if the U.S. Centers for Medicare and Medicaid Services requires that the ICF/MR franchise permit fee be reduced or eliminated. The amount of the reduction is to reflect the loss to the state of the revenue and federal financial participation generated from the franchise permit fee.

Study of ICF/MR issues

(Section 309.30.80)

The act requires ODJFS and the Ohio Department of Developmental Disabilities (ODODD) to study issues regarding Medicaid reimbursement for ICF/MR services. ODJFS and ODODD must examine revising the Individual Assessment Form (IAF) Answer Sheet in a manner that provides a more accurate assessment of the acuity and care needs of individuals who need ICF/MR services, especially for individuals with intensive behavioral or medical needs. After examining the issue of revising the IAF Answer Sheet, ODJFS and ODODD are to examine revisions to the Medicaid reimbursement formula for ICF/MR services to (1) ensure that reimbursement for capital costs is adequate for maintaining the capital assets of ICFs/MR in a manner that promotes the well-being of the residents, (2) provide capital incentives for reducing the capacity of ICFs/MR as necessary to achieve goals regarding the optimal capacity of ICFs/MR, (3) ensure that wages paid individuals who provide direct care services to ICF/MR residents are sufficient for ICFs/MR to meet staffing and quality requirements, (4) provide incentives for high quality services, and (5) achieve other goals developed for the purpose of improving the appropriateness and sufficiency of Medicaid reimbursements for ICF/MR services. A report of the study is to be submitted to the Governor and General Assembly. No deadline is established for the report.

At the same time they conduct the study, ODJFS and ODODD must work with the Governor's Office of Health Transformation and persons interested in the issue of ICF/MR services to develop recommendations regarding (1) goals regarding the ratio of ODODD-administered home and community-based Medicaid waiver services and

ICF/MR services that take into account goals regarding the optimal capacity of ICFs/MR, (2) the roles and responsibilities of ICFs/MR owned and operated by ODODD and providers of services under ODODD-administered Medicaid waiver programs that provide home and community-based services, and (3) simplifying and eliminating duplicate regulations regarding ICFs/MR in a manner that lowers the cost of ICF/MR services.

Transfer of ICF/MR services to ODODD

(R.C. 5111.226 (primary) and 5111.211; Section 309.33.20)

The act requires that ODJFS enter into an interagency agreement with ODODD that provides for ODODD to assume the powers and duties of ODJFS with regard to the Medicaid program's coverage of ICF/MR services. The agreement is subject to the approval of the U.S. Secretary of Health and Human Services if such approval is needed. The agreement must include a schedule for ODODD's assumption of the powers and duties. No provision of the agreement may violate a federal law or regulation governing the Medicaid program, unless otherwise authorized by the U.S. Secretary. Once the agreement goes into effect and to the extent necessary to implement the terms of the agreement, ODODD is to be considered ODJFS, and the ODODD Director is to be considered the ODJFS Director, for purposes of state law that gives ODJFS and the ODJFS Director powers and duties regarding ICFs/MR.

Nursing facility and ICF/MR audits and fines

The act revises the law governing audits of Medicaid cost reports that nursing facilities and ICFs/MR must annually file with ODJFS. Cost reports are used to determine Medicaid reimbursement rates.

Audit-related restriction on amending Medicaid cost report

(R.C. 5111.261, 5111.263, and 5111.28)

The act creates an audit-related exception to the right of nursing facilities and ICFs/MR to amend Medicaid cost reports. Under the act, a cost report cannot be amended if ODJFS has notified the nursing facility or ICF/MR that an audit of the cost report or a cost report for a subsequent cost reporting period is to be conducted. The nursing facility or ICF/MR may, however, provide ODJFS information that affects the costs included in the cost report. The information cannot be provided after the adjudication of the final settlement of the cost report.

Determining whether to conduct an audit

(R.C. 5111.27)

Under the act, ODJFS is no longer required, but is instead permitted, to base a decision on whether to audit, and the scope of an audit of, a Medicaid cost report on the prior performance of a nursing facility or ICF/MR.

Requirements in ODJFS manual for field audits

(R.C. 5111.27)

The act requires ODJFS to revise certain requirements included in its manual for field audits. Under prior law, the manual had to require an auditor to include a written summary as to whether the costs included in a Medicaid cost report examined during the audit were presented fairly in accordance with generally accepted accounting principles and ODJFS rules. Under the act, the manual must require an auditor to include a written summary as to whether the included costs are presented in accordance with state and federal laws and regulations. Prior law required the manual to provide for field audits to be conducted by auditors who were otherwise independent as determined by the standards of independence established by the American Institute of Certified Public Accountants. The act requires instead that standards of independence included in government auditing standards produced by the U.S. Government Accountability Office be used to determine an auditor's independence.

Nursing facility fines for adverse findings in audits

(R.C. 5111.271 (primary), 5111.27, and 5111.94)

The act requires ODJFS to fine a nursing facility if an audit report includes adverse findings exceeding (1) 3% of the total amount of Medicaid-reimbursable costs reported in the Medicaid cost report that was audited or (2) 20% of such costs for a particular cost center reported in that cost report. The audit report must include notice of the fine. No fine may be issued until all appeal rights relating to the audit report are exhausted.

Under the act, an audit-related fine is to equal the greatest of the following:

(1) If the adverse findings exceed 3% but do not exceed 10% of the total amount of Medicaid-reimbursable costs reported in the cost report, the greater of 3% of those reported costs or $10,000;

(2) If the adverse findings exceed 10% but do not exceed 20% of the total amount of Medicaid-reimbursable costs reported in the cost report, the greater of 6% of those reported costs or $25,000;

(3) If the adverse findings exceed 20% of the total amount of Medicaid-reimbursable costs reported in the cost report, the greater of 10% of those reported costs or $50,000;

(4) If the adverse findings exceed 20% but do not exceed 25% of Medicaid-reimbursable costs for a particular cost center reported in the cost report, the greater of 3% of the total amount of Medicaid-reimbursable costs reported in the cost report or $10,000;

(5) If the adverse findings exceed 25% but do not exceed 30% of Medicaid-reimbursable costs for a particular cost center reported in the cost report, the greater of 6% of the total amount of Medicaid-reimbursable costs reported in the cost report or $25,000;

(6) If the adverse findings exceed 30% of Medicaid-reimbursable costs for a particular cost center reported in the cost report, the greater of 10% of the total amount of Medicaid-reimbursable costs reported in the cost report or $50,000.

The fines are to be deposited into the Health Care Services Administration Fund.

Collection of long-term care facilities' Medicaid debts

(R.C. 5111.65 (primary), 5111.212, 5111.66, 5111.67, 5111.671, 5111.672, 5111.68, 5111.681, 5111.687, and 5111.689)

The act revises the law that establishes requirements for a nursing facility or ICF/MR that undergoes a change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation. The requirements concern the state's collection of debts a nursing facility or ICF/MR owes under the Medicaid program.

Facility closure

(R.C. 5111.65(J))

Prior law specified one circumstance under which a facility closure occurred: when the building, or part of the building, that houses the facility discontinues to be used as a nursing facility or ICF/MR and all of the facility's residents are relocated. The act specifies an additional circumstance under which a facility closure occurs: when the building, or part of the building, that houses a nursing facility or ICF/MR converts to a different use. To be considered a closure under this provision, any necessary license or

other approval needed for the different use must be obtained and one or more of the facility's residents must remain in the facility to receive services under the new use.

Notices

(R.C. 5111.66, 5111.67, 5111.687, and 5111.689)

The Medicaid debt-collection process begins when ODJFS is notified of a change of operator, facility closure, voluntary termination, or voluntary withdrawal of participation. The act requires that the notice, and any notice regarding a postponement or cancellation, be provided in accordance with a method ODJFS is to specify in rules.

The act revises the information that must be included in a written notice of a change of operator. The notice must include the exiting operator's seven-digit Medicaid legacy number and ten-digit national provider identifier number rather than the operator's Medicaid provider agreement number. The notice is to include two additional items. The first additional item is the name and address of each person to whom ODJFS should send initial correspondence regarding the change of operator. The second additional item applies when a nursing facility also participates in the Medicare program. In that case, the notice must also include notification of whether the entering operator intends to accept assignment of the exiting operator's Medicare provider agreement. Under the act, an entering operator is no longer required to include a completed application for a Medicaid provider agreement, accompanied by certain financial documents, with a written notice of a change of operator.

The act requires an exiting operator or owner and entering operator to provide ODJFS written notice of any changes to the information included in the notice of the change of operator. The notice of the changes is to be provided in accordance with a method ODJFS is to specify in rules.

Effective date of an entering operator's Medicaid provider agreement

(R.C. 5111.67, 5111.671, and 5111.672)

The act revises the law governing when an entering operator's Medicaid provider agreement for a nursing facility or ICF/MR undergoing a change of operator goes into effect.

An entering operator seeking a Medicaid provider agreement for a nursing facility or ICF/MR undergoing a change of operator must provide ODJFS with copies of certain documents relating to the change of operator. Under prior law, the following documents had to be provided: fully executed leases, management agreements, merger

agreements and supporting documents, and sales contracts and supporting documents. The act requires that ODJFS specify in rules which documents an entering operator must include with a Medicaid provider agreement application. The rules must provide for the documents to include all fully executed leases, management agreements, merger agreements and supporting documents, and *fully executed* sales contracts and other supporting documents culminating in the change of operator. The act also requires that the exiting operator or owner provide ODJFS with documents to be specified in rules.

The date on which an entering operator's Medicaid provider agreement goes into effect depends on certain factors. The provider agreement may go into effect at 12:01 a.m. on the effective date of the change of operator if ODJFS receives the notice of the change of operator by the statutorily prescribed time and the required documents not later than ten days after the effective date of the change of operator. If any of those deadlines are not met, ODJFS is to determine when the provider agreement goes into effect. The act eliminates a factor that was part of ODJFS's determination of the provider agreement's effective date. Under the act, the effective date is not required to be set at a time that gives ODJFS sufficient time to withhold a final Medicaid payment to the exiting operator under the debt collection process until 180 days after either (1) the exiting operator submits a properly completed cost report or (2) ODJFS waives the cost report requirement.

Involuntary termination

(R.C. 5111.212, 5111.65, 5111.68, and 5111.681)

The act provides for the Medicaid debt collection requirements to apply in a new situation: an involuntary termination. In the context of a nursing facility, an involuntary termination occurs when ODJFS terminates the facility's provider agreement and the termination is not at the facility's request. In the context of an ICF/MR, an involuntary termination occurs when ODJFS terminates, cancels, or refuses to renew the ICF/MR's provider agreement and that action is not taken at the ICF/MR's request.

The debt collection process is to begin on the effective date of an involuntary termination. In the case of a nursing facility, the effective date is the date that ODJFS terminates the facility's provider agreement. In the case of an ICF/MR, the effective date is the date that ODJFS terminates the ICF/MR's provider agreement or the last day that the provider agreement is in effect when ODJFS cancels or refuses to renew it.

As part of the debt collection process, ODJFS is to estimate the amount of exiting operator's Medicaid debt. After the estimation is made, ODJFS, subject to a successor liability agreement, may withhold from payment due the exiting operator under the

Medicaid program the total amount of the estimated debt. A successor liability agreement is an agreement made by the exiting operator, the entering operator, or an affiliated operator to assume all or part of the exiting operator's Medicaid debt. The act permits the exiting operator, entering operator, or affiliated operator to enter into a successor liability agreement under the same conditions that continuing law permits such individuals to enter into a successor liability agreement when a change of operator occurs, except that, in the case of an involuntary termination, a successor liability agreement is subject to ODJFS's approval.

The act permits Medicaid payments to be made for nursing facility services and ICF/MR services for up to 30 days after the effective date of an involuntary termination of the facility that provides the services if the services are provided to a Medicaid recipient who is eligible for the services and resided in the facility before the effective date of the involuntary termination.

Rebalancing long-term care

(Section 309.35.10)

The act requires ODJFS, Ohio Department of Aging, and Ohio Department of Developmental Disabilities to continue efforts to achieve a sustainable and balanced delivery system for long-term services and supports. In working to achieve such a delivery system, the Departments are to strive to meet, by June 30, 2013, certain goals regarding the utilization of non-institutionally-based long-term services and supports. The goals are to have the services and supports used as follows: (1) by at least 50% of Medicaid recipients who are age 60 or older and need long-term services and supports and (2) by at least 60% of Medicaid recipients who are less than age 60 and have cognitive or physical disabilities for which long-term services and supports are needed. "Non-institutionally based long-term services and supports" is a federal term that means services not provided in an institution, including (1) home and community-based services, (2) home health care services, (3) personal care services, (4) PACE services, and (5) self-directed personal assistance services.

Balancing Incentive Payments Program

(Sections 309.35.10(C) and 309.35.20)

ODJFS is permitted, if it determines that participating in the Balancing Incentives Payments Program will assist in achieving the goals regarding long-term services, to apply to participate. The Program was created as part of the federal health care reform law to encourage states to increase the use of non-institutional care provided under their Medicaid programs. A participating state receives a larger federal match for non-

institutionally based long-term services and supports provided under its Medicaid program.[179]

The act requires that any funds Ohio receives as the result of the larger federal match be deposited into the Balancing Incentive Payments Program Fund, which the act creates in the state treasury. ODJFS is required to use money in the Fund in accordance with federal requirements governing the use of the money. This means that ODJFS must use the money only for purposes of providing new or expanded offerings of non-institutionally based long-term services and supports under the Medicaid program. The act authorizes the ODJFS Director to seek Controlling Board approval to make expenditures from the Fund.

Ohio Access Success Project

(R.C. 5111.97)

Continuing law permits the ODJFS Director to establish the Ohio Access Success Project to help Medicaid recipients transition from residing in a nursing facility to residing in a community setting. The act eliminates the eligibility requirement under which an applicant must need a nursing facility level of care.

When the Project is being administered as a non-Medicaid program, the act specifies that an applicant must be able to remain in the community as a result of receiving the Project's benefits. The act retains the specification that the cost of the benefits provided when the Project is administered as a non-Medicaid program is not to exceed 80% of the average monthly cost of a Medicaid recipient in a nursing facility.

The act requires the ODJFS Director to assess an applicant's eligibility for participation in the Project regardless of how long the applicant has been a recipient of Medicaid-funded nursing facility services. Under prior law, the Director was to assess the applicant's eligibility only if the application was received before the applicant had been a recipient of Medicaid-funded nursing facility services for six months.

ODJFS and ODA Medicaid home and community-based services

The act revises the law governing various Medicaid programs that provide home and community-based services. Two of the programs – Ohio Home Care and Ohio Transitions II Aging Carve-Out – are administered by ODJFS. Four of the programs – PASSPORT, Assisted Living, Choices, and PACE – are administered by the Ohio Department of Aging (ODA) through an interagency agreement with ODJFS. All but

[179] Section 10202 of the Patient Protection and Affordable Care Act (Public Law 111-148).

PACE are authorized by federal Medicaid waivers. PACE is part of the state's Medicaid plan.

Home First processes are established in statute for the PASSPORT, Assisted Living, and PACE programs. ODJFS has rule-making authority to establish similar processes for other Medicaid waiver programs. Home First processes enable individuals meeting certain requirements to be enrolled in the PASSPORT, Assisted Living, or PACE program ahead of others.

State-funded components of PASSPORT and Assisted Living

(R.C. 173.40, 173.401, 173.404, 173.42, 3721.56, 5111.85, 5111.89, 5111.891, 5111.892, 5111.893, 5111.894, and 5111.971)

The act establishes state-funded components of the PASSPORT and Assisted Living programs. A more limited state-funded component of the PASSPORT program has been authorized by uncodified law for many years.[180] The state-funded components of the PASSPORT and Assisted Living programs are not to be part of the Medicaid program. ODA is to administer the state-funded components independently rather than, as is the case with the Medicaid-funded components of the programs, through an interagency agreement with ODJFS.

For an individual to be eligible for the state-funded component of the PASSPORT program, the individual must be in one of three categories and meet additional eligibility requirements to be established in rules. The three categories are (1) "grandparented" individuals, (2) former recipients, and (3) presumptively eligible individuals. To be in the category for grandparented individuals, an individual must have been enrolled in the state-funded component on September 1, 1991, (as the state-funded component was authorized by uncodified law in effect at that time) and have had one or more applications for enrollment in the Medicaid-funded component (or a replacement Medicaid waiver program) denied. To be in the category for former recipients, an individual's enrollment in the Medicaid-funded component (or a replacement Medicaid waiver program) must have been terminated and the individual must still need the home and community-based services provided under the PASSPORT program to protect the individual's health and safety. To be in the category for presumptively eligible individuals, the individual must have an application for the Medicaid-funded component (or a replacement Medicaid waiver program) pending and ODA or ODA's designee must have determined that the individual meets the nonfinancial eligibility requirements of the Medicaid-funded component (or a replacement Medicaid waiver program) and not have reason to doubt that the

[180] For example, see Section 209.20 of Am. Sub. H.B. 1 of the 128th General Assembly.

individual meets the financial eligibility requirements of the Medicaid-funded component (or a replacement Medicaid waiver program). Eligibility for the state-funded component is limited to a maximum of three months for presumptively eligible individuals.

To be eligible for the state-funded component of the Assisted Living program, an individual must meet some of the requirements that also apply to the Medicaid-funded component. The individual must need an intermediate level of care and, while participating in the program, reside in a residential care facility (popularly known as an assisted living facility). Additionally, however, an individual must be presumptively eligible for the Medicaid-funded component (or a replacement Medicaid waiver program) and meet additional eligibility requirements to be established in ODA rules. To be presumptively eligible, an individual must have an application for the Medicaid-funded component (or a replacement Medicaid waiver program) pending and ODA or ODA's designee must have determined that the individual meets the nonfinancial eligibility requirements of that component (or a replacement Medicaid waiver program) and not have reason to doubt that the individual meets the financial eligibility requirements for that component (or a replacement Medicaid waiver program). Eligibility for the state-funded component is limited to a maximum of three months.

The ODA Director is required by the act to adopt rules to implement the state-funded components of the PASSPORT and Assisted Living programs. The additional eligibility requirements established in the rules for the PASSPORT program may vary for the different eligibility categories.

The act provides that the Home First processes for the PASSPORT and Assisted Living programs apply only to the Medicaid-funded components of the programs.

Assisted Living program eligibility and administration

(R.C. 5111.891 (primary), 5111.89, 5111.893 (repealed), and 5111.894)

The act eliminates certain eligibility requirements for the Medicaid-funded component of the Assisted Living program. Under the act, an individual no longer needs to be one of the following at the time the individual applies:

(1) A nursing facility resident who is seeking to move to an assisted living facility and would remain in a nursing facility for long-term care if not for the Assisted Living program;

(2) A participant of the PASSPORT program, the Choices program, or an ODJFS-administered Medicaid waiver program who would move to a nursing facility if not for the Assisted Living program;

(3) A resident of an assisted living facility who has resided in an assisted living facility for at least six months immediately before the date the individual applies for the Assisted Living program.

The act eliminates a requirement that the Director of the Office of Budget and Management (OBM) approve the interagency agreement between ODA and ODJFS regarding the administration of the Assisted Living program as a condition of ODA being able to administer the program.

The act repeals an obsolete law that required the ODA Director to contract with a person or government entity to evaluate the cost effectiveness of the Assisted Living program and provide the results of the evaluation to the Governor, President and Minority Leader of the Senate, and Speaker and Minority Leader of the House of Representatives by June 30, 2007.

ODA unified waiting list

(R.C. 173.404)

The act provides that the requirement for ODA to establish a unified waiting list for the PASSPORT, Choices, Assisted Living, and PACE programs applies if ODA determines that there are insufficient funds to enroll all individuals who have applied and been determined eligible for the programs. Under prior law, ODA was required to establish a unified waiting list regardless of whether such a determination was made.

Evaluation and expansion of PACE

(Section 309.33.50)

The act requires the ODA Director to contract with Miami University's Scripps Gerontology Center for an evaluation of PACE. PACE, or the Program of All-Inclusive Care for the Elderly, is a managed care system that provides participants with coverage of all of needed health care, including care in both institutional and community settings. It is funded by both Medicaid and Medicare.[181]

In order to effectively administer and manage growth within PACE, the act permits the ODA Director, in consultation with the ODJFS Director, to expand PACE to additional regions of Ohio beyond the two service areas in existence on June 30, 2011.[182]

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[181] Ohio Department of Aging, *About PACE* (last visited August 7, 2011) available at: <http://aging.ohio.gov/services/PACE/>.

[182] As of June 30, 2011, the two PACE providers in Ohio are TriHealth Senior Link and McGregor PACE Center for Senior Independence. The service area for the PACE agreement with TriHealth Senior Link is

The expansion may occur only if the following apply: (1) funding is available for the expansion, (2) the Directors mutually determine, taking into consideration the results of the Scripps Gerontology Center's evaluation, that PACE is a cost-effective alternative to nursing home care, and (3) the U.S. Centers for Medicare and Medicaid Services agrees to share with Ohio any savings to Medicare resulting from an expansion of PACE. In implementing an expansion, the act prohibits the ODA Director from decreasing the number of PACE participants in the original PACE sites to a number that is below the number of individuals in those areas who were participants in the program on July 1, 2011.

Ohio Home Care and Ohio Transitions II Aging Carve-Out programs codified

(R.C. 5111.861, 5111.863, and 5111.88)

The act creates the Ohio Home Care and Ohio Transitions II Aging Carve-Out programs in statute (i.e., codifies the programs). Prior law included a reference to the programs, but the programs were not previously created in statute.

Rules for enrollment in Medicaid home and community-based waivers

(R.C. 5111.85)

The act modifies the ODJFS Director's rulemaking authority regarding Medicaid waivers for home and community-based services by doing the following:

(1) Creating a general requirement that the rules establish procedures for prioritizing and approving enrollment of eligible individuals who choose to be enrolled;

(2) Eliminating a requirement that the rules establish procedures for identifying and approving enrollment of individuals on waiting lists who are receiving inpatient hospital services or residing in a nursing facility or ICF/MR.

Unified long-term services and support Medicaid waiver program

(R.C. 5111.864 (primary), 173.40, 173.401, 173.403, 5111.861 (repealed and new enactment), 5111.862, 5111.863, 5111.865, 5111.89, and 5111.894; Section 309.33.30)

The act requires the ODJFS Director to seek federal permission to create a unified long-term services and support Medicaid waiver program to provide home and community-based services to eligible individuals of any age who require the level of care provided by nursing facilities. This requirement replaces a previous requirement

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Hamilton County and certain zip codes in Warren, Butler, and Clermont counties. Cuyahoga County is the service area for the PACE agreement with McGregor PACE.

that the ODJFS Director seek federal permission for a federal Medicaid waiver to consolidate the PASSPORT, Choices, and Assisted Living programs into one Medicaid waiver program.

In seeking federal approval for the unified long-term services and support Medicaid waiver program, the ODJFS Director must work with the ODA Director. The ODJFS Director is also to work with the ODA Director in creating and implementing the program, including adopting rules, if federal approval is obtained. The rules may authorize the ODA Director to adopt rules governing aspects of the program.

ODJFS and ODA are required by the act to work together to determine, on an individual program basis, whether the PASSPORT, Choices, Assisted Living, Ohio Home Care, and Ohio Transitions II Aging Carve-Out programs should continue to operate as separate Medicaid waiver programs or be terminated if the unified long-term services and support Medicaid waiver program is created. If they determine that a program should be terminated, the program is to cease to exist on a date ODJFS and ODA must specify.

If ODJFS and ODA terminate the PASSPORT, Choices, Assisted Living, Ohio Home Care, or Ohio Transitions II Aging Carve-Out program, all applicable statutes, and all applicable rules, standards, guidelines, or orders issued by ODJFS or ODA before the program is terminated, are to remain in full force and effect on and after that date, but solely for purposes of concluding the program's operations, including fulfilling ODJFS's and ODA's legal obligations for claims arising from the program relating to eligibility determinations, covered medical assistance provided to eligible persons, and recovering erroneous overpayments. The right of subrogation for the cost of medical assistance and an assignment of the right to medical assistance continue to apply with respect to the terminated program and remain in force to the full extent provided under law governing the right of subrogation and assignment. ODJFS and ODA are permitted to use appropriated funds to satisfy any claims or contingent claims for medical assistance provided under the terminated program before the program's termination. Neither ODJFS nor ODA has liability under the terminated program to reimburse any provider or other person for claims for medical assistance rendered under the program after it is terminated.

Home First processes

(R.C. 173.401, 173.404, 173.501, and 5111.894)

Under the act, an individual may be enrolled in the PASSPORT, Assisted Living, or PACE program through a Home First process without being placed on a unified waiting list established by ODA. In addition to eliminating a requirement that an

individual be on the unified waiting list to be enrolled through a Home First process, the act requires that an individual have been determined to be eligible, rather than only be eligible, for the PASSPORT, Assisted Living, or PACE program to qualify for enrollment through a Home First process.

The act eliminates a requirement that ODA quarterly certify to the OBM Director the estimated increase in the costs of the PASSPORT, Assisted Living, and PACE programs because of enrollments into those programs through Home First processes.

The act requires ODJFS to establish a Home First process for the Ohio Home Care Program unless it is terminated. An individual is to be eligible for the Program's Home First component if the individual has been determined to be eligible for the Program and at least one of the following applies:

(1) If the individual is under age 21, the individual received inpatient hospital services for at least 14 consecutive days, or had at least 3 inpatient hospital stays during the 12 months, immediately preceding the date the individual applies for the Program.

(2) If the individual is at least age 21 but less than age 60, the individual received inpatient hospital services for at least 14 consecutive days immediately preceding the date the individual applies for the Program.

(3) The individual received private duty nursing services under the Medicaid program for at least 12 consecutive months immediately preceding the date the individual applies for the Program.

(4) The individual does not reside in a nursing facility or hospital long-term care unit at the time the individual applies for the Program but is at risk of imminent admission due to a documented loss of a primary caregiver.

(5) The individual resides in a nursing facility at the time the individual applies for the Program.

(6) At the time the individual applies for the Program, the individual participates in the Money Follows the Person demonstration project and either resides in a residential treatment facility[183] or inpatient hospital setting.

[183] The act defines a "residential treatment facility" as a residential facility that is licensed by ODMH and serves children and either has more than 16 beds or is part of a campus of multiple facilities that, combined, have a total of more than 16 beds.

An individual determined to be eligible for the Home First component of the Ohio Home Care Program is to be enrolled in the Program in accordance with ODJFS's rules.

The act also requires ODJFS to establish a Home First process for the unified long-term services and support Medicaid waiver program if federal permission is obtained for the program. The Home First process must be similar to the Home First processes for PASSPORT, Ohio Home Care, and Assisted Living programs.

Pilot program for self-directed home and community-based care

(R.C. 5111.97 and 5111.971 (repealed))

The act repeals the requirement that the ODJFS Director create a pilot program for providing up to 200 eligible Medicaid recipients with spending authority to pay for the cost of medically necessary home and community-based services. The spending authorization was not to exceed 70% of the average cost for providing nursing facility services to an individual under Medicaid.

ODODD-administered Medicaid home and community-based services

Reimbursement for services

(R.C. 5111.873)

Continuing law authorizes the ODJFS Director to apply to the U.S. Secretary of Health and Human Services for one or more Medicaid waivers under which home and community-based services are provided to individuals with mental retardation and developmental disabilities as an alternative to placement in an ICF/MR. Prior law required the Director to adopt rules establishing statewide fee schedules for these home and community-based services administered by the Ohio Department of Developmental Disabilities (ODODD). The act requires, instead of establishing fee schedules, that the Director adopt rules establishing the amount of reimbursement or the methods by which amounts of reimbursement are to be determined. The act's conforming changes require that the rules do all of the following:

(1) Establish procedures for ODODD to follow in arranging for the initial and ongoing collection of cost information from a comprehensive, statistically valid sample of private and public entities providing the services at the time the information is obtained;

(2) Establish procedures for the collection of consumer-specific information through an assessment instrument ODODD is required to provide to ODJFS;

(3) With the information described above, an analysis of that information, and other information the Director determines relevant, establish reimbursement standards that (a) assure that the reimbursement is consistent with efficiency, economy, and quality of care, (b) consider the intensity of consumer resource need, (c) recognize variations in different geographic areas regarding the resources necessary to assure the health and welfare of consumers, and (d) recognize variations in environmental supports available to consumers.

The ODJFS and ODODD Directors must review the rules at times they determine are necessary to ensure that the amount of reimbursement or the methods by which amounts of reimbursement are to be determined continue to meet the act's reimbursement standards.

Conversion of ICF/MR beds

(R.C. 5111.874 and 5111.877)

Under continuing law, an operator of an ICF/MR that is licensed by ODODD as a residential facility may convert all of the beds in the facility from providing ICF/MR services to providing ODODD-administered home and community-based services if certain requirements are met. The act permits such an operator of an ICF/MR to convert ***some*** of the beds.

Under the act, the operator must specify whether some or all of the beds are to be converted. If only some of the beds are to be converted, the operator must specify how many of the facility's beds are to be converted and how many are to continue to provide ICF/MR services. In addition, if the operator intends to convert some but not all of the facility's beds, it must notify the residents that they may (1) continue to receive ICF/MR services from any provider willing and able to accept the resident if the resident continues to qualify for ICF/MR services or (2) begin to receive ODODD-administered home and community-based services from any provider of the services that is willing and able to provide the services to the resident, if the resident is eligible for the services and a slot for the services is available.

The act requires that the conversion be approved by both the ODODD Director and the ODJFS Director. Prior law required approval by only the ODODD Director.

Under the act, a decision by the Directors to approve or refuse to approve a proposed conversion is final. In making a decision, the Directors must consider (1) the fiscal impact on the facility if some but not all of the beds are converted, (2) the fiscal impact on the Medicaid program, and (3) the availability of home and community-based services.

If the conversion of only some of the ICF/MR's beds is approved, the Director of Health must reduce the facility's certified capacity by the number of beds being converted. The ODJFS Director must amend the operator's Medicaid provider agreement to reflect the facility's reduced certified capacity.

Under prior law, the maximum number of slots available for home and community-based services provided under an ODODD-administered Medicaid waiver was 100 for the purpose of beds that are converted from providing ICF/MR services to home and community-based services. The act increases to 200 the maximum number of such slots for which the ODJFS Director may seek federal approval.

Transfer of Transitions Developmental Disabilities Medicaid waiver program

(R.C. 5111.871, 5111.872, 5111.873, 5123.01, and 5126.01; Section 309.33.20)

In addition to transferring the powers and duties regarding ICFs/MR to ODODD, the act requires ODJFS to transfer administration of the Transitions Developmental Disabilities Medicaid waiver program to ODODD. The transfer is to be part of an interagency agreement that, under continuing law, provides for ODODD to administer certain other Medicaid waiver programs that provide home and community-based services to individuals with mental retardation and developmental disabilities as an alternative to placement in an ICF/MR. This transfer is also subject to the approval of the U.S. Secretary of Health and Human Services if such approval is needed. The interagency agreement is to include a schedule for the transfer. The act specifies that continuing laws governing ODODD-administered Medicaid waiver programs are to apply to the Transitions Developmental Disabilities Medicaid waiver program only to the extent, if any, provided in the interagency agreement.

Money Follows the Person Enhanced Reimbursement Fund

(Section 309.33.80)

The act provides for the Money Follows the Person Enhanced Reimbursement Fund to continue to exist in the state treasury for fiscal years 2012 and 2013. The Fund was created by Am. Sub. H.B. 562 of the 127th General Assembly. The federal payments made to Ohio under federal law governing Money Follows the Person demonstration projects are to be deposited in the Fund. ODJFS is required to use the money in the Fund for system reform activities related to the demonstration project.

The Deficit Reduction Act of 2005 authorizes the U.S. Secretary of Health and Human Services to award grants to states for Money Follows the Person demonstration

projects.[184] The projects are to be designed to achieve the following objectives with respect to institutional and home and community-based long-term care services under a state's Medicaid program:

(1) Increase the use of home and community-based, rather than institutional, long-term care services;

(2) Eliminate barriers or mechanisms that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice;

(3) Increase the ability of a state's Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institution to a community setting;

(4) Ensure that procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community-based services and to provide for continuous quality improvement in such services.

Dual eligible integrated care demonstration project

(R.C. 5111.981 (primary) and 5111.944; Section 309.35.30)

The act permits the ODJFS Director to seek federal approval to implement a demonstration project to test and evaluate the integration of the care that dual eligible individuals[185] receive under the Medicare and Medicaid programs. The federal approval must be from the U.S. Secretary of Health and Human Services in the form of a federal Medicaid waiver, Medicaid state plan amendment, or demonstration grant. If approval is granted, the demonstration project must be implemented in accordance with the terms of the approval, including terms regarding the project's duration. No provision of Ohio's human services laws (R.C. Title 51) applies to the demonstration project if that provision implements or incorporates a provision of federal Medicaid law that does not apply to the demonstration project.

The act also creates the Integrated Care Delivery Systems Fund in the state treasury. This Fund is to receive amounts that the demonstration project saves the

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[184] Section 6071 of the Deficit Reduction Act of 2005, Public Law No. 109-171. The federal health care reform act extended authority for Money Follows the Person demonstration project through federal fiscal year 2016 (Section 2403 of the Patient Protection and Affordable Care Act, Public Law 111-148).

[185] A "dual eligible individual" is an individual who is entitled to, or enrolled for, benefits under Medicare Part A or enrolled for benefits under Medicare Part B, and is eligible for medical assistance under the state Medicaid plan or under a waiver of the plan (42 U.S.C. 1396n(h)(2)(B)).

Medicare program if the terms of the project provide for Ohio to receive those amounts. ODJFS must use the money in the Fund to further develop integrated delivery systems and improved care coordination for dual eligible individuals. The ODJFS Director may seek Controlling Board approval to make expenditures from the Fund.

Joint Legislative Committee for Unified Long-Term Services and Supports

(Section 309.30.73)

The act creates the Joint Legislative Committee for Unified Long-Term Services and Supports. The Committee is to consist of the following members:

(1) Two members of the House of Representatives from the majority party and one member from the minority party, all appointed by the Speaker of the House of Representatives;

(2) Two members of the Senate from the majority party and one member from the minority party, all appointed by the Senate President.

The Speaker of the House is required to designate one of the House members from the majority party to serve as co-chairperson of the Committee. The Senate President is to designate one of the Senate members from the majority party to serve as the other co-chairperson. The Committee is to meet at the call of the co-chairpersons. The co-chairpersons are permitted to request assistance for the Committee from the Legislative Service Commission.

The Committee is required to study the following issues:

(1) Implementing the act's provision regarding the dual eligible integrated care demonstration project (see "**Dual eligible integrated care demonstration project**," above);

(2) Implementing the act's provision regarding a unified long-term services and support Medicaid waiver program (see "**Unified long-term services and support Medicaid waiver program**," above);

(3) Providing consumers choices regarding a continuum of services that meet their health-care needs, promote autonomy and independence, and improve quality of life;

(4) Ensuring that long-term care services and supports are delivered in a cost effective and quality manner;

(5) Subjecting county homes, county nursing homes, and district homes to the nursing home franchise permit fee;

(6) Other issues of interest to the Committee.

The act requires the Committee's co-chairpersons to provide for the Director of the Office of Ohio Health Plans in ODJFS to testify before the Committee not later than September 30, 2011, and at least quarterly thereafter regarding the issues that the Committee examines.

Children's Buy-In Program

(Section 309.33.60 (primary); R.C. 5101.5211 to 5101.5216 (repealed); conforming changes in R.C. 9.231, 9.24, 127.16, 1751.01, 1751.04, 1751.11, 1751.111, 1751.12, 1751.13, 1751.15, 1751.17, 1751.20, 1751.31, 1751.34, 1751.60, 1751.89, 2744.05, 3111.04, 3113.06, 3119.54, 3901.3814, 3923.281, 3963.01, 4731.65, 4731.71, 5101.26, 5101.571, 5101.58, 5111.0112, and 5111.941)

The act abolishes the Children's Buy-In Program as of October 1, 2011. This state-funded program, administered by ODJFS, was established by Am. Sub. H.B. 119 of the 127th General Assembly as a health care program for uninsured individuals under age 19 who had family incomes over 300% of the federal poverty limit and met other eligibility criteria. Participants were required to pay a monthly premium and co-payments.

To conclude the program's affairs, the act does all of the following:

- Suspends new enrollments as of June 30, 2011 (the act's immediate effective date);
- Repeals the program-authorizing statutes on October 1, 2011;
- Permits persons enrolled in the program when it is repealed to continue receiving services through December 31, 2011;
- Requires ODJFS to take steps as necessary to transition persons enrolled in the program to other health coverage options and otherwise conclude program operations;
- Permits ODJFS to use appropriated funds to satisfy any claims or contingent claims for services rendered prior to October 1, 2011, and services rendered to eligible persons through December 31, 2011;

- Provides that ODJFS is not liable for reimbursing any provider or other person for services rendered on or after January 1, 2012.

Military Injury Relief Fund

(R.C. 5101.98)

The act provides that an individual injured while in active service as a member of the U.S. armed forces while serving in Operation New Dawn is eligible for Military Injury Relief Fund grants. Operation New Dawn is the name for the U.S. military operation being conducted in Iraq.

Under continuing law, the ODJFS Director grants money from the Military Injury Relief Fund to individuals injured while in active service as a member of the U.S. armed forces while serving under Operation Iraqi Freedom or Operation Enduring Freedom, and to individuals diagnosed with post-traumatic stress disorder while serving or after having served in those operations. The act, as explained above, extends grant eligibility to individuals involved in Operation New Dawn.

VI. Unemployment Compensation

Unemployment compensation for seasonal employment

(R.C. 4141.33)

The act expressly prohibits an individual whose base period consists of only seasonal employment for a single seasonal employer from being paid benefits for any week between two successive seasonal periods, which is consistent with continuing law. Additionally, effective October 30, 2011, the act prohibits an individual who performs services that significantly consist of services performed in seasonal employment from being paid unemployment compensation benefits for those services for any week in the period between two successive seasonal periods if the individual performed those services in the first of the seasonal periods and there is reasonable assurance that the individual will perform those services in the later of the seasonal periods. "Significantly" means 40% or more of an individual's base period (which is used to determine an individual's unemployment compensation benefit eligibility) consists of services performed in seasonal employment. Reasonable assurance consists of a written, verbal, or implied agreement that the individual will perform services in the same or a similar capacity during the ensuing seasonal period. The act requires the ODJFS Director to adopt rules implementing this provision and concerning individuals' eligibility for benefits under this provision.

Unemployment Compensation Special Administrative Fund

(R.C. 4141.08 and 4141.11)

The act eliminates the authority of the Unemployment Compensation Council with respect to the Unemployment Compensation Special Administrative Fund. The ODJFS Director is required to request the OBM Director to transfer to the Unemployment Compensation Fund any amount in the Unemployment Compensation Special Administrative Fund considered to be excessive by the ODJFS Director, instead of by the Council as under prior law. Under the act, the balance in the Unemployment Compensation Special Administrative Fund is no longer continuously available to the Council for expenditures.

The ODJFS Director, under the act, is no longer required to obtain the approval of the Council before using funds in the Unemployment Compensation Special Administrative Fund whenever it appears that the use is necessary for:

(1) The proper administration of the Unemployment Compensation Law (R.C. Chapter 4141.) and no federal funds are available for the specific purpose for which the expenditure is to be made, provided the moneys are not substituted for appropriations from federal funds, which in the absence of such moneys would be available;

(2) The proper administration of the Unemployment Compensation Law for which purpose appropriations from federal funds have been requested and approved but not received, provided the fund would be reimbursed upon receipt of the federal appropriation;

(3) To the extent possible, the repayment to the Unemployment Compensation Administration Fund of moneys found by the proper agency of the United States to have been lost or expended for purposes other than, or an amount in excess of, those found necessary by the proper agency of the United States for the administration of the Unemployment Compensation Law.

The ODJFS Director is required to pay the operating expenses of the Council from moneys in the Unemployment Compensation Special Administrative Fund, but, under the act, the ODJFS Director no longer has to pay those expenses as determined by the Council.