DEPARTMENT OF MEDICAID

Creation of the Ohio Department of Medicaid

- Creates the Ohio Department of Medicaid (ODM).
- Makes the Medicaid Director (ODM Director) the executive head of ODM.
- Gives ODM and the ODM Director many of the same types of responsibilities and authorities that the Ohio Department of Job and Family Services (ODJFS) and the ODJFS Director have regarding administrative and program matters.
- Transfers to ODM (from ODJFS's Office of Medical Assistance) responsibility for the state-level administration of the following medical assistance programs: Medicaid, Children's Health Insurance Program (CHIP), and Refugee Medical Assistance (RMA).
- Makes CHIP and the RMA program subject to general requirements applicable to Medicaid, including requirements regarding third party liability, ODM's automatic right of recovery, automatic assignment of the right to medical support, and the rights of applicants, recipients, and former recipients to administrative appeals.
- Provides that the creation of ODM and reassignment of the functions and duties of ODJFS's Office of Medical Assistance regarding medical assistance programs are not appropriate subjects for public employees' collective bargaining.
- Authorizes the ODM Director and ODJFS Director, from July 1, 2013 to June 30, 2015, to establish, change, and abolish positions for their respective agencies and to assign, reassign, classify, reclassify, transfer, reduce, promote, or demote employees who are not subject to state law governing public employees' collective bargaining.
- Relocates and reorganizes provisions of the Revised Code governing medical assistance programs as part of the creation of ODM and the transfer of programs to ODM.

Medicaid eligibility

Mandatory and optional eligibility groups

- Repeals laws that require or permit Medicaid to cover certain groups.
- Requires Medicaid to cover all mandatory eligibility groups and permits Medicaid's eligibility requirements for aged, blind, and disabled individuals to continue to be

more restrictive than the eligibility requirements for the Supplemental Security Income (SSI) program as authorized by the federal law known as the 209(b) option.

- Requires Medicaid to cover all optional eligibility requirements that state statutes require Medicaid to cover.

- Permits Medicaid to cover optional eligibility groups that state statutes expressly permit Medicaid to cover or do not address whether Medicaid may cover.

- Prohibits Medicaid from covering any eligibility group that state statutes prohibit Medicaid from covering.

- Requires Medicaid to cover all of the following optional eligibility groups: (1) children placed with adoptive parents, (2) women during and immediately after pregnancy, infants, and children, (3) employed individuals with disabilities or medically improved disabilities who qualify for the Medicaid Buy-In for Workers with Disabilities program, (4) independent foster care adolescents, (5) women in need of treatment for breast or cervical cancer, and (6) nonpregnant individuals who may receive family planning services and supplies.

Medicaid expansion (VETOED)

- Would have prohibited Medicaid from covering the eligibility group popularly known as the Medicaid expansion (VETOED).

Transitional Medicaid

- Requires the ODM Director to implement a federal option that permits individuals to receive transitional Medicaid for a single 12-month period rather than an initial 6-month period followed by a second 6-month period.

Maintenance of effort requirement

- Repeals the law that requires Medicaid to comply with the federal maintenance of effort requirement regarding Medicaid eligibility.

Reduction in complexity

- Repeals the law that requires a reduction in the complexity of the eligibility determination processes for Medicaid caused by the different income and resource standards for numerous Medicaid eligibility categories.

Tuition Savings and scholarships exempt from consideration

- Repeals the law that requires the values of certain tuition payment contracts, scholarships, and payments made by the Ohio Tuition Trust Authority to be excluded from Medicaid eligibility determinations.

Copies of trust instruments

- Requires a Medicaid applicant or recipient who is a beneficiary of a trust to submit a complete copy of the trust instrument to the relevant county department of job and family services (CDJFS) and ODM and specifies that the copies are confidential and not public records.

Third-party payers

- Requires a medical assistance recipient and the recipient's attorney, if any, to cooperate with each of the recipient's medical providers by disclosing third-party payer information to the providers, specifies liability for failure to make those disclosures, and clarifies who must be notified about recovery actions.

- Beginning January 1, 2014, authorizes ODM to assign to a provider its right of recovery against a third party for a claim for medical assistance if ODM notifies the provider that ODM intends to recoup ODM's prior payment for the claim.

- Requires a third party, if ODM makes such an assignment, to do both of the following: (1) treat the provider as ODM, and (2) pay the provider the greater of (a) the amount ODM intends to recoup from the provider for the claim, or (b) the amount that is to be paid under an agreement between the third party and the provider.

- Repeals a provision that gives ODJFS a right of subrogation for workers' compensation benefits payable to a person who is subject to a child or spousal support order and who is a Medicaid recipient.

Provider agreements

- Requires all Medicaid provider agreements to be time-limited.

- Eliminates the phase-in period for subjecting Medicaid provider agreements to time limits.

- Provides that Medicaid provider agreements expire after a maximum of five (rather than seven) years.

- Requires that rules regarding time-limited Medicaid provider agreements be consistent with federal regulations governing provider screening and enrollment and include a process for revalidating providers' continued enrollment as providers rather than a process for re-enrolling providers.

- Requires ODM to refuse to revalidate a Medicaid provider agreement if the provider fails to file a complete application for revalidation within the time and in the manner required by the revalidation process.

- Provides that, if a provider continues operating under an expired Medicaid provider agreement while waiting for ODM to revalidate the agreement and ODM decides against revalidation, Medicaid payments are not to be made for services provided beginning on the date the provider agreement expired and ending on the effective date of a subsequent provider agreement.

- Provides that ODM is not required to issue an adjudication order in accordance with the Administrative Procedure Act when it (1) denies an application for a Medicaid provider agreement because the application is not complete or (2) under certain circumstances, refuses to revalidate a provider agreement because the provider fails to file a complete application within the required time and in the required manner.

- Clarifies that the requirement to pay an application fee for a Medicaid provider agreement applies to former providers that seek re-enrollment as providers as well as providers seeking initial provider agreements or revalidation.

- Provides that application fees are nonrefundable when collected in accordance with a federal regulation governing such fees.

- Expressly permits the ODM Director to deny, refuse to revalidate, or terminate a Medicaid provider agreement for any type of provider, rather than only nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID), when the Director determines that the action is in the best interests of Medicaid recipients or the state.

- Permits the ODM Director to exclude an individual, provider of services or goods, or other entity from participation in the Medicaid program when the Director determines that the exclusion is in the best interests of Medicaid recipients or the state.

- Permits the ODM Director to suspend a Medicaid provider agreement for any reason permitted or required by federal law and when the Director determines that the suspension is in the best interests of Medicaid recipients or the state.

- Eliminates a requirement that ODM issue an order pursuant to an adjudication conducted in accordance with the Administrative Procedure Act when entering into or revalidating a Medicaid provider agreement but maintains a requirement for such an order when ODM refuses to enter into or revalidate a provider agreement.

- Permits, until January 1, 2015, a nursing facility provider to exclude one or more of its parts from a Medicaid provider agreement if (1) the facility initially obtained its license and Medicaid certification on or after January 1, 2008, (2) the facility is located in a county that has more long-term care beds than it needs, (3) federal law permits the exclusion, and (4) the provider gives ODM notice of the exclusion.

- Creates the Nursing Facility Distinct Part Advisory Workgroup and requires the Workgroup to develop findings regarding the impact that allowing nursing facilities to exclude distinct parts of their facilities from their Medicaid provider agreements would have on access to nursing facility services, quality of care, and purchasing strategies for nursing facility services provided to Medicaid recipients with specialized health care needs.

- Permits, until January 1, 2015, a nursing facility to refuse to admit a person because the person is or may, as a resident of the nursing facility, become a Medicaid recipient if at least 25% (rather than 80%) of its Medicaid-certified beds are occupied by Medicaid recipients at the time the person would otherwise be admitted.

Criminal records checks

- Permits an individual to be any of the following despite having been found eligible for intervention in lieu of conviction for certain disqualifying offenses: (1) a Medicaid provider, (2) an owner, officer, or board member of a Medicaid provider, and (3) with certain exceptions, an employee of a Medicaid provider.

- Permits certain individuals receiving or deciding whether to receive services from the subject of a criminal records check to receive the results of that records check.

Interest on excess payments

- Requires a Medicaid provider who, without intent, obtains excess Medicaid payments to pay interest on the excess payments at the average bank prime rate in effect on the first day of the calendar quarter during which the provider receives notice of the excess payment.

Dispensing fee; generic drug copayments

- Sets the Medicaid dispensing fee for noncompounded drugs at $1.80 for the period beginning July 1, 2013, and ending on the effective date of a rule changing the amount of the fee.

- Effective July 1, 2014, provides that the survey used under continuing law to set the Medicaid drug dispensing fee applies to only Medicaid-participating terminal distributors of dangerous drugs (rather than retail pharmacy operations).

- Requires each terminal distributor that is a Medicaid provider to participate in the survey and provides that survey responses are confidential and not a public record.

- Provides for the Medicaid dispensing fee established in December of each even-numbered year to take effect the following July, rather than the following January.

- Eliminates the exclusion of generic drugs from Medicaid copayment requirements.

Miscellaneous payment rates

- Would have required that the Medicaid payment rates for certain services provided by physician practice groups meeting requirements regarding hospital outpatient clinic services be determined in accordance with a preexisting Medicaid rule, and would have required ODM to report to the General Assembly on this provision within four years (VETOED).

- Provides for the Medicaid payment rates for hospital inpatient services to be the same as the Medicaid payment rates for the services in effect on June 30, 2013, until the effective date of the first of any ODM rules establishing new diagnosis-related groups for the services.

- Requires that the Medicaid payment rates for hospital outpatient services be, until June 30, 2015, the same as the Medicaid payment rates for the services in effect on June 30, 2015.

- Requires that the ODM Director, not earlier than January 1, 2014, reduce Medicaid payment rates for certain outpatient radiological services when repeated during the same session, establish varying payment rates for physician services based on the location of the services, and align Medicaid payment methodologies with Medicare payment methodologies.

- Establishes Medicaid payment amounts for noninstitutional services provided (from January 1, 2014 to July 1, 2015) to a dual eligible individual enrolled in Medicare Part B.

- Provides that specified persons are not eligible for Medicaid payments for providing certain nursing, home health aide, or private duty nursing services to the Medicaid recipient unless conditions specified by the ODM Director are met.

Mental health services

- During fiscal years 2014 and 2015, permits Medicaid to cover inpatient psychiatric hospital services provided by psychiatric residential treatment facilities to Medicaid recipients under age 21 who are in the custody of the Ohio Department of Youth Services and have been identified as meeting a clinical criterion of serious emotional disturbance.

- Provides, for fiscal years 2014 and 2015, that a Medicaid recipient under age 21 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 and Addiction Services if the child meets certain requirements related to being an abused, neglected, dependent, unruly, or delinquent child.

Home health

- Authorizes ODM to review Medicaid-covered home health nursing services, home health aide services, and private duty nursing services to improve efficiency and individual care in long-term care services.

Wheelchair, oxygen, and resident transportation services

- Excludes, beginning January 1, 2014, custom wheelchair costs, repairs to and replacements of custom wheelchairs and parts, oxygen (other than emergency oxygen), and resident transportation services from the costs for bundled services included in the direct care costs that are part of nursing facilities' Medicaid-allowable costs and (2) beginning January 1, 2014, reduces to 86¢ (from $1.88) the amount added, because of bundled services, to Medicaid rates paid for direct care costs.

- Requires the ODM Director, for the period beginning January 1, 2014, and ending June 30, 2015, to implement strategies for purchasing custom wheelchairs, oxygen (other than emergency oxygen), and resident transportation services for Medicaid recipients residing in nursing facilities.

Nursing facility services

- To determine the Medicaid payment rates for nursing facilities in Mahoning and Stark counties for services provided during the period beginning October 1, 2013,

and ending on the first day of the first rebasing of the rates, provides that the facilities be treated as if they were in the peer group that includes such urban counties as Cuyahoga, Franklin, and Montgomery.

- Provides for nursing facilities located in Mahoning and Stark counties to be placed in the peer groups that include such urban counties as Cuyahoga, Franklin, and Montgomery counties when ODM first rebases nursing facilities' Medicaid payment rates.

- Revises the accountability measures that are used in determining nursing facilities' quality incentive payments under the Medicaid program for fiscal year 2015 and thereafter.

- Specifies a lower maximum quality incentive payment ($13.16 rather than $16.44 per Medicaid day) starting in fiscal year 2015 for nursing facilities that fail to meet at least one of the accountability measures regarding pain, pressure ulcers, physical restraints, urinary tract infections, and vaccinations.

- Would have provided for the total amount to be spent on quality bonuses paid to nursing facilities for a fiscal year to be $30 million plus the amount, if any, that is budgeted for quality incentive payments but not spent (VETOED).

- Would have required ODM to pay the quality bonuses not later than the first day of each November (VETOED).

- Would have required a nursing facility to meet at least two of certain accountability measures to qualify for the quality bonus (VETOED).

- Establishes the following additional requirement for a nursing facility to qualify for a critical access incentive payment under Medicaid for a fiscal year: the nursing facility must have been awarded at least five points for meeting accountability measures and at least one of the points must have been for meeting specific accountability measures.

- Specifies the Medicaid cost report to be used to determine the occupancy rate used in setting a nursing facility's Medicaid rate for a reserved bed.

- Permits the ODM Director to establish as a Medicaid waiver program an alternative purchasing model for nursing facility services provided to Medicaid recipients with specialized health care needs during the period beginning July 1, 2013, and ending July 1, 2015.

- Requires ODM to terminate a nursing facility's Medicaid participation if the nursing facility is placed on the federal Special Focus Facility (SFF) list and fails to make improvements or graduate from the SFF program within certain periods of time.

- Requires the Ohio Department of Aging to provide technical assistance to such a nursing facility through the nursing home quality initiative at least four months before ODM would be required to terminate the nursing facility's Medicaid participation.

- Eliminates a requirement that a nursing facility that undergoes a change of operator that is an arm's length transaction, file a Medicaid cost report that covers the period beginning with the nursing facility's first day of operation under the new provider and ends on the first day of the month immediately following the first three full months of operation under the new provider.

- Permits ODM to conduct post-payment reviews of nursing facilities' Medicaid claims to determine whether overpayments have been made and requires nursing facilities to refund overpayments discovered by the reviews.

- Increases the monthly personal needs allowance for Medicaid recipients residing in nursing facilities.

Home and community-based services

- For fiscal years 2014 and 2015, authorizes the ODM Director to contract with a person or government entity to collect patient liabilities for home and community-based services available under a Medicaid waiver component.

- Permits the ODM Director to create, as part of the Integrated Care Delivery System (ICDS), a Medicaid waiver program providing home and community-based services.

- Provides for eligible ICDS participants to be enrolled in the ICDS Medicaid waiver program instead of (1) the Medicaid-funded component of the PASSPORT program, (2) the Choices program, (3) the Medicaid-funded component of the Assisted Living program, (4) the Ohio Home Care program, and (5) the Ohio Transitions II Aging Carve-Out program.

- Requires the ODM Director to have the following additional Medicaid waiver programs cover home care attendant services: the Medicaid-funded component of the PASSPORT program and the ICDS Medicaid waiver program.

- During fiscal years 2014 and 2015, permits Medicaid to cover state plan home and community-based services for Medicaid recipients of any age who have behavioral health issues and countable incomes not exceeding 150% of the federal poverty line.

- Addresses administrative issues regarding termination of waiver programs.

Medicaid managed care

- Eliminates a requirement that ODM prepare and submit to the General Assembly an annual report on the Medicaid care management system.

- Beginning January 1, 2014, prohibits the hospital inpatient capital payment portion of the payment made to Medicaid managed care organizations from exceeding any maximum rate that the ODM Director may establish in rules, and prohibits the organizations from compensating hospitals for inpatient capital costs in an amount that exceeds that rate.

- Provides that an agreement entered into between a Medicaid managed care participant, a participant's parent, or a participant's legal guardian that violates Ohio law regarding payment for emergency services is void and unenforceable.

- Beginning January 1, 2014, modifies provisions governing Medicaid payments for graduate medical education (GME) costs by (1) requiring the ODM Director to adopt rules that govern the allocation of payments for GME costs, and (2) eliminating provisions specifying how payments for GME costs are made under the Medicaid managed care system.

- Establishes 2% (an increase from 1%) as the maximum total amount of all Medicaid managed care premiums that may be withheld for the purpose of making performance payments to Medicaid managed care organizations through the Medicaid Managed Care Performance Fund.

- Modifies the uses of the Medicaid Managed Care Performance Payment Fund by (1) permitting, rather than requiring, amounts in the fund to be used to make performance payments and (2) permitting amounts to be used to meet provider agreement obligations or to pay for Medicaid services provided by a Medicaid managed care organization.

- For fiscal years 2014 and 2015, permits ODM to provide performance payments to Medicaid managed care organizations that provide care to participants of the Integrated Care Delivery System, and requires ODM to withhold a percentage of the premium payments made to the organizations for the purpose of providing the performance payments.

- Permits, rather than requires, ODM to recognize pediatric accountable care organizations that provide care coordination and other services under the Medicaid care management system to individuals under age 21 who are blind or disabled.

- Excludes (until July 1, 2014) certain recipients of services through the Bureau for Children with Medical Handicaps who have cystic fibrosis, hemophilia, or cancer from any required participation in the Medicaid care management system.

Sources of Medicaid revenues

- Replaces the specific dollar amounts used for the franchise permit fee on nursing homes and hospital long-term care units with a formula for determining the amount of the franchise permit fee rate.

- Continues, for two additional years, both of the following: (1) the Hospital Care Assurance Program (HCAP) and (2) the assessments imposed on hospitals for purposes of obtaining funds for the Medicaid program.

- Requires ODM to continue the Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program to provide supplemental Medicaid payments to hospitals for providing Medicaid-covered inpatient and outpatient services.

- Requires ODM to continue the 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.

Recipient confidentiality

- Reinstates the penalty (misdemeanor of the first degree) for violating confidentiality provisions regarding recipients of Medicaid, CHIP, or RMA.

Electronic health record and e-prescribing applications

- Effective January 1, 2014, replaces a provision authorizing a Medicaid e-prescribing system for Medicaid with a provision authorizing the ODM Director to acquire or specify technologies to give information regarding Medicaid recipient eligibility, claims history, and drug coverage to Medicaid providers through certain electronic health record and e-prescribing applications.

State agency collaboration

- Extends to fiscal years 2014 and 2015 provisions that authorize the Office of Health Transformation (OHT) Executive Director to facilitate collaboration between certain state agencies ("participating agencies") for health transformation purposes,

authorize the exchange of personally identifiable information between participating agencies regarding a health transformation initiative, and require the use and disclosure of such information in accordance with operating protocols.

- Includes ODM and the Ohio Department of Administrative Services (ODAS) as participating agencies.

Health information exchanges

- Includes ODM and ODAS as state agencies to which covered entities may disclose certain protected health information.

- Transfers from the ODJFS Director to the ODM Director rule-making authority pertaining to (1) a standard authorization form for the use and disclosure of protected health information and substance abuse records by covered entities and (2) the operation of health information exchanges in Ohio.

Direct Care Worker Advisory Workgroup

- Creates the Direct Care Worker Advisory Workgroup with the OHT Executive Director serving as chairperson and specifies the Workgroup's responsibilities, which include recommending policies to be incorporated in legislation regarding direct care worker certification.

- Requires the Workgroup to submit a report to the General Assembly not later than December 31, 2013, describing its findings and recommendations.

Medicaid data

- Authorizes the ODM Director to enter into contracts with one or more persons to receive and process, on the Director's behalf, certain requests for Medicaid data by persons who intend to use the data for commercial or academic purposes.

Long-term services

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

- Requires ODM, Ohio Department of Aging, and Ohio Department of Developmental Disabilities to have, by June 30, 2015, noninstitutionally based long-term services 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 ODM 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.

Quality initiatives

- Permits ODM to implement a quality incentive program to reduce available hospital and nursing facility admissions and emergency department utilizations by Medicaid recipients receiving certain home and community-based waiver services, home health services, or private duty nursing services.

- Permits the ODM Director to implement a children's hospitals quality outcomes program to encourage the development of certain programs and methods aimed at improving patient care and outcomes.

- Authorizes the ODM Director to develop and implement, during fiscal years 2014 and 2015, initiatives designed to improve birth outcomes for Medicaid recipients.

Veterans services

- Authorizes ODM to collaborate with the Ohio Department of Veterans Services regarding the coordination of veterans' services and to implement, during fiscal years 2014 and 2015, certain initiatives that they determine will maximize the efficiency of the services and ensure that veterans' needs are met.

Health home services

- Authorizes the ODM Director, in consultation with the Director of Developmental Disabilities, to develop and implement a system within the Medicaid program to provide health home services to Medicaid-eligible individuals with chronic health conditions and developmental disabilities.

Telemedicine policy workgroup

- Creates a workgroup to study telemedicine and develop a comprehensive statewide policy encouraging its use.

Integrated Care Delivery System evaluation

- Requires the ODM Director, if the ICDS is implemented, to conduct an annual evaluation of the ICDS unless the same evaluation is conducted for that year by an organization under contract with the U.S. Department of Health and Human Services.

Funds

- Requires that federal payments made to Ohio for the Money Follows the Person demonstration project be deposited into the Money Follows the Person Enhanced Reimbursement Fund.

- Abolishes the Health Care Compliance Fund and provides for the money that would have been credited to that fund to be credited to the Managed Care Performance Payment Fund and the Health Care Services Administration Fund.

- Abolishes the Prescription Drug Rebates Fund and provides for the money that would have been credited to that fund to be credited to the Health Care/Medicaid Support and Recoveries Fund.

Department of Medicaid created

(R.C. 121.02 (primary), 9.231, 9.239, 9.24, 101.39, 101.391, 103.144, 109.572, 109.85, 117.10, 119.01, 121.03, 122.15, 124.30, 127.16, 169.02, 173.20, 173.21, 173.39, 173.391, 173.394, 173.42, 173.425, 173.43, 173.431, 173.432, 173.433 (repealed), 173.434, 173.45, 173.47, 173.50, 173.501, 173.51, 173.52, 173.521, 173.522, 173.523, 173.53, 173.54, 173.541, 173.542, 173.543, 173.544, 173.545, 173.55, 191.04, 191.06, 317.08, 317.36, 329.04, 329.051, 329.06, 329.14, 340.03, 340.16, 340.192, 955.201, 1337.11, 1347.08, 1739.061, 1751.01, 1751.11, 1751.12, 1751.31, 1923.14, 2113.041, 2113.06, 2117.061, 2117.25, 2133.01, 2307.65, 2317.02, 2505.02, 2744.05, 2903.33, 2913.40, 2921.01, 3101.051, 3107.083, 3111.72, 3119.29, 3121.441, 3121.898, 3125.36, 3313.714, 3313.715, 3317.02, 3323.021, 3599.45, 3701.023, 3701.024, 3701.027, 3701.132, 3701.243, 3701.507, 3701.74, 3701.741, 3701.78, 3701.881, 3702.521, 3702.62, 3702.74, 3702.91, 3712.07, 3721.011, 3721.022, 3721.024, 3721.027, 3721.042, 3721.071, 3721.08, 3721.10, 3721.12, 3721.13, 3721.15, 3721.16, 3721.17, 3721.19, 3769.08, 3742.31, 3742.32, 3793.04, 3795.01, 3901.3814, 3923.281, 3923.443, 3923.50, 3923.601, 3923.83, 3924.42, 3963.04, 4121.50, 4141.162, 4715.36, 4719.01, 4723.18, 4729.80, 4731.151, 4731.71, 4755.481, 4761.01, 5101.01, 5101.11, 5101.141, 5101.16, 5101.162, 5101.18, 5101.181, 5101.183, 5101.184, 5101.26, 5101.272, 5101.273, 5101.30, 5101.35, 5101.36, 5101.47, 5101.49, 5101.503 (repealed), 5101.514 (repealed), 5101.515 (repealed), 5101.518 (repealed), 5101.523 (repealed), 5101.525 (repealed), 5101.526 (repealed), 5101.528 (repealed), 5101.529 (repealed), 5103.02, 5107.10, 5107.14, 5107.16, 5107.20, 5107.26, 5111.012 (repealed), 5111.014 (repealed), 5111.015 (repealed), 5111.0110 (repealed), 5111.0111 (repealed), 5111.0113 (repealed), 5111.0115 (repealed), 5111.0120 (repealed), 5111.0121 (repealed), 5111.0122 (repealed), 5111.0123 (repealed), 5111.0124 (repealed), 5111.0125 (repealed), 5111.176 (repealed), 5111.211 (repealed), 5111.236 (repealed), 5111.65 (repealed), 5111.70 (repealed), 5111.701 (repealed), 5111.702 (repealed), 5111.703

(repealed), 5111.704 (repealed), 5111.705 (repealed), 5111.706 (repealed), 5111.707 (repealed), 5111.708 (repealed), 5111.709 (repealed), 5111.7011 (repealed), 5111.8710 (repealed), 5111.8811 (repealed), 5119.061, 5119.351, 5119.61, 5119.69, 5120.65, 5120.652, 5120.654, 5123.01, 5123.021, 5123.0412, 5123.0417, 5123.171, 5123.19, 5123.192, 5123.197, 5123.198, 5123.38, 5126.01, 5126.054, 5126.055, 5309.082, 5731.39, 5739.01, 5747.122, and 5751.081; R.C. Chapters 5124., 5160., 5161., 5162., 5163., 5164., 5165., 5166., 5167., and 5168.; Sections 209.50, 259.260, 259.270, 323.10.10, 323.10.20, 323.10.30, 323.10.40, 323.10.50, 323.10.60, 323.10.70, 323.480, 610.20, and 610.21)

Single state agency

Federal law requires a state participating in the Medicaid program to provide for the establishment or designation of a single state agency to administer or to supervise the administration of the Medicaid state plan.[134] Prior state law established the Office of Medical Assistance as a unit within the Ohio Department of Job and Family Services (ODJFS) and required the Office to act as the single state agency to supervise the administration of the Medicaid program. Effective July 1, 2013, the act abolishes the Office and creates the Ohio Department of Medicaid (ODM).[135] ODM replaces the Office as the single state agency to supervise the administration of the Medicaid program.

In addition to being responsible for Medicaid, the act provides for ODM to also oversee the administration of the Children's Health Insurance Program (CHIP) and the Refugee Medical Assistance (RMA) program. The act collectively identifies the programs that ODM is to administer as medical assistance programs. "Medical assistance program" is defined as including any program, in addition to Medicaid, CHIP, and RMA, that provides medical assistance and that state statutes authorize ODM to administer.

ODM Director

The act provides for the ODM Director to be the executive head of ODM. All duties conferred on ODM by law or order of the Director are under the Director's control and are to be performed in accordance with rules the Director adopts. The ODM Director is to be appointed by the Governor, with the advice and consent of the Senate,

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[134] 42 U.S.C. 1396a(a)(5).

[135] ODM is created in a Revised Code (codified) section, R.C. 121.02, which is subject to the referendum and goes into effect on September 29, 2013. It is also created in an uncodified section (Section 323.10.10) that includes an earmark and is stated to be exempt from the referendum. The uncodified section provides for ODM to be created on July 1, 2013. The act provides that when ODM's creation under the codified section comes into effect, it is a continuation of ODM as created in the uncodified section.

and is to hold office during the Governor's term unless removed earlier at the pleasure of the Governor.

Staff

The act requires the ODM Director to appoint one assistant director for ODM. The assistant director is to exercise powers, and perform duties, as ordered by the ODM Director. The assistant director is to act as the ODM Director in the Director's absence or disability and when the position of ODM Director is vacant.

The ODM Director is permitted by the act to appoint employees as are necessary for ODM's efficient operation. The Director may prescribe the title and duties of the employees.

Continuing law permits the Ohio Department of Administrative Services (ODAS) Director to fill without competition a position in the classified service that requires peculiar and exceptional qualifications of a scientific, managerial, professional, or educational character. To do this, there must be satisfactory evidence that for specified reasons competition in a special case is impracticable and that the position can best be filled by a person of high and recognized attainments in the qualifications.[136] The act provides for the ODM Director to provide the ODAS Director certification of a determination that a position with ODM can best be filled without competition because it requires peculiar and exceptional qualifications of a scientific, managerial, professional, or educational character. The ODAS Director is to suspend the competition requirement on receipt of the ODM Director's certification. The act also requires the ODM Director to provide the ODAS Director certification of a determination that a position with ODM can best be filled without regard to a residency requirement established by an ODAS rule.

Continuing law authorizes a public office to participate with the Bureau of Criminal Identification and Investigation (BCII) Superintendent in a fingerprint database program under which the Superintendent notifies the public office if an employee of the public office whose name is in the fingerprint database has been arrested for, convicted of, or pleaded guilty to any offense.[137] The act requires ODM to collaborate with the Superintendent to develop procedures and formats necessary to produce the notices in a format that is acceptable for use by ODM.

The act permits the ODM Director to require any of the employees of ODM who may be charged with custody or control of any public money or property or who is

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[136] R.C. 124.30.

[137] R.C. 109.5721, not in the act.

required to give bond, to give a bond, properly conditioned, in a sum to be fixed by the Director which, when approved by the Director, is to be filed in the Office of the Secretary of State. The costs of the bonds, when approved by the Director, must be paid from funds available for ODM. The bonds may, in the Director's discretion, be individual, schedule, or blanket bonds.

Administrative issues related to the creation of ODM

The act includes the following provisions addressing administrative issues regarding the creation of ODM and the transfer of the responsibilities regarding medical assistance programs to ODM.

(1) Employees of the Office of Medical Assistance are transferred to ODM.

(2) The vehicles and equipment assigned to the Office's employees are transferred to ODM.

(3) The assets, liabilities, other equipment not provided for, and records, irrespective of form or medium, of the Office are transferred to ODM.

(4) ODM is named as the successor to, assumes the obligations of, and otherwise constitutes the continuation of, the Office.

(5) Business commenced but not completed on July 1, 2013, by the Medical Assistance Director, Office, ODJFS Director, or ODJFS regarding a medical assistance program is to be completed by the ODM Director or ODM in the same manner, and with the same effect, as if completed by the Medical Assistance Director, Office, ODJFS Director, or ODJFS.

(6) No validation, cure, right, privilege, remedy, obligation, or liability is lost or impaired by reason of the transfer but is to be administered by the ODM Director or ODM.

(7) The rules, orders, and determinations pertaining to the Office and ODJFS regarding medical assistance programs continue in effect as rules, orders, and determinations of ODM until modified or rescinded by ODM.

(8) No judicial or administrative action or proceeding pending on July 1, 2013, is affected by the transfer of functions from the Medical Assistance Director, Office, ODJFS Director, or ODJFS to the ODM Director or ODM and is to be prosecuted or defended in the name of the ODM Director or ODM.

(9) On application to a court or other tribunal, the ODM Director or ODM must be substituted as a party in such actions and proceedings.

Creation of ODM not subject to collective bargaining

The act provides that the creation of ODM and reassignment of the functions and duties of the Office of Medical Assistance regarding medical assistance programs are not appropriate subjects for collective bargaining under the state's law governing public employee collective bargaining.

Temporary authority regarding employees

During the period beginning July 1, 2013, and ending June 30, 2015, the ODM Director has the authority under the act to establish, change, and abolish positions for ODM, and to assign, reassign, classify, reclassify, transfer, reduce, promote, or demote all employees of ODM who are not subject to the state's public employees collective bargaining law. As part of the transfer of medical assistance programs to ODM, the ODJFS has corresponding authority regarding ODJFS employees.

The authority described above includes assigning or reassigning an exempt employee to a bargaining unit classification if the ODM Director or ODJFS Director determines that the bargaining unit classification is the proper classification for that employee.[138] The actions of the ODM Director or ODJFS Director must comply with the requirements of a federal regulation establishing standards for a merit system of personnel administration. If an employee in the E-1 pay range is to be assigned, reassigned, classified, reclassified, transferred, reduced, or demoted to a position in a lower classification, the ODM Director or ODJFS Director, or in the case of a transfer outside ODM or ODJFS, the ODAS Director, must assign the employee to the appropriate classification and place the employee in Step X. The employee is not to receive any increase in compensation until the maximum rate of pay for that classification exceeds the employee's compensation. Actions the ODM Director, ODJFS Director, and ODAS Director take under this provision of the act are not subject to appeal to the State Personnel Board of Review.

Staff training regarding transfers

The act permits the ODM Director and ODJFS Director to jointly or separately enter into one or more contracts with public or private entities for staff training and development to facilitate the transfer of the staff and duties regarding medical assistance programs to the ODM. The state's law governing competitive selection for purchases does not apply to contracts entered into under this provision of the act.

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[138] An exempt employee is a permanent full-time or permanent part-time employee paid directly by warrant of the OBM Director whose position is included in the job classification plan established by the ODAS Director but who is not considered a public employee for purposes of Ohio's collective bargaining law. (R.C. 124.152, not in the act.)

New and amended grant agreements with counties

The ODJFS Director and boards of county commissioners are permitted by the act to enter into negotiations to amend an existing grant agreement or to enter into a new grant agreement regarding the transfer of medical assistance programs to ODM. Any such amended or new grant agreement must be drafted in the name of ODJFS. The amended or new grant agreement may be executed before July 1, 2013, if the amendment or agreement does not become effective sooner than that date.

Renumbering administrative rules

On and after October 1, 2013, if necessary to ensure the integrity of the numbering of the Administrative Code, the Legislative Service Commission Director is required to renumber the rules of the Office of Medical Assistance within ODJFS to reflect its transfer to ODM.

ODM given various authorities similar to ODJFS

The act gives ODM and the ODM Director many of the same types of responsibilities and authorities that ODJFS and the ODJFS Director have regarding administrative and program matters. These responsibilities and authorities are discussed below.

Rule-making procedures

There are two general statutory processes under which a state agency may adopt a rule: R.C. Chapter 119. (known as the Administrative Procedure Act) and R.C. 111.15 (known as the abbreviated rule-making procedure). The major difference between them is that Chapter 119. requires an agency to provide public notice and conduct a hearing on a proposed rule before its adoption; R.C. 111.15 does not.

The act gives the ODM Director the same direction regarding which rule-making procedure to follow as continuing law gives the ODJFS Director.[139] It provides that, when authorized by statute to adopt a rule, the Director must adopt the rule in accordance with R.C. Chapter 119. if (1) the statute requires that it be adopted in that manner or (2) except as provided below, the statute does not specify the procedure for the rule's adoption.

The Director is to adopt a rule in accordance with R.C. 111.15 (without the requirement that the rule be filed with the Joint Committee on Agency Rule Review (JCARR)) if (1) the statute authorizing the rule requires that the rule be adopted in

[139] R.C. 5101.09, not in the act.

accordance with R.C. 111.15 and, by the terms of that section, the requirement that it be filed with JCARR does not apply or (2) the statute does not specify the procedure for the rule's adoption and the rule concerns the day-to-day staff procedures and operations of ODM or financial and operational matters between ODM and a person or government entity receiving a grant from ODM. The Director is to adopt a rule in accordance with R.C. 111.15, including the requirement that it be filed it with JCARR, if the statute requires that the rule be adopted in accordance with that section and the rule is not exempt from the JCARR requirement.

Except as otherwise required by a statute, the adoption of a rule in accordance with Chapter 119. does not make ODM subject to the notice, hearing, or other requirements of the Administrative Procedure Act.

Funding issues

The act permits the ODM Director to expend funds appropriated or available to ODM from persons and government entities. For this purpose, the Director may enter into contracts or agreements with persons and government entities and make grants to persons and government entities. To the extent permitted by federal law, the Director may advance funds to a grantee when necessary for the grantee to perform duties under the grant as specified by the Director. ODJFS has the same type authority under continuing law regarding funds appropriated or available to ODJFS.[140]

The act creates the State Health Care Grants Fund in the state treasury. Money ODM receives from private foundations in support of pilot projects that promote exemplary programs that enhance programs ODM administers are to be credited to the fund. ODM is permitted to expend the money on such projects, may use the money, to the extent allowable, to match federal financial participation in support of such projects, and must comply with requirements the foundations have stipulated in their agreements with ODM as to the purposes for which the money may be expended. The State Health Care Grants Fund is similar to ODJFS's Foundation Grant Fund.[141]

Continuing law permits ODJFS, at the request of any public entity having authority to implement an ODJFS-administered program or any private entity under contract with a public entity to implement such a program, to seek federal financial participation for costs the entity incurs.[142] The act gives ODM this authority regarding the medical assistance programs it administers.

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[140] R.C. 5101.10, not in the act.

[141] R.C. 5101.111, not in the act.

[142] R.C. 5101.11.

The act authorizes ODM to enter into contracts with private entities to maximize federal revenue without the expenditure of state money. In selecting private entities with which to contract, ODM must engage in a request for proposals process. Subject to the Controlling Board's approval, ODM may also directly enter into contracts with public entities providing revenue maximization services. ODJFS has this authority under continuing law.[143]

Investigations and audits

Continuing law permits ODJFS to appoint and commission any competent person to serve as a special agent, investigator, or representative to perform a designated duty for and on behalf of ODJFS. ODJFS must give specific credentials to each person so designated, and each credential must state the person's name, the agency with which the person is connected, the purpose of the appointment, the date the appointment expires (if appropriate), and information ODJFS considers proper.[144] The act gives this authority to ODM.

ODM is permitted to conduct any audits or investigations that are necessary in the performance of its duties. For this purpose, ODM is given the same power as a judge of a county court to administer oaths and to enforce the attendance and testimony of witnesses and the production of books or papers. ODM is required to keep a record of its audits and investigations stating the time, place, charges, or subject; witnesses summoned and examined; and its conclusions. Witnesses are to be paid the fees and mileage provided for by the Administrative Procedure Act (R.C. Chapter 119.). ODJFS has this authority under continuing law.[145]

As under continuing law regarding ODJFS, a court of common pleas, on ODM's application, may compel the attendance of witnesses, the production of books or papers, and the giving of testimony before ODM, by a judgment for contempt or otherwise, in the same manner as in cases before those courts.[146]

An audit report and any working paper, other document, and record that ODM prepares for an audit that is the subject of the audit's report is not a public record until ODM formally releases the report. This is the case with ODJFS under continuing law.[147]

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[143] R.C. 5101.12, not in the act.

[144] R.C. 5101.38, not in the act.

[145] R.C. 5101.37(A), not in the act.

[146] R.C. 5101.37(C), not in the act.

[147] R.C. 5101.37(D), not in the act.

The act gives the State Auditor authority to take actions on ODM's behalf as the Auditor may do under continuing law for ODJFS.[148] Specifically, the Auditor, on the ODM Director's request, may conduct an audit of any recipient of a medical assistance program. If the Auditor decides to conduct an audit, the Auditor must enter into an interagency agreement with ODM that specifies that the Auditor agrees to comply with state law that restricts the release of information about medical assistance program recipients.

The State Auditor and Attorney General, or their designees, are permitted by the act to examine any records, whether in computer or printed format, in the possession of the ODM Director or any county director of job and family services regarding medical assistance programs. The Auditor and Attorney General have this authority under continuing law applicable to ODJFS.[149] The Auditor and Attorney General must (1) provide safeguards that restrict access to the records to purposes directly connected with an audit or investigation, prosecution, or criminal or civil proceeding conducted in connection with the administration of the programs and (2) comply, and ensure that their designees comply, with state law restricting the disclosure of information regarding medical assistance recipients. Any person who fails to comply with the restrictions is disqualified from acting as an agent or employee or in any other capacity under appointment or employment of any state board, commission, or agency.

The act makes the State Auditor responsible for the costs the Auditor incurs in carrying out the duties discussed above. The Auditor is responsible for such costs under continuing law regarding ODJFS.[150]

Assignment of rights and third party liability

The act provides for provisions of law regarding assignment of rights and third party liability to apply to all medical assistance programs ODM administers. Under prior law, certain provisions expressly applied only to Medicaid and others expressly applied to Medicaid and CHIP. For example, prior law required third parties to cooperate with ODJFS in identifying individuals for the purpose of establishing third party liability for Medicaid only.[151] The act requires instead that third parties cooperate

[148] R.C. 5101.181(E).

[149] R.C. 5101.181(G).

[150] R.C. 5101.181(H).

[151] R.C. 5101.572.

with ODM in identifying individuals for the purpose of establishing third party liability regarding all medical assistance programs that ODM administers.[152]

Certain parts of prior law governing assignment of rights and third party liability applied to the Ohio Works First program, which is one of the state's Temporary Assistance for Needy Families programs. The laws regarding assignment of rights and third party liability concern the state's ability to recoup expenses its incurs for medical assistance, but the Ohio Works First program provides cash assistance not medical assistance. The act, therefore, removes the Ohio Works First program from the application of these laws.

Confidentiality of medical assistance information

As part of the transfer of the responsibilities regarding medical assistance programs from the Office of Medical Assistance within ODJFS to ODM, the act assigns to ODM the types of duties ODJFS had under prior law regarding the restrictions on the release of information about medical assistance recipients. The act also requires ODM to enter into any necessary agreements with the U.S. Department of Health and Human Services and neighboring states to join and participate as an active member in the Public Assistance Reporting Information System. ODM is permitted to disclose information regarding a medical assistance recipient to the extent necessary to participate as an active member in the system. ODJFS continues to be required to enter into such agreements regarding the programs ODJFS administers.[153]

Income and eligibility verification system

Continuing law requires the ODJFS Director to establish an income and eligibility verification system (IEVS) that complies with federal law. Several programs use IEVS as part of their eligibility determination procedures, including the Unemployment Compensation program, Temporary Assistance for Needy Families programs, and the Supplemental Nutrition Assistance Program (also known as the Food Stamp program). Because the Medicaid program is another program that uses IEVS, the act requires the ODJFS Director to consult with the ODM Director regarding the implementation of IEVS. The act also requires the ODJFS Director to consult with the ODAS Director regarding IEVS's implementation.

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[152] R.C. 5160.39.

[153] R.C. 5101.273.

Eligibility determinations

Prior law permitted the Office of Medical Assistance to accept applications, determine eligibility, redetermine eligibility, and perform related administrative activities for Medicaid and CHIP. The Office also could enter into agreements with one or more other state agencies, local government entities, or political subdivisions to accept applications, determine eligibility, redetermine eligibility, and perform related administrative activities on behalf of the Office with respect to Medicaid and CHIP.[154]

The act gives ODM the Office's authority to accept applications, determine eligibility, redetermine eligibility, and perform related administrative activities for Medicaid and CHIP. ODM is also given this authority for the other medical assistance program, RMA. The act permits ODM to enter into agreements with one or more agencies of the federal government, the state, other states, and local governments of this or other states to accept applications, determine eligibility, redetermine eligibility, and perform related administrative activities on behalf of ODM with respect to medical assistance programs.

The act maintains provisions of law regarding eligibility determinations for Medicaid and CHIP previously applicable to the Office and makes them applicable to ODM and all three medical assistance programs. Specifically, if federal law requires a face-to-face interview to complete an eligibility determination for a medical assistance program, ODM is prohibited from conducting the face-to-face interview. If ODM elects to accept applications, determine eligibility, redetermine eligibility, and perform related administrative activities for a medical assistance program, (1) an individual may apply for the program to ODM or an agency authorized by an agreement with ODM to accept the individual's application and (2) ODM is subject to federal statutes and regulations and state statutes and rules that require, permit, or prohibit an action regarding accepting applications, determining or redetermining eligibility, and performing related administrative activities for the program.

Prior law was inconsistent regarding the role of county departments of job and family services in making Medicaid and CHIP eligibility determinations. As discussed above, the Office was authorized to make Medicaid and CHIP eligibility determinations and to enter into agreements with one or more local government entities to make the eligibility determinations. Prior law required county departments to make Medicaid eligibility determinations if the Office elected to enter into agreements with county departments to have them make Medicaid eligibility determinations. However, prior law also required county departments to make Medicaid eligibility determinations for

[154] R.C. 5101.47.

Supplemental Security Income (SSI) recipients and, if assigned by the Medical Assistance Director, make eligibility determinations for Part II or III of CHIP. The act eliminates the provisions that expressly provide for county departments to make eligibility determinations.

Appeals

Prior law permitted a Medicaid applicant, recipient, or former recipient who disagreed with a decision regarding Medicaid to receive a state hearing by ODJFS. The individual could make an administrative appeal of the state hearing decision to the ODJFS Director and, if the individual disagreed with the administrative appeal decision, to a court of common pleas.[155]

The act provides that an individual who is an applicant for, or recipient or former recipient of, any of the three medical assistance programs may appeal a decision regarding the individual's eligibility for the program or services available to the recipient under the program. ODM is required to do one or more of the following regarding such appeals:

(1) Administer an appeals process similar to the ODJFS appeals process;

(2) Contract with ODJFS to provide for ODJFS to hear the appeals;

(3) Delegate authority to hear appeals to an Exchange or Exchange appeals entity.[156]

If an individual files an appeal regarding a medical assistance program, ODM is permitted to (1) take corrective action regarding the matter being appealed before a hearing decision regarding the matter is issued and (2) if a hearing decision, administrative appeal decision, or court ruling is against the individual, take action in favor of the individual despite the contrary decision or ruling, unless, in the case of a court's ruling, the ruling prohibits ODM from taking the action.

Relocation and reorganization of Revised Code sections

The act relocates and reorganizes many provisions of the Revised Code governing medical assistance programs as part of the creation of ODM and the transfer

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[155] R.C. 5101.35.

[156] An Exchange is a governmental agency or nonprofit entity that meets applicable standards of federal regulations adopted under the Patient Protection and Affordable Care Act and makes qualified health plans available to qualified individuals and qualified employers. An Exchange may be a state Exchange, regional Exchange, subsidiary Exchange, or federally facilitated Exchange. (45 C.F.R. 155.20.)

of the programs to ODM. See below for tables regarding the relocations and reorganizations.

As part of the reorganization, the act creates the following ten new Revised Code chapters:

(1) Chapter 5124. (administration by the Ohio Department of Developmental Disabilities of Medicaid's coverage of intermediate care facility for individuals with intellectual disabilities (ICF/IID) services);

(2) Chapter 5160. (general administrative provisions, provisions applying to all medical assistance programs, and ODM's administration of RMA);

(3) Chapter 5161. (ODM's administration of CHIP);

(4) Chapter 5162. (ODM's administration of Medicaid and Medicaid funds);

(5) Chapter 5163. (Medicaid eligibility);

(6) Chapter 5164. (Medicaid state plan services, other than ICF/IID and nursing facility services, and general Medicaid provider issues);

(7) Chapter 5165. (Medicaid's coverage of nursing facility services);

(8) Chapter 5166. (federal Medicaid waiver programs);

(9) Chapter 5167. (Medicaid managed care);

(10) Chapter 5168. (Hospital Care Assurance Program and other health care provider assessments and fees).

The act provides that the ODM Director is not required to amend any rule for the sole purpose of updating the citation in the Ohio Administrative Code to the rule's authorizing statute to reflect that the act renumbers the authorizing statute or relocates it to another Revised Code section. Such citations are to be updated as the Director amends the rules for other purposes.[157]

Duplicative statutes

Many prior statutes governing Medicaid included provisions that were repeated in other statutes. The act, instead, creates general statutes that deal with particular

[157] Similar authority is given to the Director of Aging and Director of Developmental Disabilities regarding updating citations to authorizing statutes in their rules.

issues, such as the need to obtain federal approval before implementing changes to the Medicaid program. The following are examples of these general statutes.

Compliance with federal requirements

Whereas prior law included a number of provisions that required or permitted the Office of Medical Assistance to seek federal approval to implement the various components of the Medicaid program included in state statutes, the act establishes general statutes that apply to all other statutes that require or permit Medicaid to include various components.

Under the act, the Medicaid program must be implemented in accordance with (1) the Medicaid state plan approved by the U.S. Secretary of Health and Human Services, including amendments to the plan approved by the U.S. Secretary, (2) federal Medicaid waivers granted by the U.S. Secretary, including amendments to waivers approved by the U.S. Secretary, (3) other types of federal approval, including demonstration grants, that establish requirements for components of the Medicaid program, (4) except as otherwise authorized by a federal Medicaid waiver granted by the U.S. Secretary, all applicable federal statutes, regulations, and policy guidances, and (5) all applicable state statutes.

Notwithstanding any other state statute, no component, or aspect of a component, of the Medicaid program is to be implemented without (1) receipt of federal approval if the component, or aspect of the component, requires federal approval, (2) sufficient federal financial participation for the component or aspect of the component, and (3) sufficient nonfederal funds for the component or aspect of the component that qualify as funds needed to obtain the federal financial participation. A component, or aspect of a component, of the Medicaid program that requires federal approval may begin to be implemented before receipt of federal approval, however, if federal law authorizes implementation to begin before receipt of federal approval. Implementation must cease if the federal approval is ultimately denied.

The ODM Director is required to seek federal approval for all components, and aspects of components, of the Medicaid program for which federal approval is needed, except that the Director is permitted rather than required to seek federal approval for components, and aspects of components, that state statutes permit rather than require be implemented. Federal approval must be sought in the following forms as appropriate:

(1) The Medicaid state plan;

(2) Amendments to the Medicaid state plan;

(3) Federal Medicaid waivers;

(4) Amendments to federal Medicaid waivers;

(5) Other types of federal approval, including demonstration grants.

ODM's authorizing rules for other state agencies

Continuing state law authorizes ODM to contract with one or more other state agencies or political subdivisions to have the state agency or political subdivision administer one or more components of the Medicaid program, or one or more aspects of a component, under ODM's supervision. A federal regulation, however, prohibits a state's Medicaid agency from delegating, to other than its own officials, authority to issue policies, rules, and regulations on program matters. To address this federal regulation, prior law included a number of provisions that required or permitted the state Medicaid agency to adopt rules that authorize other state agencies that are administering a component, or aspect of a component, of the Medicaid program to adopt rules regarding the component or aspect of a component the other state agency administers.

The act eliminates the authorizing provisions and creates a general statute addressing the issue. The general statute requires the ODM Director to adopt rules as necessary to authorize the directors of other state agencies to adopt rules regarding Medicaid components, or aspects of Medicaid components, the other state agencies administer pursuant to contracts with ODM.

Medical assistance programs relocation tables

In the reorganization of the laws governing Medicaid, the act renumbers numerous Revised Code sections and moves provisions of some sections that are not renumbered to other sections of the Revised Code by amending preexisting sections and enacting provisions in new sections. Regarding the movement of provisions, the act does all of the following:

(1) Copies, sometimes with modifications, parts of law regarding administrative matters regarding ODJFS and enacts them in new Revised Code sections that apply to ODM;

(2) Relocates provisions of law governing Medicaid coverage of ICF/IID services to a new Revised Code chapter next to the Revised Code chapter regarding the Ohio Department of Developmental Disabilities, the agency assuming responsibilities regarding Medicaid coverage of ICF/IID services;

(3) Relocates other provisions of law regarding Medicaid to new Revised Code sections.

Table I shows the renumbering of Revised Code sections. Table II shows where certain provisions were located in prior law and where they are located in the act. As used in Table II, "ICFs/IID" refers to provisions regarding intermediate care facilities for individuals with intellectual disabilities and "NFs" refers to provisions regarding nursing facilities.

Table I

Renumbered Revised Code sections	
R.C. section number under prior law	**R.C. section number under the act**
173.40	173.52
173.401	173.521
173.402	173.524
173.403	173.53
173.404	173.55
3721.50	5168.40
3721.51	5168.42
3721.511	5168.43
3721.512	5168.44
3721.513	5168.45
3721.52	5168.46
3721.53	5168.47
3721.531	5168.48
3721.532	5168.49
3721.533	5168.50
3721.54	5168.51
3721.541	5168.52
3721.55	5168.53
3721.56	5168.54
3721.57	5168.55
3721.58	5168.56
5101.271	5160.45
5101.31	5164.756
5101.50	5161.05

Renumbered Revised Code sections	
R.C. section number under prior law	**R.C. section number under the act**
5101.501	5161.06
5101.502	5161.02
5101.51	5161.10
5101.511	5161.11
5101.5110	5161.35
5101.512	5161.12
5101.513	5161.30
5101.516	5161.22
5101.517	5161.24
5101.519	5161.27
5101.52	5161.15
5101.521	5161.16
5101.522	5161.17
5101.524	5161.20
5101.527	5161.25
5101.571	5160.35
5101.572	5160.39
5101.573	5160.40
5101.574	5160.41
5101.575	5160.42
5101.58	5160.37
5101.59	5160.38
5101.591	5160.43
5111.01	5162.03
5111.011	5163.02
5111.013	5163.40
5111.016	5164.26
5111.018	5164.07
5111.0112	5162.20
5111.0114	5164.754
5111.0116	5163.30
5111.0117	5163.31

Renumbered Revised Code sections	
R.C. section number under prior law	**R.C. section number under the act**
5111.0118	5163.32
5111.0119	5163.45
5111.02	5164.02
5111.021	5164.70
5111.022	5164.56
5111.023	5164.15
5111.024	5164.08
5111.025	5164.76
5111.027	5164.20
5111.028	5164.32
5111.029	5164.06
5111.0210	5164.92
5111.0211	5165.48
5111.0212	5164.80
5111.0213	5164.77
5111.0214	5164.82
5111.0215	5164.93
5111.03	5164.35
5111.031	5164.37
5111.032	5164.34
5111.033	5164.342
5111.034	5164.341
5111.035	5164.36
5111.04	5164.05
5111.042	5164.25
5111.05	5164.45
5111.051	5164.48
5111.052	5164.46
5111.053	5164.301
5111.054	5164.47
5111.06	5164.38
5111.061	5164.57

Renumbered Revised Code sections	
R.C. section number under prior law	**R.C. section number under the act**
5111.062	5164.39
5111.063	5164.31
5111.07	5164.752
5111.071	5164.753
5111.08	5164.759
5111.081	5164.755
5111.082	5164.751
5111.083	5164.757
5111.084	5164.7510
5111.085	5164.758
5111.086	5164.75
5111.09	5162.13
5111.091	5162.131
5111.092	5162.132
5111.10	5162.10
5111.101	5162.15
5111.102	5162.04
5111.11	5162.21
5111.111	5162.211
5111.112	5162.212
5111.113	5162.22
5111.114	5163.33
5111.12	5162.23
5111.121	5162.24
5111.13	5164.85
5111.14	5164.88
5111.141	5164.89
5111.15	5163.20
5111.151	5163.21
5111.16	5167.03
5111.161	5167.031
5111.162	5167.20

Renumbered Revised Code sections	
R.C. section number under prior law	**R.C. section number under the act**
5111.163	5167.201
5111.17	5167.10
5111.171	5167.31
5111.172	5167.12
5111.173	5167.40
5111.174	5167.41
5111.175	5167.26
5111.177	5167.11
5111.178	5167.25
5111.179	5167.13
5111.1710	5167.14
5111.1711	5167.30
5111.18	5164.86
5111.181	5163.22
5111.19	5164.74
5111.191	5164.741
5111.20	5165.01
5111.201	5165.011
5111.202	5165.03
5111.203	5165.031
5111.204	5165.04
5111.21	5165.06
5111.212	5165.35
5111.22	5165.07
5111.221	5165.37
5111.222	5165.15
5111.223	5165.071
5111.224	5124.15
5111.225	5165.155
5111.226	5124.02
5111.23	5124.19
5111.231	5165.19

Renumbered Revised Code sections	
R.C. section number under prior law	**R.C. section number under the act**
5111.232	5165.192
5111.233	5124.194
5111.235	5124.23
5111.24	5165.16
5111.241	5124.21
5111.242	5165.21
5111.244	5165.25
5111.245	5165.26
5111.246	5165.23
5111.25	5165.17
5111.251	5124.17
5111.254	5165.151
5111.255	5124.151
5111.257	5165.28
5111.258	5165.153
5111.259	5165.156
5111.26	5165.10
5111.261	5165.107
5111.262	5165.47
5111.263	5124.29
5111.264	5165.30
5111.265	5165.29
5111.266	5165.101
5111.27	5165.108
5111.271	5165.1010
5111.28	5165.40
5111.29	5165.38
5111.291	5124.154
5111.30	5165.073
5111.31	5165.08
5111.32	5165.081
5111.33	5124.34

Renumbered Revised Code sections	
R.C. section number under prior law	**R.C. section number under the act**
5111.331	5165.34
5111.35	5165.60
5111.36	5165.61
5111.37	5165.62
5111.38	5165.63
5111.39	5165.64
5111.40	5165.65
5111.41	5165.66
5111.411	5165.67
5111.42	5165.68
5111.43	5165.69
5111.44	5165.70
5111.45	5165.71
5111.46	5165.72
5111.47	5165.73
5111.48	5165.74
5111.49	5165.75
5111.50	5165.76
5111.51	5165.77
5111.511	5165.78
5111.52	5165.79
5111.53	5165.80
5111.54	5165.81
5111.55	5165.82
5111.56	5165.83
5111.57	5165.84
5111.58	5165.85
5111.59	5165.86
5111.60	5165.87
5111.61	5165.88
5111.62	5162.66
5111.63	5165.89

Renumbered Revised Code sections	
R.C. section number under prior law	**R.C. section number under the act**
5111.66	5165.50
5111.661	5165.501
5111.67	5165.51
5111.671	5165.511
5111.672	5165.512
5111.673	5165.513
5111.674	5165.514
5111.675	5165.515
5111.676	5165.516
5111.677	5165.517
5111.68	5165.52
5111.681	5165.521
5111.682	5165.522
5111.683	5165.523
5111.684	5165.524
5111.685	5165.525
5111.686	5165.526
5111.687	5165.527
5111.688	5165.528
5111.689	5165.53
5111.70	5163.09
5111.701	5163.091
5111.702	5163.092
5111.703	5163.093
5111.704	5163.094
5111.705	5163.095
5111.706	5163.096
5111.707	5163.097
5111.708	5163.098
5111.709	5163.099
5111.7011	5163.0910
5111.71	5162.36

Renumbered Revised Code sections	
R.C. section number under prior law	**R.C. section number under the act**
5111.711	5162.361
5111.712	5162.362
5111.713	5162.363
5111.714	5162.64
5111.715	5162.364
5111.83	5162.30
5111.84	5166.03
5111.85	5166.02
5111.851	5166.04
5111.852	5166.05
5111.853	5166.06
5111.854	5166.07
5111.855	5166.08
5111.856	5166.10
5111.86	5166.11
5111.861	5166.12
5111.862	5166.121
5111.863	5166.13
5111.864	5166.14
5111.865	5166.141
5111.87	5166.20
5111.871	5166.21
5111.872	5166.22
5111.873	5166.23
5111.874	5124.60
5111.875	5124.61
5111.876	5124.62
5111.877	5124.63
5111.878	5124.64
5111.879	5124.65
5111.88	5166.30
5111.881	5166.301

Renumbered Revised Code sections	
R.C. section number under prior law	**R.C. section number under the act**
5111.882	5166.302
5111.883	5166.303
5111.884	5166.304
5111.885	5166.305
5111.886	5166.306
5111.887	5166.307
5111.888	5166.308
5111.889	5166.309
5111.8810	5166.3010
5111.89	173.54
5111.891	173.541
5111.892	173.544
5111.893	173.547
5111.894	173.542
5111.90	5162.32
5111.91	5162.35
5111.911	5162.37
5111.912	5162.371
5111.914	5164.58
5111.915	5162.11
5111.92	5162.40
5111.93	5162.41
5111.94	5162.54
5111.941	5162.52
5111.943	5162.50
5111.944	5162.58
5111.945	5162.56
5111.96	5164.90
5111.97	5166.35
5111.98	5162.031
5111.981	5164.91
5111.982	5167.21

Renumbered Revised Code sections	
R.C. section number under prior law	**R.C. section number under the act**
5111.99	5165.99
5112.01	5168.01
5112.03	5168.02
5112.04	5168.05
5112.05	5168.03
5112.06	5168.06
5112.07	5168.07
5112.08	5168.09
5112.09	5168.08
5112.10	5168.04
5112.11	5168.10
5112.17	5168.14
5112.18	5168.11
5112.19	5168.12
5112.21	5168.13
5112.30	5168.60
5112.31	5168.61
5112.32	5168.62
5112.33	5168.63
5112.331	5168.64
5112.34	5168.65
5112.341	5168.66
5112.35	5168.67
5112.37	5168.68
5112.371	5168.69
5112.38	5168.70
5112.39	5168.71
5112.40	5168.20
5112.41	5168.21
5112.42	5168.22
5112.43	5168.23
5112.44	5168.24

Renumbered Revised Code sections	
R.C. section number under prior law	**R.C. section number under the act**
5112.45	5168.25
5112.46	5168.26
5112.47	5168.27
5112.48	5168.28
5112.99	5168.99
5112.991	5168.991

Table II

Relocation of Medicaid provisions	
Where the provision was found in prior law	**Where the provision is found in the act**
173.40(A)	173.51
173.40(D)	173.522
173.401(A)	173.51
173.403(A)	173.51
5101.01	5160.011
5101.02	5160.03
5101.03	5160.04
5101.05	5160.05
5101.051	5160.051
5101.08	5160.06
5101.09	5160.021
5101.10	5160.10
5101.11	5160.12
5101.111	5160.11
5101.12	5160.13
5101.141(H)	5160.52
5101.181(A)(2)	5160.01(C)
5101.181(E)	5160.21
5101.181(G)	5160.22
5101.181(H)	5160.23
5101.26(C)	5160.45(A)

Relocation of Medicaid provisions	
Where the provision was found in prior law	**Where the provision is found in the act**
5101.26(E)	5160.01(D)
5101.26(F)	5160.01(E)
5101.272	5160.46
5101.273	5160.47
5101.30(A)	5160.48
5101.30(B)	5160.481
5101.32	5160.052
5101.36	5160.36
5101.37	5160.20
5101.38	5160.16
5101.47	5160.30
5101.49	5160.50
5111.01 (third and fourth sentences of the fourth paragraph of (B))	5162.022
5111.01(C)(2)	5163.05
5111.01(C)(3)	5163.03(A)
5111.01(D)	5163.03(B)
5111.013(C)	5162.31
5111.016(A)	5164.01(A) and (C)
5111.0117(A)(5)	5163.01
5111.021(B)	5164.71
5111.021(C)	5164.59
5111.021(D)	5164.55
5111.021(E)	5164.72
5111.021(F)	5164.73
5111.03(D)	5164.33
5111.03(E)	5164.60
5111.03 (first paragraph of (G))	5164.61
5111.16(E)	5167.032
5111.162(A)	5167.01(C) and (E)
5111.163(A)	5167.01(C), (E), and (H)
5111.172 (first paragraph of (C))	5167.01(A)
5111.1711(C)	5162.60

Relocation of Medicaid provisions	
Where the provision was found in prior law	**Where the provision is found in the act**
5111.20 (ICFs/IID)	5124.01
5111.21 (ICFs/IID)	5124.06
5111.21(C) (NFs)	5165.082
5111.212 (ICFs/IID)	5124.35
5111.22 (other than the last sentence of (A), the last sentence of the second-to-last paragraph, and the last paragraph) (ICFs/IID)	5124.07
5111.22 (last sentence of (A)) (ICFs/IID)	5124.33
5111.22 (last sentence of (A)) (NFs)	5165.33
5111.22 (last sentence of the second-to-last paragraph and the last paragraph) (ICFs/IID)	5124.072
5111.22 (last sentence of the second-to-last paragraph and the last paragraph) (NFs)	5165.072
5111.211 (ICFs/IID)	5124.37
5111.222(A) (NFs)	5165.01(Y)
5111.222(C) (NFs)	5165.152
5111.223 (ICFs/IID)	5124.071
5111.225 (part of (A)) (NFs)	5160.01(A)
5111.232 (first paragraph of (C)) (ICFs/IID)	5124.191
5111.232 ((B), second paragraph of (C), (D), and (E)) (ICFs/IID)	5124.192
5111.232 (first paragraph of (C) and (E)(1) and (2)) (NFs)	5165.191
5111.251(G) (ICFs/IID)	5124.28
5111.258(A) (ICFs/IID)	5124.152
5111.258(B) (ICFs/IID)	5124.153
5111.258(B) (NFs)	5165.154
5111.26(A)(1)(a), (b), and (c) (other than the second and sixth sentences of (A)(1)(a)) (ICFs/IID)	5124.10
5111.26 (second sentence of (A)(1)(a)) (ICFs/IID)	5124.103
5111.26 (second sentence of (A)(1)(a)) (NFs)	5165.103
5111.26 (sixth sentence of (A)(1)(a)) (ICFs/IID)	5124.104
5111.26 (sixth sentence of (A)(1)(a)) (NFs)	5165.104

Relocation of Medicaid provisions	
Where the provision was found in prior law	**Where the provision is found in the act**
5111.26(A)(2) (ICFs/IID)	5124.106
5111.26(A)(2) (NFs)	5165.106
5111.26(B) (ICFs/IID)	5124.102
5111.26(B) (NFs)	5165.102
5111.26(C) (ICFs/IID)	5124.105
5111.26(C) (NFs)	5165.105
5111.264 (ICFs/IID)	5124.30
5111.27(A) (ICFs/IID)	5124.108
5111.27(B) and (D) (ICFs/IID)	5124.109
5111.27(B) and (D) (NFs)	5165.109
5111.27(C) and (D) (ICFs/IID)	5124.193
5111.27(C) and (D) (NFs)	5165.193
5111.27(E) (ICFs/IID)	5124.32
5111.27(E) (NFs)	5165.32
5111.27(F) (ICFs/IID)	5124.31
5111.28(A) (ICFs/IID)	5124.40
5111.28(B) (ICFs/IID)	5124.41
5111.28(B) (NFs)	5165.41
5111.28(C) (ICFs/IID)	5124.42
5111.28(C) (NFs)	5165.42
5111.28(D) (ICFs/IID)	5124.44
5111.28(D) (NFs)	5165.44
5111.28(E) (ICFs/IID)	5124.45
5111.28(E) (NFs)	5165.45
5111.28(F) (ICFs/IID)	5124.43
5111.28(F) (NFs)	5165.43
5111.29(A) (ICFs/IID)	5124.38
5111.29(B) (ICFs/IID)	5124.46
5111.29(B) (NFs)	5165.46
5111.31 (ICFs/IID)	5124.08
5111.32 (other than part of the second sentence of the first paragraph) (ICFs/IID)	5124.081

Relocation of Medicaid provisions	
Where the provision was found in prior law	**Where the provision is found in the act**
5111.32 (part of the second sentence of the first paragraph) (ICFs/IID)	5124.01(WW)
5111.32 (part of the second sentence of the first paragraph) (NFs)	5165.01(PP) and (RR)
5111.65(A) (ICFs/IID)	5124.01(A)
5111.65(A) (NFs)	5165.01(A)
5111.65(B) (ICFs/IID)	5124.01(E)
5111.65(B) (NFs)	5165.01(G)
5111.65(C) (ICFs/IID)	5124.01(N)
5111.65(C) (NFs)	5165.01(N)
5111.65(D) (ICFs/IID)	5124.01(O)
5111.65(D) (NFs)	5165.01(O)
5111.65(E) (ICFs/IID)	5124.01(P)
5111.65(E) (NFs)	5165.01(P)
5111.65(F) (ICFs/IID)	5124.01(Q)
5111.65(G) (NFs)	5165.01(Q)
5111.65(H) (ICFs/IID)	5124.01(R)
5111.65(H) (NFs)	5165.01(R)
5111.65(I) (ICFs/IID)	5124.01(S)
5111.65(I) (NFs)	5165.01(S)
5111.65(J) (ICFs/IID)	5124.01(U)
5111.65(J) (NFs)	5165.01(T)
5111.65(L) (ICFs/IID)	5124.01(CC)
5111.65(L) (NFs)	5165.01(X)
5111.65(M) (ICFs/IID)	5124.01(ZZ)
5111.65(N) (NFs)	5165.01(VV)
5111.66 (ICFs/IID)	5124.50
5111.67 (ICFs/IID)	5124.51
5111.671 (ICFs/IID)	5124.511
5111.672 (ICFs/IID)	5124.512
5111.673 (ICFs/IID)	5124.513
5111.674 (ICFs/IID)	5124.514
5111.675 (ICFs/IID)	5124.515

Relocation of Medicaid provisions	
Where the provision was found in prior law	**Where the provision is found in the act**
5111.676 (ICFs/IID)	5124.516
5111.677 (ICFs/IID)	5124.517
5111.68 (ICFs/IID)	5124.52
5111.681 (ICFs/IID)	5124.521
5111.682 (ICFs/IID)	5124.522
5111.683 (ICFs/IID)	5124.523
5111.684 (ICFs/IID)	5124.524
5111.685 (ICFs/IID)	5124.525
5111.686 (ICFs/IID)	5124.526
5111.687 (ICFs/IID)	5124.527
5111.688 (ICFs/IID)	5124.528
5111.689 (ICFs/IID)	5124.53
5111.71(A)	5162.01(B)(12)
5111.85(A)	5166.01
5111.851(A)	5166.01
5111.874(A) (ICFs/IID)	5124.01(X), (Y), (BB), and (VV)
5111.89(A)	173.51
5111.89(D)	173.543
5111.90(A)(1)	5162.01(B)(10)
5111.90(A)(2)	5162.01(B)(13)
5111.91 (third paragraph)	5162.62
5111.94(A)	5162.01(B)(14)
5111.944 (definition of "dual eligible individual")	5160.01(A)
5111.944 (definition of "Medicare program")	5162.01(A)(2)
5111.981 (definition of "dual eligible individual")	5160.01(A)
5111.981 (definition of "Medicare program")	5162.01(A)(2)

Medicaid eligibility

Federal law establishes mandatory and optional eligibility groups for the Medicaid program. Generally, a state's Medicaid program must cover all of the

mandatory eligibility groups and may cover one or more of the optional eligibility groups.

The act revises the law governing the different eligibility groups covered by Medicaid in Ohio. Many of the revisions reflect corresponding provisions of federal law.

Eligibility groups under prior law

(R.C. 5111.01 (primary and renumbered as 5162.03), 5101.18, 5111.014 (repealed), 5111.015 (repealed), 5111.0110 (repealed), 5111.0111 (repealed), 5111.0113 (repealed), 5111.0115 (repealed), 5111.0120 (repealed), and 5111.0121 (repealed))

The Medicaid program was permitted by prior state law to cover, as long as federal funds were provided, all of the following:

(1) Families with children that met the income, resource, and family composition requirements in effect July 16, 1996, for the former Aid to Dependent Children program or any changes made to those requirements in accordance with federal law that permits states to make such changes;

(2) Aged, blind, and disabled persons who received aid under the Supplemental Security Income (SSI) program or were eligible for but not receiving SSI, provided that the income from all other sources for individuals with independent living arrangements did not exceed an amount adjusted annually;

(3) Aged, blind, and disabled persons who would have been eligible for SSI if not for having countable income above the SSI eligibility limit and would have incurred medical expenses that equaled or exceeded the amount by which their income exceeded the SSI eligibility limit;

(4) Aged, blind, and disabled individuals who did not receive SSI but received Aid for the Aged, Aid to the Blind, or Aid for the Permanently and Totally Disabled before January 1, 1974, and continued to meet all the same eligibility requirements;

(5) Aged, blind, and disabled individuals who ceased to receive SSI as a result of a general increase in Old-Age, Survivors, and Disability Insurance benefits;

(6) Persons required by federal law to be covered by Medicaid as a condition of state participation in Medicaid;

(7) Persons under age 21 who met the income requirements for the Ohio Works First program but did not meet other eligibility requirements for the program specified in rules.

Prior law also permitted Medicaid to cover all of the following:

(1) If sufficient funds were appropriated, persons in groups designated by federal law as groups to which a state, at its option, may cover;

(2) Individuals under age 19 with family incomes not exceeding 150% of the federal poverty line;

(3) If federal funds were provided, former participants of the Ohio Works First program who (a) were ineligible for Ohio Works First solely as a result of increased income due to employment, (b) were not covered by, and did not have access to, medical insurance coverage through an employer with benefits comparable to those provided under Medicaid, and (c) met any other requirements established in rules.

In addition to having authority to cover the groups discussed above, prior state law required the Medicaid program to cover all of the following:

(1) Pregnant women with family incomes not exceeding 200% of the federal poverty line;

(2) Women under age 65 who (a) were not otherwise eligible for Medicaid, (b) had been screened for breast and cervical cancer under the U.S. Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection program, (c) needed treatment for breast or cervical cancer, and (d) were not otherwise covered under creditable coverage;

(3) Any individual under age 21 who (a) was in foster care under the responsibility of the state on the individual's 18th birthday and (b) received foster care maintenance payments or independent living services under a Title IV-E program before the individual's 18th birthday;[158]

(4) Children who were in the temporary or permanent custody of a certified public or private nonprofit agency or institution or in state-subsidized adoptions;

(5) Parents of children under age 19 who (a) resided with their children, (b) had family income not exceeding 90% of the federal poverty line, and (c) were not otherwise eligible for Medicaid.

[158] Title IV-E is the part of the Social Security Act that makes federal funds available to states for foster care and adoption assistance programs.

Eligibility groups under the act

Mandatory eligibility groups and 209(b) exception

(R.C. 5163.03 (primary), 5163.01, and 5163.05)

With one exception, the act requires the Medicaid program to cover all mandatory eligibility groups. "Mandatory eligibility groups" is defined as the groups of individuals that must be covered by the Medicaid state plan as a condition of the state receiving federal financial participation for Medicaid.

The exception to the requirement to cover all mandatory eligibility groups concerns the aged, blind, and disabled group. Generally, an individual receiving SSI benefits is eligible for Medicaid as part of a mandatory eligibility group established by federal law. However, federal law permits states to establish more restrictive Medicaid eligibility requirements for aged, blind, and disabled persons that cause some individuals receiving SSI benefits to not qualify for Medicaid. This option is often referred to as the "209(b)" option, which reflects the section of the Social Security Act that authorizes the option. Ohio's Medicaid program has implemented the 209(b) option. The act expressly authorizes the Medicaid program to continue to implement the 209(b) option.

Optional eligibility groups

(R.C. 5163.03 (primary), 5163.01, 5163.06, 5163.061, and 5163.07)

The act (1) requires Medicaid to cover all of the optional eligibility groups that state statutes require Medicaid to cover, (2) permits Medicaid to cover any of the optional eligibility groups that state statutes either expressly permit Medicaid to cover or do not address whether Medicaid may cover, and (3) prohibits Medicaid from covering any eligibility group that state statutes prohibit Medicaid from covering. "Optional eligibility groups" is defined as the groups of individuals who may be covered by the Medicaid state plan or a federal Medicaid waiver and for whom Medicaid receives federal financial participation.

The act requires Medicaid to cover all of the following optional eligibility groups:

(1) The group consisting of children placed with adoptive parents;[159]

[159] 42 U.S.C. 1396a(a)(10)(A)(ii)(VIII).

(2) The group consisting of women during pregnancy (and the 60-day period beginning on the last day of the pregnancy), infants, and children (see "**Income eligibility threshold for pregnant women**," below);[160]

(3) The group consisting of employed individuals with disabilities, and the group consisting of employed individuals with medically improved disabilities, who qualify for the Medicaid Buy-In for Workers with Disabilities program (see "**Medicaid Buy-In for Workers with Disabilities program**," below);[161]

(4) The group consisting of independent foster care adolescents;[162]

(5) The group consisting of women in need of treatment for breast or cervical cancer;[163]

(6) The group consisting of nonpregnant individuals who may receive family planning services and supplies.[164]

Income eligibility threshold for parents and caretaker relatives

(R.C. 5163.07 (primary) and 5163.01)

The act requires the ODM Director to continue to implement an option available under federal law regarding the income eligibility threshold for parents and caretaker relatives. Under this option, the income eligibility threshold for parents and caretaker relatives is set at 90% of the federal poverty line instead of the amount of the income eligibility threshold for the former Aid to Dependent Children program in effect on July 16, 1996.

Income eligibility threshold for pregnant women

(R.C. 5163.061 (primary) and 5163.01)

The act provides that the income eligibility threshold continues to be 200% of the federal poverty line for women during pregnancy and the 60-day period beginning on the last day of the pregnancy.

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[160] 42 U.S.C. 1396a(a)(10)(A)(ii)(IX).

[161] 42 U.S.C. 1396a(a)(10)(A)(ii)(XVI) and (XVII).

[162] 42 U.S.C. 1396a(a)(10)(A)(ii)(XVII).

[163] 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII).

[164] 42 U.S.C. 1396a(a)(10)(A)(ii)(XXI).

Presumptive eligibility for pregnant woman and children

(R.C. 5163.10 and 5163.101 (both primary) and 5163.01)

The act retains laws that require Medicaid to implement options authorized by federal law under which 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 eligibility threshold 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.

Medicaid Buy-In for Workers with Disabilities program

(R.C. 5163.09 to 5163.0910 (primary) and 5163.01)

The act retains the Medicaid Buy-In for Workers with Disabilities program. The program is the method by which Medicaid covers the following two optional eligibility groups: the group consisting of employed individuals with disabilities and the group consisting of employed individuals with medically improved disabilities.

Medicaid expansion (VETOED)

(R.C. 5163.04 (primary), 5163.01, and 5163.03)

The federal health care reform legislation enacted in 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, includes a major expansion of the Medicaid program. As enacted, the federal health care reform legislation requires a state's Medicaid program to cover, beginning January 1, 2014, individuals who (1) are under age 65, (2) not pregnant, (3) not entitled to (or enrolled for) benefits under Medicare Part A, (4) not enrolled for benefits under Medicare Part B, (5) not otherwise eligible for Medicaid, and (6) have incomes not exceeding 133% (138% after using individuals' modified adjusted gross incomes) of the federal poverty line.[165] Although the federal health care reform legislation made the Medicaid expansion a mandatory eligibility group, the U.S. Supreme Court, in its 2012 ruling on the reform, effectively made the expansion an optional eligibility group by prohibiting the U.S. Secretary of Health and Human Services from withholding all or part of a state's other federal Medicaid funds for failure to implement the expansion.[166]

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[165] 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) and (e)(14).

[166] *National Federation of Independent Business v. Sebelius* (2012), 132 S. Ct. 2566.

The Governor vetoed a provision that would have prohibited the Medicaid program from covering the expansion group. Under the vetoed provision, the prohibition would not have affected the Medicaid eligibility of any individual who began to participate in the MetroHealth Care Plus Medicaid waiver program on or after February 5, 2013.

Transitional Medicaid

(R.C. 5163.08)

Federal law includes a provision for transitional Medicaid. This provision requires a state's Medicaid program to continue to cover certain low-income families with dependent children that would otherwise lose Medicaid eligibility because of changes to their incomes for an additional six months and, if certain requirements are met, up to another additional six months. The requirements for the second 6-month period of eligibility include reporting and income requirements. Federal law gives states the option to provide the low-income families transitional Medicaid for a single 12-month period rather than an initial 6-month period followed by a second 6-month period.[167] The 12-month option enables the low-income families to receive transitional Medicaid for up to a year without having to meet the additional requirements for the second 6-month period.

The act requires the ODM Director to implement the single 12-month eligibility period for transitional Medicaid.

Federal maintenance of effort requirement

(R.C. 5111.0122 (repealed))

Federal law requires states participating in Medicaid to comply with a maintenance of effort requirement regarding Medicaid eligibility. During the period that begins on March 23, 2010, and ends on the date on which the U.S. Secretary of Health and Human Services determines that a health care benefits exchange is fully operational in the state, a state cannot have in effect eligibility standards, methodologies, or procedures for its Medicaid program that are more restrictive than the eligibility standards, methodologies, or procedures in effect on March 23, 2010. This maintenance of effort requirement continues through September 30, 2019, with respect

[167] 42 U.S.C. 1396r-6. This federal law is scheduled to expire December 31, 2013. Congress has extended the law when it was scheduled to expire on previous occasions.

to the eligibility standards, methodologies, and procedures for individuals under age 19 (or a higher age as the state may have elected).[168]

The act repeals a requirement that Ohio comply with the maintenance of effort requirement while it is in effect except to the extent, if any, otherwise authorized by the U.S. Secretary.

Eligibility simplification

(R.C. 5111.0123 (repealed))

The act repeals a requirement that rules be adopted 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. The Office of Medical Assistance adopted such rules after this provision was enacted in 2011.

Tuition savings and scholarships exempt from consideration

(R.C. 5111.015 (repealed))

The act repeals a law that required the value of the following to be exempt from consideration in Medicaid eligibility determinations: tuition payment contracts entered into under state law; scholarships for college savings programs authorized by state law; and payments made by the Ohio Tuition Trust Authority pursuant to the contract or scholarship.

Trust reporting for Medicaid eligibility

(R.C. 5163.21)

The act requires a Medicaid applicant or recipient who is a beneficiary of a trust to submit a complete copy of the trust instrument to the relevant county department of job and family services (CDJFS) and ODM. A copy is considered to be complete if it contains all pages of the trust instrument and all schedules, attachments, and accounting statements referenced in or associated with the trust. The act specifies that the copy is confidential and is not subject to disclosure under Ohio's Public Records Law.[169]

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

[169] R.C. 149.43.

Under law generally unchanged by the act, the CDJFS must determine what type of trust it is and whether the trust or a portion of it is a resource available to the applicant or recipient, contains income available to the applicant or recipient, or both, for purposes of determining the applicant's or recipient's eligibility for Medicaid. The act requires this responsibility to be completed when the CDJFS receives the trust instrument or when the CDJFS determines that the applicant or recipient is a trust beneficiary.

The act also eliminates a reference to an obsolete category of low-income Medicare beneficiaries – known as "qualifying individuals-2" or "Q2s" – who participated in a federal program called the "Qualified Individuals Program." Since January 1, 2003, that program has paid the Medicare Part B premiums for only one category of low-income Medicare beneficiaries known as "qualifying individuals-1" or "Q1s." Q2s had to have incomes between 135% and 175% of the federal poverty level; Q1s have even lower income (between 120% and 135% of the federal poverty level).[170]

Third-party payers

Disclosure of third-party payer information

(R.C. 5160.37 and 5160.371)

Congress intended that Medicaid be the payer of last resort; that is, if a Medicaid recipient has another source of payment for health services, that source is to pay instead of Medicaid.[171] Consistent with this principle, prior law gave ODJFS and a CDJFS an automatic right of recovery against the liability of a third party for the cost of medical assistance paid on behalf of a medical assistance recipient. The act continues to give that right to a CDJFS and gives that right to ODM in place of ODJFS.

In connection with the right of recovery, a medical assistance recipient and the recipient's attorney (if any) must, pursuant to continuing law, cooperate with ODM and the relevant CDJFS. In furtherance of this requirement, the recipient or attorney must, not later than 30 days after initiating informal recovery activity or filing a legal recovery action against a third party, provide written notice of the activity or action to ODM or, under the act, the relevant CDJFS if it has paid medical assistance.

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[170] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *List and Definitions of Dual-Eligibles* (revised April 2, 1999), available at: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/downloads/Buy-InDefinitions.pdf.

[171] U.S. Government Accountability Office, *Medicaid Third Party Liability: Federal Guidance Needed to Help States Address Continuing Problems* (Sept. 2006), available at www.gao.gov/new.items/d06862.pdf, at p. 1.

Similar to the requirement in continuing law described above, the act requires a medical assistance recipient and the recipient's attorney (if any) to cooperate with each medical provider of the recipient. The act specifies that cooperation consists of disclosing to the provider all information the recipient and attorney possess that would assist the provider in determining each third party that is responsible for the payment or processing of a claim for medical assistance provided to the recipient. If such disclosure is not made, the act specifies that the recipient and the recipient's attorney are liable to reimburse ODM for the amount that would have been paid by a third party had a third party been disclosed to the provider by the recipient or the recipient's attorney.

Assignment of ODM's right of recovery

(R.C. 5160.37(K) and 5160.40; Section 812.40)

Beginning January 1, 2014, the act authorizes ODM to assign to a medical assistance provider its right of recovery against a third party for a claim for medical assistance if ODM notifies the provider that ODM intends to recoup ODM's prior payment for the claim. If ODM makes such an assignment, the act requires the third party to treat the provider as ODM and pay the provider the greater of the following:

(1) The amount ODM intends to recoup from the provider for the claim;

(2) If the third party and the provider have an agreement that requires the third party to pay the provider at the time the provider presents the claim to the third party, the amount that is to be paid under that agreement.

Medicaid subrogation for workers' compensation benefits

(R.C. 5101.36)

The act repeals a provision that gives ODJFS a right of subrogation for workers' compensation benefits payable to a person who is subject to a child or spousal support order and who is a Medicaid recipient (to the extent Medicaid payments were made on the recipient's behalf). The act does not modify continuing law that gives ODJFS a right of subrogation for workers' compensation benefits payable to a person who is subject to a child or spousal support order and who is a recipient of public assistance under the Ohio Works First Program; the Prevention, Retention, and Contingency Program; or the Disability Financial Assistance Program.

Medicaid services

Mandatory and optional services

(R.C. 5164.03 (primary) and 5164.01)

As with eligibility groups, federal law requires a state's Medicaid program to cover certain health care services and permits the program to cover other health care services. The services that must be covered are called mandatory health care services and the services that may be covered are optional services.

Continuing state law specifies certain services that the Medicaid program must, may, or cannot cover. Generally, however, whether Ohio's Medicaid program covers a service is specified in rules authorized by continuing law that establish the amount, duration, and scope of Medicaid services.

The act establishes general requirements regarding the Medicaid program's coverage of services. It requires Medicaid to cover all mandatory services and all of the optional services that state statutes require Medicaid to cover. The act permits Medicaid to cover any of the optional services that state statutes expressly permit Medicaid to cover and optional services that state statutes do not address whether Medicaid may cover. Medicaid is prohibited by the act from covering any optional services that state statutes prohibit Medicaid from covering.

Rules regarding payment amounts

(R.C. 5164.02)

The rules regarding Medicaid services are to establish the payment amount for each Medicaid service or, in lieu of the payment amount, the method by which the payment amount is to be determined for each Medicaid service. The act provides that the ODM Director is not required to adopt a rule establishing the payment amount for a Medicaid service if the Director adopts a rule establishing the method by which the payment amount is to be determined for the Medicaid service and makes the payment amount available on the Internet web site maintained by ODM.

Provider agreements

Requirement to have provider agreement with ODM

(R.C. 5164.30)

Continuing law has many provisions regarding Medicaid provider agreements that indirectly establish the requirement for providers to have such an agreement to

participate in Medicaid. The act expressly prohibits any person or government entity from participating in Medicaid as a provider without a valid provider agreement with ODM.

Time limit on provider agreements

(R.C. 5164.32 (primary), 5164.31, 5164.38, and 5165.07)

Continuing law requires the ODM Director to adopt rules establishing procedures for the use of time-limited Medicaid provider agreements. The act revises the law governing time-limited Medicaid provider agreements. Under the revisions, all provider agreements, including provider agreements with Medicaid managed care organizations, nursing facilities, ICFs/IID, and hospitals, are to be time-limited. The act eliminates the phase-in process for converting provider agreements to time-limited provider agreements. The act also eliminates provisions that permitted ODM to (1) take an action to convert a provider agreement by sending a notice by regular mail to the address of the provider on record with ODM advising the provider of the conversion and (2) make the effective date of a provider agreement retroactive for a period not to exceed one year from the date of the provider's application for the agreement, as long as the provider met all Medicaid program requirements during that period. Whereas prior law provided that a provider agreement was to expire not later than seven years from its effective date, the act sets the maximum duration of a provider agreement to five years.

The act requires that ODM's rules regarding time-limited provider agreements include a process for revalidating providers' continued enrollment as providers rather than a process for re-enrolling providers. The rules must be consistent with federal Medicaid regulations regarding provider screening and enrollment. All of the following apply to the revalidation process:

(1) ODM must refuse to revalidate a provider's provider agreement when the provider fails to file a complete application for revalidation within the time and in the manner required under the revalidation process.

(2) If a provider files an application for revalidation within the required time and in the required manner, but the provider agreement expires before ODM acts on the application or before the effective date of ODM's decision on the application, the provider may continue operating under the terms of the expired provider agreement until the effective date of ODM's decision. However, if ODM denies the provider's application, Medicaid payments cannot be made for Medicaid services provided during the period beginning on the date the provider agreement expired and ending on the

effective date of a subsequent provider agreement, if any, that ODM enters into with the provider.

Adjudications regarding provider agreements

(R.C. 5164.38)

Generally, ODM is required to issue an order pursuant to an adjudication conducted in accordance with the Administrative Procedure Act (R.C. Chapter 119.) when taking various actions regarding Medicaid provider agreements, such as refusing to enter into a provider agreement. The act eliminates a requirement to issue an order pursuant to an adjudication when ODM enters into a provider agreement.

Renewing and refusing to renew a provider agreement were other actions that generally required an adjudication under prior law. The act replaces references to renewal with references to revalidation to conform with the changes discussed above regarding time limits on provider agreements. It eliminates the requirement to issue an order pursuant to an adjudication when revalidating a provider agreement. Therefore, an adjudication is required when ODM refuses to revalidate a provider agreement but not when ODM agrees to revalidate a provider agreement.

The act provides that the requirement to issue an order pursuant to an adjudication does not apply when ODM (1) denies an application for a Medicaid provider agreement because the application is not complete or (2) unless the provider is a nursing facility or ICF/IID, refuses to revalidate a provider agreement because the provider fails to file a complete application for revalidation within the required time and in the required manner.

Application fees for provider agreements

(R.C. 5164.31)

ODM was required by prior law to charge an application fee to a provider seeking to enter into or renew a Medicaid provider agreement, unless the provider was exempt from paying the fee under federal Medicaid regulations. The act requires ODM to collect an application fee from a provider before (1) entering into a Medicaid provider agreement with a provider seeking initial enrollment as a provider, (2) entering into a provider agreement with a former provider seeking re-enrollment as a provider, and (3) revalidating a provider's continued enrollment as a provider. The act maintains the exception for providers who are exempt under the federal Medicaid regulations.

The act specifies that the application fees are nonrefundable when collected in accordance with the federal Medicaid regulation governing the fees.

Denying, terminating, and suspending provider agreements

(R.C. 5164.33 (primary), 5164.38, and 5165.07)

Continuing law provides that a Medicaid provider agreement may be denied or terminated for any reason permitted or required by federal law. Also, an individual, provider of services or goods, or other entity may be excluded from participating in Medicaid for any reason permitted or required by federal law. Under prior law, a provider agreement for a nursing facility or ICF/IID could be denied, not renewed, or terminated when ODM determined that the provider agreement would not be in the best interests of Medicaid recipients or the state.

The act permits the ODM Director to deny, refuse to revalidate, or terminate a Medicaid provider agreement for any type of provider, rather than only nursing facilities and ICFs/IID, when the Director determines that the action is in the best interests of Medicaid recipients or the state. The act also permits the Director to exclude an individual, provider of services or goods, or other entity from participation in the Medicaid program when the Director determines that the exclusion is in the best interests of Medicaid recipients or the state. The ODM Director is permitted by the act to suspend a Medicaid provider agreement for any reason permitted or required by federal law and when the Director determines that the suspension is in the best interests of Medicaid recipients or the state.

Nursing facilities' provider agreement terms

(R.C. 5165.08, 5165.513, 5165.515, and 5165.99; Sections 110.25, 110.26, 110.27, and 323.235)

Distinct part of a nursing facility

The act revises the terms that must be included in a provider agreement for a nursing facility. Under prior law, every provider agreement with a nursing facility had to include any part of the facility that met standards for certification of compliance with federal and state laws and rules for participation in the Medicaid program. However, beds added during the period beginning July 1, 1987, and ending July 1, 1993, were not required to be included in a provider agreement unless otherwise required by federal law. If a nursing facility chose to include such a bed in a provider agreement, the bed could not be removed from the provider agreement unless the nursing facility withdrew entirely from the Medicaid program.

In place of the prior law provisions described above, the act provides that a nursing facility may exclude, until January 1, 2015, one or more of its parts from the provider agreement, even though those parts meet federal and state standards for Medicaid certification, if all of the following apply:

(1) The nursing facility initially obtained both its nursing home license and Medicaid certification on or after January 1, 2008;

(2) The nursing facility is located in a county that has, according to the Director of Health, more long-term care beds than it needs at the time the nursing facility excludes the parts from the provider agreement;

(3) Federal law permits the provider to exclude the parts from the provider agreement;

(4) The provider gives ODM written notice of the exclusion not less than 45 days before the first day of the calendar quarter in which the exclusion is to occur.

The act provides that a nursing facility that so excludes one or more of its parts from a provider agreement does not violate continuing law that prohibits a person who is granted a certificate of need (CON) from carrying out the reviewable activity authorized by the CON in a manner that is not in substantial accordance with the approved application for the CON.

Distinct part advisory workgroup

The act creates the Nursing Facility Distinct Part Advisory Workgroup to develop findings regarding the impact that allowing nursing facilities to exclude distinct parts of their facilities from their Medicaid provider agreements would have on access to nursing facility services, quality of care, and purchasing strategies for nursing facility services provided to Medicaid recipients with specialized health care needs.

The Workgroup is to consist of all of the following members:

(1) The Office of Health Transformation (OHT) Executive Director or the Executive Director's designee;

(2) The Director of Aging or the Director's designee;

(3) The Director of Health or the Director's designee;

(4) The ODM Director or the Director's designee;

(5) The State Long-Term Care Ombudsman or the Ombudsman's designee;

(6) Two representatives, from each of the following, appointed by the organization's chief executive officer or the individual serving in an equivalent capacity for the organization: the Ohio Health Care Association, LeadingAge Ohio, AARP Ohio, and the Academy of Senior Health Sciences;

(7) Two members of the House of Representatives, one from the majority party and one from the minority party, appointed by the Speaker;

(8) Two members of the Senate, one from the majority party and one from the minority party, appointed by the Senate President.

The act requires that members of the Workgroup be appointed not later than October 14, 2013. Vacancies are to be appointed in the same manner as the original appointments. Each member is to serve without compensation or reimbursement for expenses incurred while serving on the Workgroup, except to the extent that serving on the Workgroup is considered to be among the member's employment duties.

The OHT Executive Director, or the Executive Director's designee, is to serve as the Workgroup's chairperson. ODM must provide staff and other support services.

The Workgroup is required to submit a report to the General Assembly not later than December 31, 2013. The report is to include the Workgroup's findings and recommendations for policies on nursing facilities' excluding distinct parts of their facilities from their Medicaid provider agreements. The Workgroup is to cease to exist on submission of its report.

Denials of admissions

Another term of a provider agreement for a nursing facility that the act revises concerns denials of admission on the basis that an individual is or may become a Medicaid recipient. Under prior law, a provider agreement had to prohibit a nursing facility from failing or refusing to accept an individual because the individual was, or as a resident of the nursing facility could become, a Medicaid recipient if less than 80% of its residents were Medicaid recipients.[172] Under the act, a nursing facility may fail or refuse, until January 1, 2015, to admit such an individual if at least 25% (rather than 80%) of its Medicaid-certified beds are occupied by Medicaid recipients at the time the individual would otherwise be admitted. The 80% occupancy-rate standard is restored on January 1, 2015.

[172] The prohibition against refusing admission does not apply when a nursing facility is subject to an order denying Medicaid payments for new residents due to failure to comply with certification requirements. The act does not affect this exception.

Medicaid-related criminal records checks

(R.C. 5164.34 (primary), 109.572, 5164.341, and 5164.342)

The act revises the law governing Medicaid-related criminal records checks. Continuing law requires an independent provider of home and community-based services covered by an ODM-administered Medicaid waiver program to submit to a criminal records check as a condition of obtaining or maintaining a provider agreement. Continuing law also requires an individual to submit to a database review and, unless the individual fails the database review, a criminal records check as a condition of being employed by a waiver agency in a position that involves providing home and community-based services covered by an ODM-administered Medicaid waiver program. (An individual already employed in such a position is subject to a database review and criminal records check only if so required by ODM rules.)

ODM has authority under continuing law to require the following: (1) that other providers, including applicants for provider agreements, submit to criminal records checks as a condition of maintaining or obtaining provider agreements, (2) that other providers, including applicants for provider agreements, require their owners, officers, and board members (including prospective owners, officers, and board members) to submit to criminal records checks, and (3) that other providers, including applicants for provider agreements, (a) determine, pursuant to database reviews, whether any employee or prospective employee is included in certain databases and (b) unless a provider cannot employ an employee or prospective employee because of the results of the database review, require the employee or prospective employee to submit to a criminal records check. These provisions do not apply to individuals who are subject to other laws regarding criminal records checks applicable to providers or employees of various health services, including hospice, home health, and nursing home care.

Intervention in lieu of conviction

The act eliminates a requirement for ODM to terminate or deny a provider agreement, as well as the requirement for a provider to prohibit a person from being an owner, officer, board member, or employee, when the provider or person has been found eligible for intervention in lieu of conviction for a disqualifying offense.

Release of results of criminal records check

Continuing law provides that the report of a criminal records check to which a Medicaid provider (or owner, officer, board member, or employee of a provider) submits is not a public record and may be made available only to certain persons, such as the subject of the check and the ODM Director. The act permits the results to be released to an individual receiving or deciding whether to receive, from the subject of

the check, home and community-based services available under an ODM-administered Medicaid waiver program or the Medicaid state plan. In the case of a criminal records check of an independent provider of home and community-based services covered by an ODM-administered Medicaid waiver program, the law already permitted the results to be released to an individual receiving the services from the provider. The act permits the results to be released, in addition, to an individual deciding whether to receive the services from the provider.

System for Award Management web site

Before a waiver agency providing home and community-based services covered by an ODM-administered Medicaid waiver program requires an employee or prospective employee to submit to a criminal records check, continuing law requires the waiver agency to conduct a review of certain databases to determine whether the waiver agency may employ the employee or prospective employee. (The requirement to conduct a database review for an existing employee applies only if ODM rules require that the database review be conducted.) The Excluded Parties List System is one of the databases that must be reviewed. It is maintained by the U.S. General Services Administration. The act specifies that the Excluded Parties List System is available at the federal web site known as the System for Award Management.

Interest on Medicaid provider excess payments

(R.C. 5164.60)

Under the act, any Medicaid provider who, without intent, obtains excess Medicaid payments is liable for payment of interest on the amount of the excess payments. The interest is to be paid at the average bank prime rate in effect on the first day of the calendar quarter during which the provider receives notice of the excess payment. ODM must determine the average bank prime rate using Statistical Release H.15, "Selected Interest Rates," a weekly publication of the Federal Reserve Board, or any successor publication. If Statistical Release H.15, or its successor, ceases to include the bank prime rate information or ceases to be published, ODM is to request a written statement of the bank prime rate from the Federal Reserve Bank of Cleveland or the Federal Reserve Board.

Prior law similarly made a Medicaid provider liable for payment of interest on the amount of excess payments, but the interest was to be paid at the maximum interest rate allowable for real estate mortgages on the date the payment was made to the provider for the period from the date on which payment was made to the date on which repayment was made to the state.

Dispensing fee; generic drug copayments

Medicaid dispensing fee for noncompounded drugs

(Section 323.130)

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, 2013, and ending on the effective date of a rule changing the amount of the fee that the ODM Director adopts. This is the same amount that has been in effect since July 1, 2009.

Drug dispensing fee survey

(R.C. 5164.752 and 5164.753; Section 812.40)

For the purpose of establishing a Medicaid drug dispensing fee, continuing law requires ODM to conduct a survey of retail pharmacy operations. Under prior law, retail pharmacy operations in Ohio were the subject of the survey.

Effective July 1, 2014, the act modifies the provisions regarding the survey. The act requires that all Medicaid-participating terminal distributors of dangerous drugs participate in the survey. In place of a provision specifying that the survey is private, the act specifies that survey responses are confidential and not a public record, except as necessary to publish the survey's results.

The act retains provisions requiring that the survey include operational data and direct prescription expenses, professional services and personnel costs, and usual and customary overhead expenses of the survey participants. The requirement that the survey include "profit data," however, is eliminated.

Under prior law, the dispensing fee was effective the January following the survey. The act instead provides that the fee is effective the following July.

Medicaid copayments for drugs

(R.C. 5162.20 (primary), 5162.01, 5164.01, 5164.20, 5164.751, 5164.752, 5164.758, 5164.7510, 5167.01, 5167.12, and 5167.13)

Continuing law imposes cost-sharing requirements on Medicaid recipients. The act eliminates a provision that excluded of generic drugs from the cost-sharing requirements.

The act replaces, in the Medicaid law, references to prescription drugs with references to prescribed drugs. The act provides that "prescribed drugs" has the same meaning as in a federal regulation. The federal regulation defines "prescribed drugs" as

simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are (1) prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by federal and state law, (2) dispensed by licensed pharmacists and licensed authorized practitioners in accordance with state law, and (3) dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.[173]

Miscellaneous payment rates

Physician groups acting as outpatient hospital clinics (VETOED)

(R.C. 5164.78)

The Governor vetoed a provision that would have required that the Medicaid payment rates for physician, pregnancy-related, evaluation, and management services provided by a physician group practice be determined in accordance with provisions based on a preexisting administrative rule.[174] The rule requires different Medicaid payment amounts (generally the regular Medicaid payment multiplied by 1.4) for physician group practices that meet both of the following criteria:

(1) The physician group practice is physically attached to a hospital that does not provide physician clinic outpatient services and the hospital and physician group practice have signed a letter of agreement indicating that the physician group practice provides the outpatient hospital clinic service for that hospital;

(2) The state Medicaid provider utilization summary for calendar year 1990 establishes that the physician group practice, in that year, provided at least 40% of the total number of Medicaid physician visits provided in the county in which the physician group practice is located and an aggregate total of at least 10% of the physician visits provided in the contiguous counties.

Under the vetoed provision, ODM would have been required to submit a report to the General Assembly within four years.

[173] 42 C.F.R. 440.120.

[174] See O.A.C. 5101:3-1-60.1.

Medicaid rates for hospital inpatient and outpatient services

(Section 323.103)

The act requires that the Medicaid payment rates for Medicaid-covered hospital inpatient services be the same as the Medicaid payment rates for the services in effect on June 30, 2013, until the effective date of the first of any ODM rules establishing new diagnosis-related groups for the services. Medicaid payment rates for hospital outpatient services must be, until June 30, 2015, the same as the rates for the services in effect on June 30, 2013.

Medicaid payment rate adjustments

(Sections 323.250, 323.260, and 323.270)

The ODM Director is required by the act to make all of the following adjustments to Medicaid payment rates:

(1) Reduce the payment rate for radiological services in situations in which the services are provided (a) in a physician's office or an independent diagnostic testing facility and (b) more than once by the same provider for the same Medicaid recipient during the same session;

(2) Identify physician services for which Medicaid payment rates should vary depending on where the services are provided and establish varying Medicaid payment rates for those services;

(3) Identify Medicaid services for which Medicaid payment methodologies should be aligned with Medicare payment methodologies for the services and establish those aligned payment methodologies.

The act requires the adjustments to be made by adopting rules. It specifies that the rules cannot take effect before January 1, 2014.

Medicaid payments for noninstitutional services to Medicare Part B enrollees

(Section 323.230)

The act establishes Medicaid payment amounts for noninstitutional services, provided from January 1, 2014 through July 1, 2015, to a Medicaid recipient who is a dual eligible individual enrolled for benefits under Medicare Part B. Physician services are excluded from this provision of the act, but free standing dialysis center services are included. Under the act, a Medicaid payment for noninstitutional services is to equal the lesser of the following:

(1) The sum of the Medicare Part B deductible, coinsurance, and copayment for the services that apply to the individual;

(2) The greater of: (a) the maximum allowable Medicaid payment for the services when provided to other Medicaid recipients, less the total Medicaid payment (if any) most recently paid on the Medicaid recipient's behalf for such services, or (b) zero.

Medicaid payments for home health and private duty nursing services

(Section 323.233)

For fiscal years 2014 and 2015, the act authorizes Medicaid payments to be made for home health and private duty nursing services provided by the responsible adult of a Medicaid recipient if the provision of services meets conditions to be established by the ODM Director. "Responsible adult" under the act is the spouse of a Medicaid recipient or, in the case of a minor, the minor's parent, foster caregiver, stepparent, guardian, legal custodian, or any other person who stands in the place of a parent for the minor.

The ODM Director is required to consult with provider representatives, consumer representatives, and other stakeholders in developing rules regarding Medicaid payments to responsible adults for such services. The rules may include any of the following:

(1) Qualification and training requirements necessary for responsible adults to receive Medicaid payments;

(2) Oversight requirements necessary for responsible adults to receive Medicaid payments;

(3) Procedures designed to protect against fraud, waste, and abuse that may occur as a result of making Medicaid payments to responsible adults;

(4) Any other procedures, standards, or requirements the ODM Director considers appropriate.

Mental health services

Inpatient psychiatric hospital services for certain individuals under age 21

(Section 323.340)

During fiscal years 2014 and 2015, the act permits Medicaid to cover inpatient psychiatric hospital services provided by psychiatric residential treatment facilities to

Medicaid recipients under age 21 who are in the custody of the Ohio Department of Youth Services (ODYS) and have been identified as meeting a clinical criterion of serious emotional disturbance.

The act requires ODYS, in collaboration with ODM and the Ohio Department of Mental Health and Addiction Services (ODMHAS), to specify the clinical criterion of serious emotional disturbance to be used for purposes of identifying these individuals.

Prior authorization for community mental health services

(Section 323.80)

The act continues for fiscal years 2014 and 2015 a provision that H.B. 153 of the 129th General Assembly established for fiscal years 2012 and 2013. Under the provision, 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 ODMHAS 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 ODYS, or (5) is an alleged or adjudicated delinquent or unruly child receiving services under the Felony Delinquent Care and Custody Program.

Review of home health services

(Section 323.290)

The act authorizes ODM to review home health nursing services, home health aide services, and private duty nursing services covered by the Medicaid program to identify opportunities to improve the efficiency of, and individual care provided by, long-term care services and supports. In its review, ODM may consider establishing any of the following:

(1) New methods for authorizing and coordinating long-term care services and supports, including such services and supports covered by the Medicaid state plan, using case managers or care coordinators;

(2) Competency and training requirements for the case managers or care coordinators;

(3) Other mechanisms for improving efficiency and individual care in the delivery of long-term care services and supports.

Medicaid coverage of wheelchairs, oxygen, and transportation

(R.C. 5165.01 and 5165.19; Section 323.236)

Services removed from bundling

H.B. 1 of the 128th General Assembly included the costs of wheelchairs, oxygen, and resident transportation services among the costs included in nursing facilities' Medicaid allowable costs.[175] The inclusion of wheelchair, oxygen, and resident transportation costs in nursing facilities' costs is part of what has been called "bundling." Other costs that are part of bundling include, over-the-counter pharmacy products, physical therapy, occupational therapy, speech therapy, and audiology. Bundling affects nursing facilities' Medicaid payments.

The act removes custom wheelchairs from nursing facilities' Medicaid-allowable costs, as well as repairs to and replacements of custom wheelchairs and parts that are made in accordance with the instructions of the physician of the individual who uses the custom wheelchair. "Custom wheelchair" is defined as a wheelchair that (1) has been measured, fitted, or adapted in consideration of the body size or disability of the individual who is to use the wheelchair or the individual's period of need for, or intended use of, the wheelchair and (2) has customized features, modifications, or components that the supplier or manufacturer added or made in accordance with the instructions of the individual's physician. The act also removes oxygen (other than emergency oxygen) and resident transportation services from nursing facilities' Medicaid-allowable costs. All of the removals take effect January 1, 2014.

Continuing law provides for a portion of nursing facilities' Medicaid payment rates for direct care costs to be based on their costs for bundled services. Under prior law, this was reflected in an $1.88 per Medicaid day payment rate increase for nursing facilities' costs per case-mix unit, a factor in determining their Medicaid payment rates for direct care costs. With the removal of custom wheelchair, oxygen (other than emergency oxygen), and resident transportation costs, this amount is reduced to 86¢ beginning January 1, 2014.

Both the prior increase and the act's lower increase are to cease when ODM first rebases nursing facilities' costs per case-mix unit. Rebasing is a redetermination of nursing facilities' costs per case-mix unit using information from Medicaid cost reports for a calendar year that is later than the calendar year used for the previous determination of such costs. Continuing law provides that ODM does not have to conduct a rebasing more than once every ten years.

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[175] Emergency oxygen had already been a Medicaid-allowable cost for nursing facilities.

Purchasing strategies

The act requires the ODM Director to implement, for the period beginning January 1, 2014, and ending June 30, 2015, strategies for purchasing custom wheelchairs, oxygen (other than emergency oxygen), and resident transportation services for Medicaid recipients residing in nursing facilities. In implementing the purchasing strategies, the Director is to seek to achieve a more efficient allocation of resources and price and quality competition among providers of the goods and services. The Director must consider one or more of the following when determining the purchasing strategies:

(1) Establishing competitive bidding;

(2) Establishing manufacturers rebate programs;

(3) Another purchasing strategy that saves the Medicaid program an amount equivalent to the savings that would be realized from one or both of the purchasing strategies specified above.

Nursing facility services

Nursing facilities' peer groups

(R.C. 5165.15, 5165.16, 5165.17, and 5165.19)

Nursing facilities are placed into various peer groups for the purposes of determining their Medicaid payment rates for ancillary and support costs, capital costs, and direct care costs. The act provides for a nursing facility located in Mahoning or Stark county to be treated as if it were in a different peer group when its Medicaid payment rate is determined for the period beginning October 1, 2013, and ending on the first day of the first rebasing of nursing facilities' Medicaid payment rates. This will affect the Medicaid payment rates only for nursing facilities located in those counties. Nursing facilities located in either county are to become a part of the different peer groups beginning with the first rebasing. This will affect the Medicaid payment rates for all nursing facilities in the peer groups affected by the changes. A rebasing is a redetermination of nursing facilities' Medicaid payment rates for certain cost centers using information from Medicaid cost reports for a calendar year that is later than the calendar year used for the previous determination of the costs.

For the purpose of determining nursing facilities' Medicaid payment rates for ancillary and support costs and capital costs, a nursing facility located in Mahoning or Stark county is placed in either peer group five or six, depending on how many beds it has. If it has fewer than 100 beds, it is placed in peer group five. If it has 100 or more

beds, it is placed in peer group six. Nursing facilities located in any of the following counties are also placed in peer group five or six, depending on their number of beds: Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot.

During the period beginning October 1, 2013, and ending on the first day of the first rebasing, a nursing facility located in Mahoning or Stark county is to be treated as if it were part of peer group three if it has fewer than 100 beds and peer group four if it has 100 or more beds. Beginning with the first rebasing, nursing facilities located in Mahoning or Stark County are to be placed, rather than just treated as if they were part of, peer group three or four. Under continuing law, peer groups three and four consist of nursing facilities located in any of the following counties: Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union, and Wood.

For the purpose of determining nursing facilities' Medicaid payment rates for direct care costs, a nursing facility located in Mahoning or Stark county is placed in peer group three. Peer group three also consists of nursing facilities located in any of the following counties: Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot. During the period beginning October 1, 2013, and ending on the first day of the first rebasing, a nursing facility is to be treated as if it were part of peer group two. Beginning with the first rebasing, nursing facilities located in Mahoning or Stark County are to be placed, rather than just treated as if they were part of, peer group two. Under continuing law, peer group two consists of nursing facilities located in any of the following counties: Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union, and Wood.

Nursing facilities' quality incentive payments

(R.C. 5165.25 (primary), 173.47, and 5165.26)

Maximum quality incentive payment

Continuing law provides for a quality incentive payment to be part of nursing facilities' Medicaid payments. A nursing facility's per Medicaid day quality incentive payment for a fiscal year is the product of $3.29 and the number of points it is awarded for meeting accountability measures. There is, however, a cap on the quality incentive payment that may be paid. Under prior law, the maximum per Medicaid day payment was $16.44 for all nursing facilities. Beginning with fiscal year 2015, the act revises the law governing the maximum payment as follows:

(1) The maximum payment is to remain at $16.44 per Medicaid day for a nursing facility that is awarded at least one point for meeting accountability measures regarding pain, pressure ulcers, physical restraints, urinary tract infections, and vaccinations.

(2) The maximum payment is to be reduced to $13.16 per Medicaid day for a nursing facility that fails to be awarded at least one point for the accountability measures specified above.

Fiscal year 2014 accountability measures

The act retains the accountability measures for which nursing facilities may be awarded points for fiscal year 2014. However, the act includes specific percentage amounts to be used for certain accountability measures rather than having those percentages determined administratively in accordance with directions included in provisions the act eliminates. The following are the accountability measures for which the act establishes specific percentage amounts to be used and the percentage amounts so specified:

(1) Not more than 13.35% of a nursing facility's long-stay residents report severe to moderate pain during the minimum data set assessment process;[176]

(2) Not more than 5.73% of a nursing facility's long-stay, high-risk residents have been assessed as having one or more stage two, three, or four pressure ulcers during the minimum data set assessment process;

[176] The minimum data set is the standardized, uniform, and comprehensive assessment of nursing facility residents that is used to identify potential problems, strengths, and preferences of residents and is part of the resident assessment instrument required by federal Medicaid law.

(3) Not more than 1.52% of a nursing facility's long-stay residents were physically restrained as reported during the minimum data set assessment process;

(4) Less than 7.78% of a nursing facility's long-stay residents had a urinary tract infection as reported during the minimum data set assessment process.

Fiscal year 2015 and thereafter accountability measures

The act revises the list of accountability measures for which nursing facilities can be awarded points for fiscal year 2015 and thereafter. A nursing facility is to be awarded one point for each of the following accountability measures it meets:

(1) Its overall score on its resident satisfaction survey is at least 87.5;

(2) Its overall score on its family satisfaction survey is at least 85.9;

(3) It satisfies the requirements for participation in the Advancing Excellence in America's Nursing Homes campaign;

(4) Both of the following apply:

(a) It had not been listed on Table B of the Special Focus Facility list for 18 or more consecutive months during any time during the calendar year immediately preceding the fiscal year for which the point is to be awarded.[177]

(b) It had neither of the following on its most recent standard survey conducted not later than the last day of the calendar year immediately preceding the fiscal year for which the point is to be awarded or any complaint surveys conducted in the calendar year immediately preceding the fiscal year for which the point is to be awarded: (i) a health deficiency with a scope and severity level greater than F, or (ii) a deficiency that constitutes a substandard quality of care.

(5) It does all of the following:

(a) Offers at least 50% of its residents at least one of the following dining choices for at least two meals each day: restaurant-style dining, buffet-style dining, family-style dining, open dining, or 24-hour dining;

[177] See "**Special Focus Facility Program**," below, for a discussion of the Special Focus Facility list and its tables.

(b) Maintains a written policy specifying the manner or manners in which residents' dining choices for meals are offered;

(c) Communicates the policy to its staff, residents, and families of residents.

(6) It does all of the following:

(a) Enables at least 50% of its residents to take a bath or shower when they choose;

(b) Maintains a written policy regarding residents' choices in bathing;

(c) Communicates the policy to its staff, residents, and families of residents.

(7) It has at least both of the following scores on its resident satisfaction survey:

(a) With regard to the question in the survey regarding residents' ability to choose when to go to bed in the evening, at least 89;

(b) With regard to the question in the survey regarding residents' ability to choose when to get out of bed in the morning, at least 76.

(8) It has at least both of the following scores on its family satisfaction survey:

(a) With regard to the question in the survey regarding residents' ability to choose when to go to bed in the evening, at least 88;

(b) With regard to the question in the survey regarding residents' ability to choose when to get out of bed in the morning, at least 75.

(9) Not more than 13.35% of its long-stay residents report severe to moderate pain during the minimum data set assessment process.

(10) Not more than 5.16% of its long-stay, high-risk residents have been assessed as having one or more stage two, three, or four pressure ulcers during the minimum data set assessment process.

(11) Not more than 1.52% of its long-stay residents were physically restrained as reported during the minimum data set assessment process.

(12) Less than 7% of its long-stay residents had a urinary tract infection as reported during the minimum data set assessment process.

(13) It does both of the following:

(a) Uses a tool for tracking residents' admissions to hospitals;

(b) Annually reports to ODM data on hospital admissions by month for all residents.

(14) Both of the following apply:

(a) At least 95% of its long-stay residents are vaccinated against pneumococcal pneumonia, decline the vaccination, or are not vaccinated because the vaccination is medically contraindicated;

(b) At least 93% of its long-stay residents are vaccinated against seasonal influenza, decline the vaccination, or are not vaccinated because the vaccination is medically contraindicated.

(15) An average of at least 50% of its Medicaid-certified beds are in either, or in a combination of both, of the following:

(a) Private rooms;

(b) Semi-private rooms to which all of the following apply: (i) each room provides a distinct territory for each resident occupying the room, (ii) each distinct territory has a window and is separated by a substantial wall from the other distinct territories in the room,[178] (iii) each resident is able to enter and exit the distinct territory of the resident's room without entering or exiting another resident's distinct territory, and (iv) complete visual privacy for each distinct territory may be obtained by drawing a curtain or other screen.

(16) It obtains at least a 95% compliance rate with requesting resident reviews required by a federal regulation for individuals who are exempted hospital discharges.[179]

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[178] "Substantial wall" is defined as a permanent structure that reaches from floor to ceiling and divides a semi-private room into two distinct living spaces, each with its own window.

[179] "Exempted hospital discharge" is defined as an individual (1) who is admitted to a nursing facility directly from a hospital after receiving acute inpatient care at the hospital, (2) who requires nursing facility services for the condition for which the individual received care in the hospital, and (3) whose attending physician has certified before admission to the nursing facility that the individual is likely to require less than 30 days of nursing facility services (42 C.F.R. 483.106(b)(2)(i)).

(17) It does both of the following:

(a) Maintains a written policy that requires consistent assignment of nurse aides and specifies the goal of having a resident receive nurse aide care from not more than 12 different nurse aides during a 30-day period;

(b) Communicates the policy to its staff, residents, and families of residents.

(18) Its staff retention rate is at least 75%.

(19) Its turnover rate for nurse aides is not higher than 65%.

(20) For at least 50% of its resident care conferences, a nurse aide who is a primary caregiver for the resident attends and participates in the conference.

(21) All of the following apply:

(a) At least 75% of its residents have the opportunity, following admission and before completing or quarterly updating their individual plans of care, to discuss their goals for the care they are to receive there, including their preferences for advance care planning, with a member of the resident's health care teams that the facility, its residents, and residents' sponsors consider appropriate.

(b) It records the residents' care goals, including their advance care planning preferences, in their medical records.

(c) It uses the residents' care goals, including their advance care planning preferences, in the development of their individual plans of care.

(22) It does both of the following:

(a) Maintains a written policy that prohibits the use of overhead paging systems or limits their use to emergencies, as defined in the policy;

(b) Communicates the policy to its staff, residents, and families of residents.

Points may be awarded for the accountability measures specified in (21) and (22), above, only for fiscal year 2015. Not later than July 1, 2014, ODM is required to submit recommendations to the General Assembly for accountability measures to replace the accountability measures specified in (21) and (22), above.

As with the accountability measures to be used until fiscal year 2015, to be awarded a point for meeting an accountability measure for fiscal year 2015 and thereafter (other than the accountability measure specified in (4)(b), above), a nursing facility must meet the accountability measure in the calendar year immediately preceding the fiscal year for which the point is to be awarded. A nursing facility is to be awarded points for meeting accountability measures regarding resident satisfaction surveys or family satisfaction surveys only if a resident satisfaction survey or family satisfaction survey, as appropriate, was initiated for the nursing facility in the calendar year immediately preceding the fiscal year for which the points are to be awarded.

Nursing facilities' quality bonuses (VETOED)

(R.C. 5165.26)

The Governor vetoed a provision that would have revised the eligibility requirements that a nursing facility must meet to qualify for a quality bonus and would have provided for quality bonuses to be paid each fiscal year regardless of whether the total amount budgeted for quality incentive payments was spent. Under the vetoed provision, a total of at least $30 million would have been spent each fiscal year for quality bonuses. Any amount budgeted for quality incentive payments for a fiscal year but not spent was to be added to the $30 million to determine the total amount to be spent on quality bonuses for that fiscal year. The quality bonuses would have been paid not later than the first day of each November.

To qualify for a quality bonus for a fiscal year under continuing law, a nursing facility must be awarded, for that fiscal year, more than five points for meeting accountability measures applicable to the quality incentive payments. The Governor vetoed a provision that would have required that at least two of the points be awarded for the following:

(1) In the case of fiscal year 2014, for meeting accountability measures regarding pain, pressure ulcers, physical restraints, urinary tract infections, and tools for tracking hospital admissions;

(2) In the case of fiscal year 2015 and thereafter, for meeting accountability measures regarding the same topics described in (1), above, as well as accountability measures regarding vaccinations.

Critical access incentive payments

(R.C. 5165.23)

Continuing law requires ODM to pay, each fiscal year, a critical access incentive payment to each nursing facility that qualifies as a critical access nursing facility. The act adds a new requirement that a nursing facility must meet to qualify as a critical access nursing facility. A nursing facility meets the new requirement if it is awarded at least five points for meeting accountability measures applicable to quality incentive payments for the fiscal year and at least one of the five points is awarded as follows:

(1) For fiscal year 2014, for meeting accountability measures regarding pain, pressure ulcers, physical restraints, and urinary tract infections;

(2) For fiscal year 2015 and thereafter, for meeting accountability measures regarding the same topics described in (1), above, as well as accountability measures regarding vaccinations.

Medicaid payment to reserve nursing facility bed

(R.C. 5165.34)

Continuing law permits ODM to make Medicaid payments to a nursing facility provider to reserve a bed for a Medicaid recipient during a temporary absence under conditions prescribed by ODM. The Medicaid payment rate to reserve a bed for a day is to equal the following:

(1) In the case of a nursing facility that had an occupancy rate exceeding 95%, an amount not exceeding 50% of the payment rate the provider would be paid if the recipient were not absent from the facility that day;

(2) In the case of a nursing facility that had an occupancy rate not exceeding 95%, an amount not exceeding 18% of the payment rate the provider would be paid if the recipient were not absent from the facility that day.

The act specifies the Medicaid cost report to be used to determine a nursing facility's occupancy rate. For the purpose of setting a nursing facility's payment rate to reserve a bed for a day during the period beginning on September 29, 2013, and ending December 31, 2013, ODM is to determine the facility's occupancy rate by using information reported on its Medicaid cost report for calendar year 2012. For the purpose of setting a nursing facility's payment rate to reserve a bed for January 1, 2014, or thereafter, ODM is to determine the facility's occupancy rate by using information reported on its Medicaid cost report for the calendar year preceding the fiscal year in which the reservation falls.

Alternative purchasing model for nursing facility services

(Section 323.280)

The act permits the ODM Director to establish as a Medicaid waiver program an alternative purchasing model for nursing facility services that are provided during the period beginning July 1, 2013, and ending July 1, 2015, to Medicaid recipients with specialized health care needs, including recipients dependent on ventilators, recipients who have severe traumatic brain injury, and recipients who would be admitted to long-term acute care hospitals or rehabilitation hospitals if they did not receive nursing facility services. If established, the alternative purchasing model must (1) recognize a connection between enhanced Medicaid payment rates and improved health outcomes capable of being measured, (2) include criteria for identifying Medicaid recipients with specialized health care needs, and (3) include procedures for ensuring that Medicaid recipients so identified receive facility services under the alternative purchasing model. The total Medicaid payment rate for nursing facility services provided under the alternative purchasing model may differ from the rate that would otherwise be paid.

Special Focus Facility Program

(R.C. 5165.771 and 5165.80)

The act requires ODM to terminate a nursing facility's Medicaid participation if the nursing facility is placed on the federal Special Focus Facility (SFF) list and fails to make improvements or graduate from the SFF program within certain periods of time. The SFF list is part of the SFF program that federal law requires the U.S. Department of Health and Human Services to create for nursing facilities identified as having substantially failed to meet applicable requirements of the Social Security Act.[180] The SFF list has different tables. Table A identifies nursing facilities that are newly added to the list. Table B identifies nursing facilities that have not improved. Table C identifies nursing facilities that have shown improvement. Table D identifies nursing facilities that have recently graduated from the SFF program.

Under the act, ODM is to issue an order terminating a nursing facility's participation in Medicaid if any of the following apply:

(1) The nursing facility is listed in Table A or Table B on September 29, 2013, and fails to be placed on Table C not later than September 29, 2014 (12 months after the provision's effective date);

[180] 42 U.S.C. 1396r(f)(10).

(2) The nursing facility is listed in Table A, Table B, or Table C on September 29, 2013, and fails to be placed on Table D not later than September 29, 2015 (24 months after the provision's effective date);

(3) The nursing facility is placed in Table A after September 29, 2013, and fails to be placed in Table C not later than 12 months after the placement in Table A;

(4) The nursing facility is placed in Table A after September 29, 2013, and fails to be placed in Table D not later than 24 months after the placement in Table A.

An order terminating a nursing facility's Medicaid participation is not subject to appeal under the Administrative Procedure Act (R.C. Chapter 119.).

To help a nursing facility avoid having its participation in the Medicaid program terminated, the Ohio Department of Aging is required to provide the nursing facility technical assistance through the nursing home quality initiative at least four months before ODM would be required to terminate the nursing facility's participation (see "**ODA nursing home quality initiative**," above).

Under continuing law, ODM or an agency under contract with ODM may do either of the following when a nursing facility's Medicaid participation is terminated for certain reasons: (1) appoint a temporary manager for the nursing facility subject to the provider's continuing consent or (2) apply to a common pleas court for such injunctive relief as is necessary for the appointment of a special master. The act permits ODM or the contract agency to take either of these actions when a nursing facility's Medicaid participation is terminated pursuant to the act's provisions regarding the SFF list.

Nursing facility cost report after a change of operator

(R.C. 5165.10)

Nursing facilities are required to file annual cost reports with ODM as part of the process of determining their Medicaid payment rates. Usually, a cost report is due not later than 90 days after the end of the calendar year that the report covers.

Under certain circumstances, a nursing facility must submit a cost report before the annual report is due. The act eliminates one of these cost reports. A nursing facility that undergoes a change of provider that is an arm's length transaction no longer must submit a Medicaid cost report for that facility not later than 90 days after the end of the facility's first three full calendar months of operation under the new provider.

Post-payment reviews of nursing facility Medicaid claims

(R.C. 5165.49 (primary) and 5165.41)

The act permits ODM to conduct a post-payment review of a claim submitted by a nursing facility and paid by the Medicaid program to determine whether the nursing facility was overpaid. ODM must provide the nursing facility a written summary of the review's results. The results are not subject to an adjudication under the Administrative Procedure Act (R.C. Chapter 119.). However, the nursing facility may request that the ODM Director reconsider the results. The ODM Director is to reconsider the results on receipt of a request made in good faith. ODM is prohibited from deducting from the nursing facility's Medicaid payments any amounts that ODM claims to be due from the nursing facility as a result of the review until the conclusion of the Director's reconsideration, if any.

ODM is required to redetermine a nursing facility's Medicaid payment rate for a nursing facility using revised information if a post-payment review results in a determination that the nursing facility received a higher Medicaid payment rate than it was entitled to receive. The nursing facility must refund the overpayment and ODM may charge interest on the overpayment.

Nursing facility resident's personal needs allowance

(R.C. 5163.33)

Continuing law establishes a personal needs allowance for residents of a nursing facility. A personal needs allowance is income used for personal items that must be disregarded in determining a nursing facility resident's eligibility for Medicaid or patient liability for the cost of services.

The act increases the amount of the personal needs allowance for Medicaid recipients residing in nursing facilities as follows:

(1) For calendar year 2014, increases the amount to not less than $45 (from $40) for an individual and not less than $90 (from $80) for a married couple;

(2) Beginning in calendar year 2015, increases the amount to not less than $50 for an individual and not less than $100 for a married couple.

Home and community-based services

Collection of patient liabilities

(Section 323.320)

The act authorizes the ODM Director, for fiscal years 2014 and 2015, to (1) contract with a person or government entity to collect patient liabilities for home and community-based services available under a Medicaid waiver component and (2) adopt rules as necessary to implement the above provision.

Integrated Care Delivery System Medicaid waiver

(R.C. 5166.16)

The act permits the ODM Director to create, as part of the Integrated Care Delivery System (ICDS), a Medicaid waiver program covering home and community-based services.[181] ICDS is a program created to test and evaluate the integration of care that individuals eligible for both Medicaid and Medicare (dual eligible individuals) receive under those programs.

When the ICDS Medicaid waiver program begins to accept enrollments, no ICDS participant who is eligible for the waiver program is to be enrolled in another Medicaid waiver program (the PASSPORT program, Choices program, Ohio Home Care program, and Ohio Transitions II Aging Carve-Out program) regardless of whether the participant prefers to remain enrolled or be enrolled in the other Medicaid waiver program administered by ODM or the Ohio Department of Aging (ODA). A dual eligible individual who is eligible for another ODM- or ODA-administered Medicaid waiver program may enroll in that waiver program before the individual begins to participate in ICDS. But the dual eligible individual must disenroll from the other ODM- or ODA-administered Medicaid waiver program and enroll in the ICDS Medicaid waiver program once the individual becomes an ICDS participant and it is possible to enroll the individual in the ICDS Medicaid waiver program. This requirement applies regardless of whether the dual eligible individual prefers to remain enrolled in the other ODM- or ODA-administered Medicaid waiver program.

An ICDS participant's disenrollment from another ODM- or ODA-administered Medicaid waiver program and enrollment in the ICDS Medicaid waiver program must be accomplished without a disruption in the participant's services.

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[181] See "**Integrated Care Delivery System evaluation**," below, for more detailed information about ICDS.

Home care attendant services

(R.C. 5166.30, 5166.301, 5166.302, 5166.305, 5166.306, 5166.307, 5166.309, 5166.3010, and 5811.8811 (repealed))

The act provides for two additional Medicaid waiver programs, the PASSPORT program and the ICDS Medicaid waiver program, to cover home care attendant services. Under prior law, only the Ohio Home Care program and Ohio Transitions II Aging Carve-Out program covered those services. Home care attendant services are all of the following as provided by a home care attendant: (1) personal care aide services, (2) assistance with self-administration of medication, and (3) assistance with nursing tasks.

Because ODA administers the PASSPORT program, the act provides for the ODA Director to perform many of the same types of actions regarding the PASSPORT program's coverage of home care attendant services that the ODM Director performs regarding home care attendant services covered by ODM-administered Medicaid waiver programs. For example, a home care attendant providing services under the PASSPORT program annually must provide the ODA Director satisfactory evidence of having completed not less than 12 hours of in-service continuing education regarding home care attendant services. However, the ODM Director is to enter into provider agreements with all home care attendants, including those who are to provide services under the PASSPORT program.

Home and community-based services regarding behavioral health

(Section 323.330)

During fiscal years 2014 and 2015, the act permits Medicaid to cover state plan home and community-based services for Medicaid recipients of any age who have behavioral health issues and countable incomes not exceeding 150% of the federal poverty line. A Medicaid recipient is not required to undergo a level of care determination to be eligible for the services. The act authorizes the ODM Director to adopt rules as necessary to implement these provisions.

Administrative issues related to termination of waiver programs

(Section 323.110)

If ODM and ODA terminate the PASSPORT, Choices, Assisted Living, Ohio Home Care, or Ohio Transitions II Aging Carve-Out program, the act provides that all applicable statutes, and all applicable rules, standards, guidelines, or orders issued by ODM 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 ODM'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. ODM 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 ODM 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.

Medicaid managed care

Annual report

(R.C. 5167.03)

The act eliminates a requirement that ODM prepare and submit to the General Assembly an annual report on the Medicaid care management system. The requirement for the annual report, which had to address ODM's ability to implement the system, was established when the Medicaid managed care system was expanded by H.B. 66 of the 126th General Assembly. The first report was due by October 1, 2007.

Hospital inpatient capital payments

(R.C. 5167.10; Section 812.40)

One part of the payment made by ODM to Medicaid managed care organizations is referred to in statute as the hospital inpatient capital payment portion. ODM or its actuary must base this portion of the payment on data for services provided to all recipients enrolled in Medicaid managed care organizations, as reported by hospitals on relevant cost reports.

The act provides that, beginning January 1, 2014, the hospital inpatient capital payment portion may not exceed any maximum rate established in rules the ODM Director may adopt. If ODM establishes a maximum rate, the act prohibits a Medicaid managed care organization from compensating hospitals for inpatient capital costs in an amount that exceeds the maximum rate.

Emergency services

(R.C. 5167.201)

Law unmodified by the act provides that, when a Medicaid recipient enrolled in a Medicaid managed care organization receives emergency services from a provider that is not under contract with that organization, the provider must accept from the organization, as payment in full, not more than the amounts that the provider could collect if the Medicaid recipient received Medicaid other than through the managed care system.

The act provides that any agreement entered into by a Medicaid managed care participant, or a participant's parent or legal guardian, that requires payment for emergency services in violation of this law is void and unenforceable.

Graduate medical education costs

(R.C. 5164.74 and 5164.741; Section 812.40)

Continuing law requires the ODM Director to adopt rules governing the calculation and payment of graduate medical education (GME) costs associated with services rendered to Medicaid recipients, including reimbursement of allowable and reasonable GME costs associated with services rendered to Medicaid managed care recipients. Beginning January 1, 2014, the act eliminates provisions specifying how payments for GME costs are made under the Medicaid managed care system. Also beginning on that date, the act requires the ODM Director to adopt rules governing the allocation of payments for GME costs associated with both the fee-for-service component of Medicaid and the managed care system.

Under the eliminated provisions, if ODM required a Medicaid managed care organization to pay for GME costs, ODM had to include in its payment to the organization an amount sufficient for the organization to pay those costs; if ODM did include a sufficient amount, all of the following applied:

(1) Unless the provider was a hospital that refused without good cause to contract with a Medicaid managed care organization, ODM had to pay the provider for GME costs;

(2) The provider was prohibited from seeking reimbursement from the organization for those costs;

(3) The organization was not required to pay providers for those costs.

Medicaid Managed Care Performance Payment Program

(R.C. 5167.30 (primary), 5162.60, and 5162.62; Section 323.60)

A portion of the premiums made to Medicaid managed care organizations are withheld and used by ODM to make payments under the Managed Care Performance Payment Program. Under prior law, the sum of all funds withheld could not exceed 1% of all premium payments made to all Medicaid managed care organizations. The act increases the total that may be withheld to 2% of all premium payments made to all Medicaid managed care organizations.

Continuing law provides for amounts withheld from Medicaid managed care organizations to be held in the Managed Care Performance Payment Fund. The act provides that the fund also is to include any fines imposed on and collected from Medicaid managed care organizations for failure to meet performance standards or other requirements specified in a provider agreement or by the ODM Director (see "**Health Care Compliance Fund abolished**," below). The act also modifies the use of the fund to provide that the amounts in it may, rather than must, be used to make performance payments. The amounts may also be used to (1) meet obligations specified in provider agreements, (2) pay for Medicaid services provided by a Medicaid managed care organization, (3) reimburse Medicaid managed care organizations that have been fined and have later come into compliance or (4) make performance payments to Medicaid managed care organizations providing care under a demonstration project for integration of care received by individuals dually eligible for Medicare and Medicaid, as described below.

ICDS performance payments

(Section 323.300)

ODM is authorized under continuing law to implement a demonstration project to test and evaluate the integration of care received by individuals dually eligible for Medicaid and Medicare. The project is to be known as the Integrated Care Delivery System (ICDS).[182] For fiscal years 2014 and 2015, the act requires ODM, if it implements ICDS in a way that provides participants with care through Medicaid managed care organizations, to do both of the following:

(1) Develop quality measures designed specifically to determine the effectiveness of the health care and other services provided to participants by Medicaid managed care organizations;

[182] R.C. 5164.91. In Section 323.300, ICDS is referred to as the Dual Eligible Integrated Care Demonstration Project.

(2) Determine an amount to be withheld from the Medicaid premium payments paid to Medicaid managed care organization for participants.

For purposes of the amount to be withheld from premium payments, the act requires ODM to establish a percentage amount and apply the same percentage to all Medicaid managed care organizations providing care to ICDS participants. Each organization must agree to the withholding as a condition of receiving or maintaining its Medicaid provider agreement. The act authorizes the ODM Director to use these amounts to provide performance payments to Medicaid managed care organizations providing care to ICDS participants in accordance with rules that the Director may adopt. The act provides that an organization providing care under ICDS is not subject to withholdings under the Medicaid Managed Care Performance Payment Program, described above.

Pediatric accountable care organizations

(R.C. 5167.031)

The act permits, rather than requires, ODM to recognize pediatric accountable care organizations that provide care coordination and other services under the Medicaid care management system to individuals under age 21 who are in the category of individuals who receive Medicaid on the basis of being aged, blind, or disabled. H.B. 153 of the 129th General Assembly required the recognition system to be implemented by July 1, 2012.[183] The act also eliminates a provision specifying that the purpose of the recognition system is to meet the complex medical and behavioral needs of disabled children through new approaches to care coordination.

Exclusion of BCMH participants from Medicaid managed care

(Section 323.70)

Until July 1, 2014, the act excludes from any required participation in the Medicaid care management system certain recipients of services through Bureau for Children with Medical Handicaps (BCMH) in the Ohio Department of Health. The exclusion applies to BCMH recipients who have one or more of the following: cystic fibrosis, hemophilia, or cancer. The act provides, however, that such a BCMH recipient may be designated for participation in the Medicaid care management system if the individual was receiving services through the system immediately before July 1, 2013.[184]

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[183] Rules to develop the recognition system have not been adopted.

[184] Similar exclusions were granted by the 129th General Assembly. (*See* Section 309.30.53 of H.B. 153, as amended by H.B. 487.)

Sources of Medicaid revenues

Nursing home and hospital long-term care franchise permit fees

(R.C. 5168.41 (primary) and 5168.40; Sections 812.20 and 812.30)

The act revises the law governing the amount of the franchise permit fee that nursing homes and hospital long-term care units are assessed for each fiscal year. The fees are a source of revenue for nursing facility and home and community-based services covered by the Medicaid program and the Residential State Supplement program.

Under prior law, the franchise permit fee rate was $11.67 per bed per day. The act replaces the specific dollar amount of the per bed per day rate of the fee with a formula to be used to determine the per bed per day fee rate. Effective July 1, 2013, the franchise permit fee rate is to be determined each fiscal year as follows:

(1) Determine the estimated total net patient revenues for all nursing homes and hospital long-term care units for the fiscal year;

(2) Multiply the amount estimated above by the lesser of (a) the indirect guarantee percentage[185] or (b) 6%;

(3) Divide the product determined above by the number of days in the fiscal year;

(4) Determine the sum of (a) the total number of beds in all nursing homes and hospital long-term care units that are subject to the franchise permit fee for the fiscal year and (b) the total number of nursing home beds that are exempt from the fee for the fiscal year because of a federal waiver;

(5) Divide the quotient determined under (3), above, by the sum determined under (4) above.

In determining the estimated total net patient revenue for all nursing homes and hospital long-term care units for a fiscal year, ODM is required to use at least (1) information from Medicaid cost reports that are the most recent at the time the determination is made, (2) the projected total Medicaid payment rates for nursing

[185] The indirect guarantee percentage is the percentage specified in federal law that is to be used to determine whether a class of providers is indirectly held harmless for any portion of the costs of a broad-based health-care related tax. The indirect guarantee percentage is currently 6%. (42 U.S.C. 1396b(w)(4)(C)(ii).)

facility services for the fiscal year, and (3) the projected total number of Medicaid days for the fiscal year.

Hospital Care Assurance Program

(Sections 125.10 and 125.12)

The act continues the Hospital Care Assurance Program (HCAP) for two additional years. HCAP was scheduled to end October 16, 2013, but under the act, will continue until October 16, 2015. Under HCAP, hospitals are annually assessed an amount based on their total facility costs and government hospitals make annual intergovernmental transfers. ODM 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 line.

Hospital assessments

(Sections 125.11, 125.13, and 323.100)

The act continues the assessments imposed on hospitals for two additional years, ending October 1, 2015, rather than October 1, 2013. The assessments are in addition to HCAP, but like HCAP, they raise money to help pay for the Medicaid program.

The act provides for a portion of the hospital assessments to be used during fiscal years 2014 and 2015 to continue the Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program, to continue the Medicaid Managed Care Hospital Incentive Payment Program, and to pay the Medicaid rates for hospital inpatient and outpatient services required by the act. Under the first program, supplemental payments are made to hospitals for Medicaid-covered inpatient and outpatient services. Under the second program, additional funds are provided 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 (see "**Medicaid rates for hospital inpatient and outpatient services**," above).

Medical assistance confidentiality

(R.C. 5160.99)

Continuing law prohibits, with certain exceptions, any person or government entity from using or disclosing information regarding a medical assistance recipient for

any purpose not directly connected with the administration of a medical assistance program.[186] The act provides that, in addition to Medicaid, CHIP, and RMA, the prohibition applies to any other program that provides medical assistance and that state statutes authorize ODM to administer.

The act reinstates a penalty that previously applied with respect to violations of the confidentiality provisions applicable to medical assistance programs. The penalty was inadvertently eliminated when H.B. 153 of the 129th General Assembly relocated statutory medical assistance provisions to a Revised Code section separate from the confidentiality provisions that apply to other public assistance programs, such as Ohio Works First.

Technologies to monitor eligibility, claims history, and drug coverage

(R.C. 5164.757; Section 812.40)

In place of a prior law provision authorizing establishment of an e-prescribing system for Medicaid, the act authorizes the ODM Director to acquire or specify technologies to give information regarding Medicaid eligibility, claims history, and drug coverage to Medicaid providers through electronic health record and e-prescribing applications. The act's provisions granting this authority take effect January 1, 2014.

If the ODM Director chooses to acquire or specify the technologies, the act requires the e-prescribing applications of the technologies to enable a Medicaid provider to do what the provider could do under the preexisting e-prescribing system – prescribe a drug for a Medicaid recipient through an electronic system without issuing prescriptions by handwriting or telephone. Like the e-prescribing system authorized by prior law, the technologies acquired or specified by the Director also must give Medicaid providers an up-to-date, clinically relevant drug information database and a system of electronically monitoring Medicaid recipients' medical history, drug regimen compliance, and fraud and abuse.

Associated with the elimination of the authority to establish an e-prescribing system, the act eliminates the requirement that the Director take the following actions: (1) determine before the beginning of each fiscal year the ten Medicaid providers that issued the most prescriptions for Medicaid recipients receiving hospital services during the preceding calendar year and make certain notifications to those providers, and (2) seek the most federal financial participation available for the development and implementation of the system.

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[186] R.C. 5160.45.

Exchange of certain information by state agencies

(R.C. 191.01, 191.02, 191.04, and 191.06; Section 323.10.63)

H.B. 487 of the 129th General Assembly authorized the Office of Health Transformation (OHT) Executive Director or the Executive Director's designee to facilitate the coordination of operations and exchange of information between certain state agencies ("participating agencies") during fiscal year 2013. H.B. 487 specified that the purpose of this authority was to support agency collaboration for health transformation purposes, including modernization of the Medicaid program, streamlining of health and human services programs in Ohio, and improving the quality, continuity, and efficiency of health care and health care support systems in Ohio. In furtherance of this authority, H.B. 487 required the OHT Executive Director or the Executive Director's designee to identify each health transformation initiative in Ohio that involved the participation of two or more participating agencies and that permitted or required an interagency agreement. For each health transformation initiative identified, the OHT Executive Director or the Executive Director's designee had to, in consultation with each participating agency, adopt one or more operating protocols.

H.B. 487 also authorized a participating agency to exchange, during fiscal year 2013 only, personally identifiable information with another participating agency for purposes related to or in support of a health transformation initiative that had been identified as described above. If a participating agency used or disclosed personally identifiable information during fiscal year 2013, it was required to do so in accordance with all operating protocols adopted as described above that applied to the use or disclosure.

The act extends the authorizations and requirements regarding the use and disclosure of personally identifiable information, described above, to fiscal years 2014 and 2015. It also includes ODM and the Ohio Department of Administrative Services as participating agencies effective June 30, 2013.

Health information exchanges

(R.C. 3798.01, 3798.10, 3798.13, 3798.14, 3798.15, and 3798.16)

H.B. 487 of the 129th General Assembly enacted provisions, largely consistent with those in the HIPAA Privacy Rule,[187] governing the disclosure of protected health information.[188] Two of H.B. 487's provisions do the following:

(1) Prohibit a covered entity[189] from disclosing protected health information without patient authorization (meeting requirements set forth in the HIPAA Privacy Rule) unless the disclosure is to a health information exchange approved by the ODJFS Director and certain conditions are satisfied. Those conditions do not, however, render unenforceable or restrict in any manner a continuing provision of Ohio law that existed before H.B. 487's immediate effective date (June 11, 2012) and requires a person or governmental entity to disclose protected health information to a state agency, political subdivision, or other governmental entity.

(2) Specify that, in general, H.B. 487's provisions are to be supreme if they conflict with any of the following pertaining to the confidentiality, privacy, security, or privileged status of protected health information transacted, maintained in, or accessed through a health information exchange: a section of the Revised Code not in R.C. Chapter 3798., a rule, an internal management rule, guidance issued by an agency, orders or regulations of a local board of health, an ordinance or resolution adopted by a political subdivision, or a professional code of ethics. The supremacy policy does not

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[187] The HIPAA Privacy Rule, otherwise known as the "standards for privacy of individually identifiable health information," provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information while at the same time permitting the disclosure of personal health information needed for patient care and other important purposes. U.S. Department of Health and Human Services, *Understanding Health Information Privacy*, accessible at www.hhs.gov/ocr/privacy/hipaa/understanding/index.html>.

[188] "Protected health information" is defined in federal regulations (45 C.F.R. 160.103) generally as individually identifiable health information that is transmitted or maintained in electronic media or any other form or medium. "Individually identifiable health information" (also defined in federal regulations (45 C.F.R. 160.103)) is health information, including demographic information collected from an individual, that meets all of the following criteria: (1) it is created or received by a health care provider, a health plan, an employer, or a health care clearinghouse, (2) it relates to (a) the past, present, or future physical or mental health or condition of an individual, (b) the provision of health care to an individual, or (c) the past, present, or future payment for the provision of health care to an individual, and (3) it identifies the individual, or there is reasonable basis to believe it could be used to identify the individual.

[189] "Covered entity" is defined in federal regulations (45 C.F.R. 160.103) as a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by the HIPAA Privacy Rule.

apply, however, to a continuing provision of the Revised Code that existed before H.B. 487's immediate effective date (June 11, 2012) and requires a person or governmental entity to disclose protected health information to a state agency, political subdivision, or other governmental entity.

The act includes ODM and the Ohio Department of Administrative Services as "state agencies" for purposes of the two provisions described above. As a result, the act authorizes covered entities to disclose protected health information in accordance with state law to these additional two state agencies notwithstanding H.B. 487's provisions pertaining to conditions on the disclosure of protected health information and supremacy, described above.

The act also transfers to the ODM Director (from the ODJFS Director) rule-making authority pertaining to (1) a standard authorization form for the use and disclosure of protected health information and substance abuse records by covered entities, and (2) the operation of health information exchanges in Ohio.

Direct Care Worker Advisory Workgroup

(Section 323.234)

Creation and membership

The act creates the Direct Care Worker Advisory Workgroup. The act defines "direct care worker" as an individual who, for direct or indirect payment, provides direct care services to a Medicaid recipient in the recipient's home or other place of residence. "Direct care services" is defined as health care services, ancillary services, or services related to or in support of the provision of health care or ancillary services. "Direct payment" is a Medicaid payment made directly to a direct care worker for the worker's provision of direct care services to a Medicaid recipient. "Indirect payment" is a Medicaid payment made to a third party who pays a direct care worker for the worker's provision of direct care services to a Medicaid recipient.

The Workgroup consists of the following members:

--The Director of Aging or the Director's designee.

--The Director of Developmental Disabilities or the Director's designee.

--The Director of Health or the Director's designee.

--The ODM Director or the Director's designee.

--The Office of Health Transformation (OHT) Executive Director or the Executive Director's designee.

--Two representatives from each of the following organizations, appointed by the organization's chief executive officer or the individual serving in an equivalent capacity for the organization:

- The Ohio Council for Home Care and Hospice;
- The Ohio Health Care Association;
- The Ohio Provider Resource Association;
- The Ohio Nurses Association;
- The Midwest Care Alliance;
- The Ohio Assisted Living Association;
- LeadingAge Ohio.

--Two members of the House of Representatives, one from the majority party and the other from the minority party, appointed by the Speaker.

--Two members of the Senate, one from the majority party and the other from the minority party, appointed by the President of the Senate.

The act specifies that the OHT Executive Director or the Executive Director's designee must serve as the Workgroup's chairperson and that the Ohio Department of Health and ODM must provide staff and other support services for the Workgroup. Members must be appointed not later October 14, 2013. Vacancies must be filled in the same manner as the original appointments. Each member must serve without compensation or reimbursement for expenses incurred while serving on the Workgroup, except to the extent that serving on the Workgroup is considered to be among the member's employment duties.

Responsibilities

The act requires the Workgroup to do all of the following:

- Determine core competencies – the minimum standards a direct care worker must meet when providing direct care services and engaging in any one or more of the following activities associated with care for a

Medicaid recipient: maintaining a clean and safe environment, ensuring recipient-centered care, promoting the recipient's development, assisting the recipient with activities of daily living, communicating with the recipient, completing administrative tasks, and participating in professional activities;

- Designate which direct care workers should meet core competencies;
- Determine whether existing regulatory requirements are equivalent or similar to core competencies;
- Identify funding sources that could be used to assist direct care workers in meeting core competencies;
- Recommend policies that may be incorporated in legislation the General Assembly intends to consider regarding certification of direct care workers and Medicaid payments for direct care services provided by those workers.

Report

Not later than December 31, 2013, the Workgroup must submit a report to the General Assembly describing its findings and recommendations.[190] On submission of the report, the Workgroup ceases to exist.

Future legislation intended

The act specifies that it is the General Assembly's intent to enact legislation in the future that takes into account the Workgroup's recommendations regarding certification of direct care workers and Medicaid payments for direct care services provided by those workers. The legislation is intended to:

--Require the Director of Health to establish, not later than October 1, 2014, a direct care worker certification program that applies to the workers designated by the Workgroup; and

--Prohibit ODM, beginning October 1, 2015, from allowing a direct or indirect payment to be made for direct care services provided by a direct care worker to whom

[190] In submitting the report to the General Assembly, the Workgroup must provide it to the Senate President, Senate Minority Leader, Speaker of the House of Representatives, House Minority Leader, and the Director of the Legislative Service Commission (R.C. 101.68(B), not in the act).

the certification program applies unless the worker is appropriately certified by that program.

Contracts for the management of Medicaid data requests

(R.C. 5162.12 and 5162.54)

The act authorizes the ODM Director to enter into a contract with one or more persons to receive and process, on the Director's behalf, requests for Medicaid recipient or claims payment data, data from nursing facility audit reports, or extracts or analyses of any of the foregoing data, made by persons who intend to use the items for commercial or academic purposes. The contracts must do both of the following:

--Authorize the contracting person to engage in the activities described above for compensation, which must be stated as a percentage of the fees paid by persons who are provided the items;

--Specify the schedule of fees the contracting person is to charge for the items.

The act requires the ODM Director to use the fees received pursuant to a contract to pay obligations the Director has to the persons who have entered into the contracts. Any money remaining after those obligations are paid must be deposited in the Health Care Services Administration Fund created under continuing law.

The act specifies that, except as otherwise required by federal or state law and subject to certain exclusions, both of the following conditions apply with respect to a request for data covered by a contract:

--The request must be made through a person who has entered into a contract with the ODM Director as described above;

--An item prepared pursuant to a request may be provided to ODM and is confidential and not subject to disclosure under Ohio's Public Records Law[191] or the statute governing the confidentiality of personal information held by state and local agencies.[192]

Exclusions

The act specifies that requests for Medicaid recipient or claims payment data, data from nursing facility audit reports, and extracts or analyses of any of the foregoing

[191] R.C. 149.43.

[192] R.C. 1347.08.

data that are for any of the following reasons are excluded from the act's contracting provisions:

--Treatment of Medicaid recipients;

--Payment of Medicaid claims;

--Establishment or management of Medicaid third party liability;

--Compliance with the terms of an agreement the ODM Director enters into for purposes of administering the Medicaid program;

--Compliance with an operating protocol the Office of Health Transformation Executive Director or the Executive Director's designee adopts under continuing law for health transformation initiatives.[193]

Long-term services

Joint Legislative Committee for Unified Long-Term Services and Supports

(Section 323.90)

The act provides for the continued existence of the Joint Legislative Committee for Unified Long-Term Services and Supports, which was created under H.B. 153 of the 129th General Assembly. 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;

(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 may examine the following issues:

(1) Implementing the Dual Eligible Integrated Care Demonstration Project;

[193] R.C. 191.06(D).

(2) Implementing the 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;

(6) Other issues of interest to the Committee.

The act requires the Committee's co-chairpersons to provide for the ODM Director to testify before the Committee at least quarterly regarding the issues that the Committee examines.

Rebalancing long-term care

(Section 323.160)

The act requires ODM, the Ohio Department of Aging, and the 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 three agencies are to strive to meet, by June 30, 2015 (extended from an earlier date of 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[194] services, and (5) self-directed personal assistance services.

The act permits ODM, if it determines that participating in the Balancing Incentives Payments Program will assist in achieving the goals regarding long-term

[194] "PACE" stands for the Program of All-inclusive Care for the Elderly, a component of the Medicaid program.

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.[195]

Prior law required that any funds Ohio receives as the result of the larger federal match be deposited into the Balancing Incentive Payments Program Fund. The act, however, does not specify where such funds are to be placed. As a result, any such funds are to be deposited into the General Revenue Fund.[196]

Quality initiatives

Quality incentive program to reduce avoidable admissions

(Section 323.30)

The act permits ODM to implement, for fiscal years 2014 and 2015, a quality incentive program to reduce the use of avoidable emergency department services, as well as avoidable hospital and nursing facility admissions, by Medicaid recipients who are enrolled in a home and community-based services Medicaid waiver component administered by ODM, are receiving nursing or home health aide services available under the Medicaid home health services benefit, or are receiving private duty nursing services.

If ODM implements the quality incentive program, the act requires that ODM establish methods to determine the program's actual savings to Medicaid. Moreover, if the program is implemented, ODM must distribute not more than 50% of the savings to participating Medicaid providers.

Children's hospitals quality outcomes program

(Section 323.40)

The act permits the ODM Director to implement, for fiscal years 2014 and 2015, a children's hospitals quality outcomes program. The act defines "children's hospital" as a hospital (1) located in Ohio, (2) primarily serving patients 18 years of age or younger, (3) subject to the Medicaid prospective payment system for hospitals established in ODM rules, and (4) excluded from Medicare prospective payments under federal law.

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

[196] R.C. 113.09, not in the act.

The quality outcomes program is to encourage children's hospitals to develop the following:

(1) Infrastructures that are needed to care for patients in the least restrictive setting and that promote the care of patients and their families;

(2) Programs designed to improve birth outcomes and measurably reduce neonatal intensive care admissions;

(3) Patient-centered methods to measurably reduce utilization of emergency department services for primary care needs and nonemergency health conditions;

(4) Other quality-focused reforms that the ODM Director identifies.

Improved birth outcomes initiatives

(Section 323.360)

The act authorizes the ODM Director to develop and implement, during fiscal years 2014 and 2015, initiatives designed to improve birth outcomes for Medicaid recipients, including improvements designed to (1) reduce the number of preterm births, (2) reduce Medicaid costs, and (3) improve the quality of Medicaid services. In developing the initiatives, the ODM Director is permitted to consult with experts in practice improvement, Medicaid managed care organizations, hospitals, and other Medicaid providers.

The ODM Director, Medicaid managed care organizations, and other Medicaid providers involved in the initiatives must make information about the initiatives available on their web sites.

Medicaid and Veterans' Services collaboration

(Section 323.350)

The act authorizes ODM to collaborate with the Ohio Department of Veterans Services to determine ways to improve the coordination of veterans' services in a manner that enhances veterans' receipt of the services. It also authorizes both agencies to implement, during fiscal years 2014 and 2015, initiatives that they determine during the collaboration will maximize the efficiency of the services and ensure that veterans' needs are met.

Health home services

(R.C. 5164.881)

The act authorizes the ODM Director, in consultation with the Director, to develop and implement a system within the Medicaid program under which Medicaid-eligible individuals with chronic conditions and mental retardation or other developmental disabilities may receive health home services.

Federal law defines "eligible individual with chronic conditions" as someone who is eligible for assistance and has at least two chronic conditions, one chronic condition and is at risk for another, or one serious and persistent mental health condition. It further defines "chronic condition" as a mental health condition, substance use disorder, asthma, diabetes, heart disease, or being overweight. "Health home services" is defined as comprehensive and timely high-quality services that are furnished by a designated provider, a team of health care professionals operating with a provider, or a health team.[197]

Under the act, when developing a health home services system, the ODM Director and Director of Developmental Disabilities must consult with representatives of county boards of developmental disabilities, the Ohio Provider Resource Association, and the ARC of Ohio. The act also permits the Directors to consult with other individuals or entities that have an interest in the well-being of those with developmental disabilities.

If the ODM Director develops and implements the system, the act requires that it focus on the needs of individuals and aim to improve Medicaid services and outcomes by better integrating long-term care and supportive services with primary and acute health care services.

Telemedicine policy workgroup

(Section 737.20)

The act authorizes the Office of Health Transformation Executive Director to convene a workgroup of state agency directors to study policy matters regarding the potential benefits of using telemedicine as a means of increasing the quality and availability of health care services in Ohio. If established, the workgroup must include at least the ODM Director and Superintendent of Insurance and may include others at the Executive Director's discretion. The act requires a study conducted by the

[197] 42 U.S.C. 1396w-4(h).

workgroup to focus on developing a comprehensive statewide policy that encourages the use of telemedicine as an integral component of Ohio's health care system. The workgroup is to focus on telemedicine practice, technology, implementation, and reimbursement.

Integrated Care Delivery System evaluation

(R.C. 5164.911 (primary), 5164.01, and 5166.01)

Continuing law permits the ODM Director to implement a demonstration project called the Integrated Care Delivery System (ICDS) to test and evaluate the integration of the care received by individuals who are eligible for both Medicaid and Medicare (dual eligible individuals). The act requires the Director, if ICDS is implemented, to conduct an annual evaluation of ICDS unless the same evaluation is conducted by an organization under contract with the U.S. Department of Health and Human Services.

All of the following are to be examined as part of the evaluation:

(1) The health outcomes of ICDS participants;

(2) How changes to the administration of ICDS affect claims processing, the appeals process, the number of reassessments requested, and prior authorization requests for services;

(3) The provider panel selection process used by Medicaid managed care organizations participating in ICDS.

When conducting the evaluation, the Director must do all of the following:

(1) Compare the health outcomes of ICDS participants to the health outcomes of individuals who are not ICDS participants;

(2) Use a control group consisting of ICDS participants who receive health care services from providers not participating in ICDS and a control group consisting of ICDS participants who receive health care services from alternative providers that are not part of a Medicaid managed care organization's provider panel but provide health care services in the geographic service area in which ICDS participants receive health care services;

(3) To the extent the data is available, use data from Medicaid's fee-for-service component, Medicaid managed care organizations, and managed care organizations participating in the Medicare Advantage Program;

(4) Identify (a) changes in the amount of time it takes to process claims and the number of claims denied and the reasons for the changes, (b) the impact that changes to the administration of ICDS had on the appeals process and number of reassessments requested, and (c) the number of prior authorization denials that were overturned and the reasons for the overturned denials;

(5) Require Medicaid managed care organizations participating in ICDS to submit to the Director any data the Director needs for the evaluation.

The act requires the Director to complete a report of the evaluation not later than the first day of each July. The Director must provide a copy of the report to the General Assembly and make it available to the public.

Funds

Money Follows the Person Enhanced Reimbursement Fund

(Section 323.140)

The act provides for federal funds Ohio receives for the Money Follows the Person demonstration project to be deposited into the Money Follows the Person Enhanced Reimbursement Fund. The fund was created in 2008 by H.B. 562 of the 127th General Assembly after Ohio was first awarded a federal grant for the demonstration project. ODM is required to continue 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.[198] 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;

[198] Section 6071 of the Deficit Reduction Act of 2005, Public Law No. 109-171. The federal health care reform law 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).

(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.

Health Care Compliance Fund abolished

(R.C. 5111.946 (repealed), 5162.54, and 5162.60; Section 323.380)

The act abolishes the Health Care Compliance Fund. Under prior law, the fund was in the state treasury and all of the following had to be credited to it:

(1) All fines imposed on and collected from Medicaid managed care organizations for failure to meet performance standards or other requirements specified in Medicaid provider agreements or ODM rules;

(2) Money that ODM receives in a fiscal year for performing eligibility verification services necessary for compliance with a federal regulation regarding independent, certified audits, other than the amounts credited to the Health Care/Medicaid Support and Recoveries Fund;

(3) The fund's investment earnings.

Prior law required that money credited to the Health Care Compliance Fund be used solely for the following purposes:

(1) To reimburse Medicaid managed care organizations that paid fines for failure to meet performance standards or other requirements and had come into compliance by meeting requirements specified by ODM;

(2) To provide financial incentive awards to Medicaid managed care organizations.

The act provides for part of the money that would have been credited to the Health Care Compliance Fund to be credited to the Managed Care Performance Payment Fund and the remaining money to be credited to the Health Care Services Administration Fund. The Managed Care Performance Payment Fund is to be credited with all fines imposed on and collected from Medicaid managed care organizations for failure to meet performance standards or other requirements specified in Medicaid provider agreements or ODM rules. The Health Care Services Administration Fund is to be credited with money that ODM receives in a fiscal year for performing eligibility

verification services necessary for compliance with a federal regulation regarding independent, certified audits, other than the amounts that are to be credited to the Health Care/Medicaid Support and Recoveries Fund.

Prescription Drug Rebates Fund abolished

(R.C. 5111.942 (repealed) and 5162.52; Section 323.370)

The act abolishes the Prescription Drug Rebates Fund. Under prior law, the fund was in the state treasury and both of the following had to be credited to it:

(1) The nonfederal share of all rebates paid by drug manufacturers to ODM in accordance with rebate agreements required by federal law;

(2) The nonfederal share of all supplemental rebates paid by drug manufacturers to ODM in accordance with the Supplemental Drug Rebate program established by continuing state law.

Prior law required ODM to use money credited to the fund to pay for Medicaid services and contracts. The act provides for the money that would have been credited to the Prescription Drug Rebates Fund to be credited instead to the Health Care/Medicaid Support and Recoveries Fund.