State agency collaboration for health transformation initiatives

- Extends to fiscal years 2016 and 2017 provisions that authorize the Office of Health Transformation's Executive Director to facilitate collaboration between certain state agencies for health transformation purposes, authorize the exchange of personally identifiable information regarding a health transformation initiative, and require the use and disclosure of such information in accordance with operating protocols.

Medicaid third party liability

- Establishes a rebuttable presumption (rather than an automatic right) regarding the right to recover a portion of a medical assistance recipient's tort action or claim against a third party.

- Establishes processes whereby a party may rebut the presumption and specifies that one process is retroactive to the extent it may be used by a party who repaid money, on or after September 29, 2007, to the Department of Medicaid (ODM) or a county department of job and family services (CDJFS).

- Specifies that a third party's payment to ODM or a Medicaid managed care organization (MCO) regarding a medical assistance claim is final two years after the payment is made.

- Authorizes a third party to seek recovery of all or part of an overpayment by filing a notice with ODM or the MCO before that date.

- If ODM or the MCO agrees that an overpayment was made, requires ODM or the MCO to pay the amount to the third party or authorize the third party to offset the amount from a future payment.

Continuing issues regarding creation of ODM

- Extends through June 30, 2017, the authority of the ODM and Ohio Department of Job and Family Services (ODJFS) directors to establish, change, and abolish positions for their agencies and to assign, reassign, classify, reclassify, transfer, reduce, promote, or demote employees who are not subject to collective bargaining.

- Continues the authority of the ODJFS Director and boards of county commissioners to negotiate about amending or entering into a new grant agreement regarding the transfer of Medicaid, the Children's Health Insurance Program, and the Refugee Medical Assistance Program to ODM.

Contracts for management of data requests

- Requires, instead of permits as under prior law, the ODM Director to enter into contracts with persons to receive and process requests for certain Medicaid-related data that will be used for commercial or academic purposes.

- Requires a person with such a contract to charge a person seeking the data a fee equal to 102% of the cost ODM incurs in making the data available.

Integrated Care Delivery System (PARTIALLY VETOED)

- Requires ODM to ensure that each Integrated Care Delivery System (ICDS) participant who is a Holocaust survivor receives, while enrolled in a Medicaid waiver program, home and community-based services (HCBS) that the participant would have received if enrolled in another HCBS Medicaid waiver program.

- For fiscal years 2016 and 2017, permits ODM to provide performance payments to Medicaid managed care organizations that provide care to ICDS participants, and requires ODM to withhold a percentage of the premium payments made to the organizations for the purpose of providing the performance payments.

- Would have permitted a medical transportation provider to submit a claim to Medicaid for a service provided to an ICDS participant without Medicare first denying the claim if Medicaid is responsible for paying the claim (VETOED).

Termination of waiver programs

- Addresses administrative issues regarding termination of Medicaid waiver programs.

Money Follows the Person

- 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.

Behavioral health

- During fiscal years 2016 and 2017, permits Medicaid to cover state plan HCBS for Medicaid recipients of any age who have behavioral health issues and countable incomes not exceeding 150% of the federal poverty line.

Medicaid School Program

- Makes a qualified Medicaid school provider solely responsible for timely repaying any overpayment that the provider receives under the Medicaid School Program and that is discovered by a federal or state audit.

- Prohibits ODM, with regard to an overpayment, from paying the federal government to meet or delay the provider's repayment obligation and from assuming or forgiving the provider's repayment obligation.

- Requires each qualified Medicaid school provider to indemnify and hold harmless ODM for any cost or penalty resulting from a federal or state audit.

Optional Medicaid eligibility groups (PARTIALLY VETOED)

- Would have prohibited Medicaid from covering optional eligibility groups that state statutes do not address whether Medicaid may cover (VETOED).

- Would have specified that, if the income eligibility threshold for an optional eligibility group is not specified in state statute, the threshold is to be a percentage of the federal poverty line not exceeding the percentage that is the group's threshold on the effective date of this provision (VETOED).

- Eliminates a requirement that the Medicaid program cover the group consisting of nonpregnant individuals who may receive family planning services and supplies.

209(b) option

- Prohibits ODM from terminating, before July 1, 2016, the federal 209(b) option under which the Medicaid program's eligibility requirements for aged, blind, and disabled individuals are more restrictive than the eligibility requirements for the Supplemental Security Income program.

- Requires ODM, if it terminates the 209(b) option, to establish a Medicaid waiver program under which an individual who has cystic fibrosis and is enrolled in the Program for Medically Handicapped Children or a program for adults with cystic fibrosis may qualify for Medicaid under a spenddown process.

- Requires the Program for Medically Handicapped Children and the program for adults with cystic fibrosis to continue to assist recipients in qualifying for Medicaid under the spenddown process.

Transitional Medicaid

- Repeals a requirement that the ODM Director 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).

Medicaid ineligibility for transfer of assets – exception

- Permits an institutionalized individual to enroll in Medicaid despite a transfer of assets for less than fair market value under an additional circumstance.

Medicaid eligibility – revocable self-settled trusts (VETOED)

- Would have enacted in Ohio law a federal provision prohibiting the home of a Medicaid applicant or recipient held in a revocable self-settled trust from being (1) considered for purposes of determining Medicaid eligibility and (2) included in the computation of spousal share determined under federal law (VETOED).

- Would have excluded the transfer of a Medicaid applicant's or recipient's home from a revocable self-settled trust to the applicant or recipient or that individual's spouse from being considered an improper disposition of assets with respect to Medicaid eligibility (VETOED).

Personal needs allowance

- Increases the monthly personal needs allowance for Medicaid recipients residing in intermediate care facilities for individuals with intellectual disabilities (ICFs/IID).

Independent provider study

- States that it is the General Assembly's intent to study the issue of independent providers' Medicaid provider agreements and to resolve it not later than December 31, 2015.

Medicaid expansion group report

- Requires ODM to submit a report to the General Assembly evaluating the Medicaid program's effect on clinical care and outcomes for individuals included in the Medicaid expansion group (also referred to as Group 8).

Pre-enrollment provider screenings and reviews

- States the General Assembly's recommendation that ODM, during fiscal years 2016 and 2017, perform pre-enrollment screenings and reviews of Medicaid providers designated as moderate or high categorical risks to the Medicaid program.

Medicaid rates for medical transportation services (VETOED)

- Would have required that the Medicaid payment rate for medical transportation services include a component paying for providers' fuel costs and that the fuel component be at least 5% higher than the national average for fuel prices (VETOED).

- Would have required that the Medicaid rates for ambulette services provided during fiscal years 2016 and 2017 be at least 10% higher than the rates in effect on June 30, 2015 (VETOED).

Nursing facilities' Medicaid rates (PARTIALLY VETOED)

- Requires ODM, with the first rebasing of Medicaid rates for nursing facilities, to place nursing facilities in Allen County or Trumbull County in the peer groups used to determine Medicaid rates for facilities in Mahoning County or Stark County.

- Replaces, for the purpose of determining the regular Medicaid payment rate for nursing facility services beginning with fiscal year 2017, the quality incentive payment with a quality payment and eliminates the quality bonus.

- Provides for $16.44 (the maximum quality incentive payment) to be added to the sum of a nursing facility's rates for the cost centers and, if applicable, its critical access incentive payment when determining the facility's regular Medicaid payment rate.

- Provides for the amount determined above to be reduced by $1.79 and requires ODM to use all of the funds made available by this reduction to determine the amount of each nursing facility's quality payment.

- Requires ODM to add the quality payment to the regular payment rate of each nursing facility that meets at least one of five quality indicators and requires that the largest quality payment be paid to facilities that meet all of the quality indicators.

- Provides for a new nursing facility to be paid a quality payment that is the mean quality payment rate determined for nursing facilities and that $14.65 be added to a new nursing facility's initial total rate.

- Would have required ODM, when determining nursing facilities' case-mix scores on and after July 1, 2016, to use the grouper methodology designated by the federal government as the resource utilization group (RUG)-IV, 48 group model (VETOED).

- Provides for the per Medicaid day rate for nursing facility services provided to low resource utilization residents on and after July 1, 2016, to be (1) $115 per Medicaid day if ODM is satisfied that the facility is cooperating with the Long-Term Care

Ombudsman Program to help the residents receive the most appropriate services or (2) $91.70 if ODM is not so satisfied.

- Requires, rather than permits as under prior law, ODM to establish an alternative purchasing model for nursing facility services provided to Medicaid recipients with specialized health care needs by designated discrete units of nursing facilities.

Nursing facility demonstration project

- Requires ODM to seek a federal Medicaid waiver to operate a two-year demonstration project under which Medicaid recipients are admitted to participating nursing facilities in lieu of freestanding long-term care hospitals.

- Requires ODM to select four nursing facilities meeting certain requirements and located in Cuyahoga, Franklin, Hamilton, and Lucas counties (or other counties if necessary to find four qualifying facilities) to participate in the demonstration.

- Requires each participating nursing facility to develop admission criteria and to give the criteria to hospitals located within 50 miles that routinely refer Medicaid recipients to freestanding long-term care hospitals.

- Requires hospitals that receive the criteria to consider the criteria when determining where to refer Medicaid recipients who need the type of services freestanding long-term care hospitals provide.

- Permits Medicaid recipients to refuse referrals to participating nursing facilities.

- Requires that the Medicaid payment rate for nursing facility services provided under the demonstration project not exceed the Medicaid payment rate for comparable freestanding long-term care hospital services.

Medicaid rate for home health aide services

- Requires that the Medicaid payment rates for home health aide services provided during the period beginning January 1, 2016, and ending June 30, 2017, other than such services provided by independent providers, be at least 5% higher than the rate in effect on October 1, 2015.

Medicaid care management system

Elimination of mandatory participation

- Repeals a requirement that ODM designate for participation in the Medicaid care management system Medicaid recipients identified as part of the covered families

and children group and, with certain exceptions, aged, blind, and disabled recipients.

Behavioral health services

- Repeals a prohibition against including certain alcohol, drug addiction, and mental health services in the care management system.
- Requires ODM to begin to include alcohol, drug addiction, and mental health services in care management system not later than January 1, 2018.
- Provides that alcohol, drug addiction, and mental health services cannot be included in the care management system before January 1, 2018, without the approval of the Joint Medicaid Oversight Committee (JMOC).
- Requires JMOC to monitor ODM's actions in preparing to implement and implementing inclusion of alcohol, drug addiction, and mental health services in the care management system.

Integrity strategies

- Requires ODM to implement strategies to improve the integrity of the care management system.

Value-based provider payments

- Requires Medicaid MCOs to implement strategies that base payments to providers on the value received from their services and their success in reducing waste in the provision of services.
- Requires Medicaid MCOs to ensure, not later than July 1, 2020, that at least 50% of the aggregate net payments it makes to providers is based on the value of the providers' services.

Community health worker services (VETOED)

- Would have required Medicaid managed care organizations to provide (or arrange for the provision of) community health worker and similar services to pregnant enrollees or enrollees capable of becoming pregnant who lived in ODH-identified communities with high infant mortality and met other criteria (VETOED).

Enhanced care management

- Requires a Medicaid MCO to provide enhanced care management services to pregnant women and women capable of becoming pregnant in ODH-identified communities with high infant mortality.

Help Me Grow home visits

- Requires a Medicaid MCO to provide (or arrange for the provision of) home visits (including depression screenings) and cognitive behavioral therapy to an enrollee who is a Help Me Grow participant and is either pregnant or the birth mother of a child under age three.

- Requires the cognitive behavioral therapy to be provided in the enrollee's home at her request.

- Requires ODM to modify (for the period beginning January 1, 2016, and ending June 30, 2017) the default enrollment process for the Medicaid managed care program in a manner that gives preference to Medicaid MCOs that have reduced infant mortality rates.

Study about self-selection of Medicaid MCOs

- Requires ODM to conduct a study about the feasibility and potential savings of delaying an individual's Medicaid coverage until the individual self-selects a Medicaid managed care organization if the individual is required to participate in the care management system.

Healthy Ohio Program

- Requires the ODM Director to establish the Healthy Ohio Program (HOP).

- Provides that, under HOP, certain Medicaid recipients, in lieu of Medicaid coverage through the Medicaid fee-for-service or the care management system, are required to enroll in a comprehensive health plan offered by a managed care organization under contract with ODM.

- Requires that an account, to be known as a Buckeye account, be established for each HOP participant and that the account consist of Medicaid funds and contributions made by and on behalf of the participant.

- Requires a health plan in which a HOP participant enrolls to (1) cover certain services, (2) require copayments for services under certain circumstances, (3) not begin to pay for services until the noncore portion of the participant's Buckeye account is zero, and (4) have a $300,000 annual payout limit and $1 million lifetime payment limit.

- Prohibits a Buckeye account from having more than $10,000.

- Requires, with certain exceptions, that $1,000 of Medicaid funds be deposited annually into a HOP participant's Buckeye account.

- Requires, with certain exceptions, that a HOP participant annually contribute to the participant's Buckeye account the lesser of $99 or 2% of the participant's annual countable family income.

- Permits, with certain limitations, the following to make contributions to a HOP participant's Buckeye account on the participant's behalf: the participant's employer, a not-for-profit organization, and the managed care organization that offers the health plan in which the participant enrolls.

- Prohibits an individual from beginning to participate in HOP until an initial contribution is made to the individual's Buckeye account unless the individual is exempt from the requirement to make contributions.

- Provides for all or part of the amount remaining in a HOP participant's Buckeye account at the end of a year to carry forward in the account for the next year and for the amount that the participant must contribute to the account that next year be reduced by the amount that carries forward.

- Specifies what a Buckeye account may be used for.

- Requires a managed care organization that offers the health plan in which a HOP participant enrolls to issue a debit swipe card.

- Requires the ODM Director to establish a system under which amounts are awarded to a HOP participant's Buckeye account if the participant (1) provides for the participant's contributions to be made electronically, (2) achieves health care goals, and (3) satisfies health care benchmarks.

- Terminates a HOP participant's participation in HOP under certain circumstances.

- Requires that a HOP participant's contributions to his or her Buckeye account be returned to the participant when the participant ceases to participate in HOP unless the amount in the account is transferred to a bridge account.

- Transfers to a bridge account the entire amount remaining in a HOP participant's Buckeye account if the participant ceases to qualify for Medicaid due to increased family countable income and the participant purchases a health insurance policy or obtains health care coverage under an eligible employer-sponsored health plan.

- Requires that a HOP participant be transferred to the fee-for-service component of Medicaid or the care management system if the participant exhausts the annual or lifetime payout limits.

- Requires a CDJFS to offer to refer to a workforce development agency each HOP participant who is either unemployed or employed for less than an average of 20 hours per week.

- Permits a HOP participant to refuse to accept the referral and to participate in workforce development activities without any effect on the participant's eligibility for, or participation in, HOP.

HCAP

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

- Eliminates a requirement for a portion of the money generated by the HCAP assessments and intergovernmental transfers to be deposited into the Legislative Budget Services Fund.

- Abolishes the Fund when all the remaining money in the Fund has been spent.

Hospital franchise permit fees

- Continues the assessments (i.e., franchise permit fees) imposed on hospitals for two additional years.

- Requires ODM to establish a payment schedule for hospital franchise permit fees for each year and to include the payment schedule in the preliminary determination notice that ODM is required to mail hospitals.

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

- Provides that a bed surrender does not occur for the purpose of the franchise permit fee charged nursing homes unless the bed is removed from a nursing home's licensed capacity in a manner that makes it impossible for the bed to ever be a part of any nursing home's licensed capacity.

- Provides that a bed surrender does not occur for the purpose of the franchise permit fee charged hospital long-term care units unless the bed is removed from registration as a skilled nursing facility bed or long-term care bed in a manner that makes it impossible for the bed to ever be registered as such a bed.

- Requires ODM to notify, electronically or by U.S. Postal Service, nursing homes and hospital long-term care units of (1) the amount of their franchise permit fees, (2) redeterminations of the fees triggered by bed surrenders, and (3) the date, time, and place of hearings to be held for appeals regarding the fees.

Home care services contracts (VETOED)

- Would have required ODM, for contracts for home care services paid for with public funds, to require that providers have a system for monitoring the delivery of services (VETOED).

Annual report on Medicaid effectiveness

- Requires additional information to be included in an ODM annual report on the effectiveness of the Medicaid program in meeting the health care needs of low-income pregnant women, infants, and children.

Graduate Medical Education Study Committee

- Creates the Graduate Medical Education Study Committee.

- Requires the Committee to study the issue of Medicaid payments to hospitals for the costs of graduate medical education, including the feasibility of targeting the payments in a manner that rewards medical school graduates who practice in Ohio for at least five years after graduation.

- Requires the Committee to complete a report by December 31, 2015.

Medicaid waiver for married couple to retain eligibility (VETOED)

- Would have required ODM to establish a Medicaid waiver program under which Medicaid recipients who are married to each other would have retained, under certain circumstances, Medicaid eligibility despite employment earnings that exceed the applicable threshold (VETOED).

Medicaid Recipients' ID and Benefits Cards Workgroup

- Creates the 11-member Workgroup to Study the Feasibility of Medicaid Recipients' ID and Benefits Cards.

- Requires the Workgroup to evaluate the feasibility of using state-issued licenses and identification cards to establish an individual's eligibility for all state public assistance programs (e.g., Medicaid) and benefits under them.

- Requires the Workgroup, by July 1, 2018, to submit to the General Assembly a report of its findings and recommendations, at which time it ceases to exist.

Health and Human Services Fund

- Creates the Health and Human Services Fund in the state treasury to pay costs associated with state-provided programs or services to enhance public health and overall health care quality of citizens of this state.

State agency collaboration for health transformation initiatives

(R.C. 191.04 and 191.06)

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 main appropriations act of the 130th General Assembly, H.B. 59, extended the authorizations and requirements regarding the use and disclosure of personally identifiable information, described above, to fiscal years 2014 and 2015. The act further extends these authorizations and requirements to fiscal years 2016 and 2017.

Medicaid third party liability

Portion of tort award subject to government right of recovery

(R.C. 5160.37)

An individual who receives medical assistance under Medicaid, the Children's Health Insurance Program (CHIP), or the Refugee Medical Assistance Program (RMA) gives an automatic right of recovery to the Department of Medicaid (ODM) or a county department of job and family services (CDJFS) against the liability of a third party for the cost of medical assistance paid on the medical assistance recipient's behalf. If a recipient receives a tort recovery for injuries a third party caused the recipient, prior law specified that ODM or the appropriate CDJFS had to receive no less than the lesser of (1) one-half of the amount remaining after attorneys' fees, costs, and other expenses are deducted from the recipient's total judgment, award, settlement, or compromise or (2) the actual amount of medical assistance paid on the recipient's behalf.

In 2013, the U.S. Supreme Court found that a North Carolina statute specifying that an irrebuttable presumption exists that one-third of a Medicaid recipient's tort recovery is attributable to medical expenses was pre-empted by the federal Medicaid anti-lien provision (42 U.S.C. 1396p(a)(1)).[107] The federal provision prohibits a state from making a claim to any part of a Medicaid recipient's tort recovery that is not designated for medical care.[108]

The act responds to the Supreme Court decision by specifying that there is a rebuttable presumption (rather than a right) that ODM or a CDJFS is to receive (1) not less than one-half of a judgment, award, settlement, or compromise from a medical assistance recipient's tort action or claim against a third party, or (2) the actual amount of medical assistance paid on the recipient's behalf (whichever is less). The act permits a party to rebut the presumption by using one of two processes, depending on whether the party has already paid an amount to ODM or the CDJFS.

Process for rebutting the presumption – payment not yet made

If a party has not yet made a payment to ODM or the CDJFS, the party may submit to ODM or the CDJFS a request for a hearing in accordance with a procedure the act requires ODM to establish in rules for this purpose. The act specifies that the amount sought by ODM or the CDJFS must be held in escrow or in an Interest on Lawyers' Trust Account (IOLTA) until the hearing examiner renders a decision or the

[107] *Wos v. E.M.A.*, 133 S.Ct. 1391 (2013).

[108] 42 U.S.C. 1396p(a)(1).

case is otherwise concluded. A party successfully rebuts the presumption by a showing of clear and convincing evidence that a different allocation is warranted.

Process for rebutting the presumption – payment already made

If a party has made a payment on or after September 29, 2007[109] to ODM or the CDJFS pursuant to that agency's right of recovery, the act permits the party to request a hearing in accordance with a procedure that ODM must establish in rules for this purpose. The act requires the request to be made by the later of March 28, 2016, or 90 days after the payment is made. A party successfully rebuts the presumption by a showing of clear and convincing evidence that a different allocation is warranted.

Hearings

A hearing that is requested pursuant to either of the two processes is subject to all of the following:

(1) The hearing examiner may consider, but is not bound by the allocation of, medical expenses specified in a settlement agreement between the medical assistance recipient and the relevant third party.

(2) ODM or the CDJFS may raise affirmative defenses during the hearing, including the existence of a prior settlement with the medical assistance recipient, the doctrine of accord and satisfaction, or the common law principle of *res judicata*.[110]

(3) If the parties agree, live testimony is not to be presented at the hearing.

(4) The hearing may be governed by rules that ODM is authorized to adopt; if adopted, the Administrative Procedure Act (R.C. Chapter 119.) applies to the hearing only to the extent specified in those rules.

(5) The hearing examiner's decision is binding on ODM or the CDJFS and the medical assistance recipient unless the decision is reversed or modified by the Medicaid Director on appeal.

Administrative appeals

If a medical assistance recipient disagrees with a hearing examiner's decision, the recipient may file an administrative appeal with the Medicaid Director in accordance

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[109] September 29, 2007, is the date that prior law governing the amount of a tort judgment or settlement subject to ODM's or a CDJFS's right of recovery became effective.

[110] *Res judicata* is the principle that a decision by a competent court in a case fully and fairly litigated is final and conclusive as to the claims and issues of the parties and cannot be re-litigated.

with the procedure the act requires ODM to establish in rules for this purpose. A hearing is not required during the administrative appeal, but the Medicaid Director or the Director's designee must review the hearing examiner's decision and any prior relevant administrative action. After the review, the Medicaid Director or the Director's designee must affirm, modify, remand, or reverse the hearing decision. The decision of the Medicaid Director or the Director's designee is final and binding on ODM or the CDJFS and the medical assistance recipient unless it is reversed or modified on appeal by a court of common pleas.

The administrative appeal may be governed by rules that ODM is authorized to adopt; if adopted, the Administrative Procedure Act (R.C. Chapter 119.) applies to the appeal only to the extent specified in those rules.

Common pleas court appeals

A party may appeal a decision made by the Medicaid Director or the Director's designee through the administrative appeal process. A party may file the appeal in accordance with the Administrative Procedure Act (R.C. 119.12).

Sole remedy

The act specifies that the hearing and appeals processes are remedial in nature and must be liberally construed by the courts of this state in accordance with continuing law (R.C. 1.11). In addition, the act specifies that the hearing and appeals processes are the sole remedy available to a party who claims that ODM or a CDJFS has received or is to receive more money than that to which it is entitled pursuant to its right of recovery.

Recovery of overpayments

(R.C. 5160.401)

According to the federal Centers for Medicare & Medicaid Services, it is common for Medicaid recipients to have one or more additional sources of coverage for health care services. "Third party liability" refers to the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under Medicaid. Under federal law, all other available third party resources must meet their legal obligation to pay claims before Medicaid pays for a Medicaid recipient's care.[111]

[111] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Medicaid Third Party Liability and Coordination of Benefits*, available at medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/tpl-cob-page.html.

Continuing Ohio law reflects federal policy by requiring a responsible third party to pay a claim for payment of a medical item or service provided to an individual who receives medical assistance from Medicaid, the Children's Health Insurance Program, or the Refugee Medical Assistance Program.[112] The act specifies that a payment a third party makes is final on the date that is two years after the payment was made to ODM or the applicable Medicaid managed care organization (MCO). After a claim is final, the claim is subject to adjustment only if the third party commences an action for recovery of an overpayment before the date the claim became final and the recovery is agreed to by ODM or the MCO.

The act authorizes a third party that determines that it overpaid a claim for payment to seek recovery of all or part of the overpayment by filing a notice of its intent to seek recovery with ODM or the relevant MCO. The notice of recovery must be filed in writing before the date the payment is final and specify all of the following:

--The full name of the medical assistance recipient who received the medical item or service that is the subject of the claim;

--The date or dates on which the medical item or service was provided;

--The amount allegedly overpaid and the amount the third party seeks to recover;

--The claim number and any other number that ODM or the MCO has assigned to the claim;

--The third party's rationale for seeking recovery;

--The date the third party made the payment and the method of payment used;

--If payment was made by check, the check number; and

--Whether the third party would prefer to receive the amount being sought by payment from ODM or the MCO, either by check or electronic means, or by offsetting the amount from a future payment owed to ODM or the MCO.

The act specifies that if ODM or the appropriate MCO determines that a notice of recovery was filed before the claim for payment is final and agrees to the amount sought by the third party, ODM or the MCO must notify the third party in writing of its determination and agreement. Thereafter, the third party's recovery must proceed by the method specified by the third party.

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[112] R.C. 5160.40(A)(4).

Continuing issues regarding creation of ODM

(Sections 327.20 and 327.30)

Medical assistance programs (Medicaid, CHIP, and RMA) were administered by the Office of Medical Assistance in the Ohio Department of Job and Family Services (ODJFS) before ODM was created. The 2013 biennial budget act, H.B. 59 of the 130th General Assembly, created ODM and transferred the medical assistance programs to ODM.

Temporary authority regarding employees

The act extends until June 30, 2017, the authority of the ODM and ODJFS directors with respect to employee positions within their departments.

H.B. 59 gave the ODM Director authority, from July 1, 2013, to June 30, 2015, 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. H.B. 59 gave the ODJFS Director corresponding authority regarding ODJFS employees as part of the transfer of medical assistance programs to ODM.

The authority 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.[113] The actions of the ODM Director or ODJFS Director must comply with the 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 Director of Administrative Services, 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 Director of Administrative Services take under this provision of H.B. 59 are not subject to appeal to the State Personnel Board of Review.

[113] 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 Director of Administrative Services but who is not subject to collective bargaining law. (R.C. 124.152.)

New and amended grant agreements with counties

H.B. 59 permitted the ODJFS Director and boards of county commissioners 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 had to be drafted in the name of ODJFS. The amended or new grant agreement had to be executed before July 1, 2013, if the amendment or agreement did not become effective sooner than that date.

Under the act, the ODJFS Director and boards of county commissioners continue to have this authority. An amended or new grant agreement may be executed before July 1, 2015, if the amendment or agreement does not become effective sooner than that date.

Contracts for management of data requests

(R.C. 5162.12)

The act revises the law under which the ODM Director contracts with persons to receive and process requests for Medicaid recipient or claims payment data, data from nursing facility audit reports, or extracts or analyses of such data made by persons who intend to use the data for commercial or academic purposes. Prior law permitted the Director to enter into such contracts. The act requires the Director to enter into such contracts.

Under prior law, such a contract had to specify the schedule of fees the contracting person was to charge for the data. The act requires instead that the contract require the contracting person to charge for an item prepared pursuant to a request for the data a fee equal to 102% of the cost ODM incurs in making the data used to prepare the item available to the contracting person.

Integrated Care Delivery System

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. In statute the project is called the Integrated Care Delivery System (ICDS).[114] It may be better known, however, as MyCare Ohio.

[114] R.C. 5164.91, not in the act.

Holocaust survivors

(R.C. 5166.161 (primary) and 5166.16)

The act requires ODM to ensure that each ICDS participant who is a Holocaust survivor receives, while enrolled in the part of the ICDS that is a Medicaid waiver program, home and community-based services (HCBS) of the type and in at least the amount, duration, and scope that the participant is assessed to need and would have received if enrolled in another HCBS Medicaid waiver program operated by the Department of Aging (ODA) or ODM.

ICDS performance payments

(Section 327.70)

For fiscal years 2016 and 2017, 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 MCOs;

(2) Determine an amount to be withheld from the Medicaid premium payments paid to Medicaid MCOs 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 MCOs providing care to ICDS participants. Each Medicaid MCO 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 MCOs providing care to ICDS participants in accordance with rules that the Director may adopt. The act provides that a Medicaid MCO providing care under ICDS is not subject to withholdings under the Medicaid Managed Care Performance Payment Program for premium payments attributed to ICDS participants during fiscal years 2016 and 2017.

Claims for medical transportation services (VETOED)

(R.C. 5164.912)

The Governor vetoed a provision that would have permitted a medical transportation provider to submit a Medicaid claim for a medical transportation service provided to an ICDS participant without the Medicare program first denying the claim if the Medicaid program was responsible for paying the claim.

Administrative issues – termination of waiver programs

(Section 327.100)

If ODM and ODA terminate the PASSPORT, 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, remain in full force and effect on and after that date, but solely for concluding the program's operations, including fulfilling ODM's and ODA's legal obligations for claims arising from 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.

Money Follows the Person

(Section 327.110)

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 must continue to use the money in the fund for system reform activities related to the demonstration project.

Home and community-based services – behavioral health

(Section 327.190)

During fiscal years 2016 and 2017, the act permits Medicaid to cover state plan HCBS 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 HCBS. The act authorizes the ODM Director to adopt rules as necessary to implement this provision.

Medicaid School Program

(R.C. 5162.365 (primary), 5162.01, 5162.36, 5162.361, and 5162.363)

The act makes a qualified Medicaid school provider solely responsible for timely repaying any overpayment that the provider receives under the Medicaid School Program and that is discovered by a federal or state audit. This is the case regardless of whether the audit's finding identifies the provider, ODM, or the Department of Education as being responsible for the overpayment.

ODM is prohibited by the act from doing any of the following regarding an overpayment that the provider is responsible for repaying:

(1) Making a payment to the federal government to meet or delay the provider's repayment obligation;

(2) Assuming the provider's repayment obligation;

(3) Forgiving the provider's repayment obligation.

Each qualified Medicaid school provider must indemnify and hold harmless ODM for any cost or penalty resulting from a federal or state audit finding that a claim submitted by the provider did not comply with a federal or state requirement, including a requirement of a Medicaid waiver program.

Optional Medicaid eligibility groups (PARTIALLY VETOED)

(R.C. 5163.03, 5163.04, and 5163.06)

Federal law requires a state's Medicaid program to cover certain groups (mandatory eligibility groups). A state's Medicaid program is permitted to cover other groups (optional eligibility groups).

State law requires Medicaid to cover all optional eligibility groups that state statutes require Medicaid to cover. Medicaid is permitted to cover an optional eligibility group if state statutes expressly permit Medicaid to cover the group or if state statutes do not address whether Medicaid may cover the group. Medicaid is prohibited from covering an optional eligibility group if state statutes prohibit Medicaid from covering the group.

The Governor vetoed a provision that would have permitted Medicaid to cover optional eligibility groups that state statutes do not require Medicaid to cover only if (1) state statutes expressly permit Medicaid to cover the group or (2) Medicaid covers the group on September 29, 2015. If not for the veto, the act would have prohibited

Medicaid from covering an optional eligibility group if (1) state statutes expressly prohibit Medicaid from covering the group or (2) state statutes do not address whether Medicaid may cover the group.

The Governor also vetoed a provision that would have required that the income eligibility threshold for an optional eligibility group be the percentage of the federal poverty line specified in state statute for the group. If state statutes do not specify the income eligibility threshold for an optional eligibility group, the income eligibility threshold was to be a percentage of the federal poverty line that does not exceed the percentage that is the group's income eligibility threshold on September 29, 2015.

The act eliminates a requirement that the Medicaid program cover the optional eligibility group consisting of nonpregnant individuals who may receive family planning services and supplies.

209(b) option (PARTIALLY VETOED)

(R.C. 5166.32 (primary), 3701.023, and 5166.01; Section 327.310)

One of the eligibility groups for the Medicaid program consists of aged, blind, or disabled individuals who are eligible for the Supplemental Security Income (SSI) program. However, federal law permits states to establish Medicaid eligibility requirements for aged, blind, or disabled individuals that are more restrictive than the eligibility requirements for the SSI program. This option is known as the 209(b) option. Ohio's Medicaid program implements the 209(b) option.

Restriction on termination

The act prohibits ODM from terminating the implementation of the 209(b) option before July 1, 2016.

Continued spenddown process for individuals with cystic fibrosis

A state that implements the 209(b) option is required by federal law to permit aged, blind, and disabled individuals who have incomes exceeding the Medicaid eligibility limit to qualify for Medicaid through a spenddown process under which medical expenses are subtracted from their incomes.

The act requires ODM, if it terminates implementation of the 209(b) option, to establish a Medicaid waiver program under which an individual who has cystic fibrosis and is enrolled in the Ohio Department of Health's (ODH's) Program for Medically Handicapped Children or an ODH program for adults with cystic fibrosis may qualify for Medicaid under the same type of spenddown process that is part of the 209(b) option. The ODH programs are required by the act to continue to assist enrollees with

cystic fibrosis in qualifying for Medicaid under the spenddown process in the same manner the programs assist such enrollees on September 29, 2015. This requirement applies regardless of whether ODM terminates the 209(b) option. The Governor vetoed a provision that would have provided that this requirement also applies regardless of whether ODM establishes the Medicaid waiver program for individuals with cystic fibrosis.

Transitional Medicaid

(R.C. 5163.08 (repealed))

Federal law includes a provision for transitional Medicaid. It requires a state's Medicaid program to continue to cover, for an additional six months and, if certain requirements are met, up to another additional six months certain low-income families with dependent children that would otherwise lose Medicaid eligibility because of changes to their incomes. 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.[115] 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 repeals a requirement that the ODM Director implement the option regarding the single 12-month eligibility period for transitional Medicaid.

Medicaid ineligibility for transfer of assets – exception

(R.C. 5163.30)

Generally, an institutionalized individual is ineligible for nursing facility services, nursing facility equivalent services, and HCBS for a certain period of time if the individual or individual's spouse disposes of assets for less than fair market value on or after the look-back date. An institutionalized individual is (1) a nursing facility resident, (2) an inpatient in a medical institution for whom a payment is made based on a level of care provided in a nursing facility, or (3) an individual who would be eligible for Medicaid if the individual was in a medical institution, would need hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID) services if not for HCBS available under a Medicaid waiver program, and is to receive HCBS. The look-back date is the date that is a certain number of months before (1) the date an individual becomes an institutionalized individual if the Medicaid

[115] 42 U.S.C. 1396r-6.

recipient is eligible for Medicaid on that date or (2) the date an individual applies for Medicaid while an institutionalized individual.

There are exceptions to this period of ineligibility. For example, an institutionalized individual may be granted a waiver of all or portion of the period of ineligibility if the ineligibility would cause an undue hardship for the individual.

The act establishes a new exception. An institutionalized individual may be granted a waiver of all of the period of ineligibility if all of the assets that were disposed of for less than fair market value are returned to the individual or individual's spouse or if the individual or spouse receives cash or other personal or real property that equals the difference between what the individual or spouse received for the assets and the assets' fair market value. Unless the institutionalized individual is eligible for a waiver under another exception, no waiver of any part of the period of ineligibility is to be granted if the amount the individual or spouse receives is less than the difference between what the individual or spouse received for the assets and the assets' fair market value.

Medicaid eligibility – revocable self-settled trusts (VETOED)

(R.C. 5163.21)

When a Medicaid applicant or recipient is a trust beneficiary, the CDJFS must determine what type of trust it is and, for purposes of determining Medicaid eligibility, whether the trust or a portion of it (1) is a resource available to the applicant or recipient, (2) contains income available to the applicant or recipient, (3) constitutes both an available resource and contains available income, or (4) is neither an available resource nor contains available income.

A self-settled trust is a trust not established by will. Under ongoing Ohio law, a CDJFS must treat a revocable self-settled trust as follows:

(a) The corpus of the trust[116] must be considered an available resource;

(b) Payments from the trust to or for the benefit of the applicant or recipient must be considered unearned income of the applicant or recipient; and

[116] The "corpus" is all property and other interests held by the trust, including accumulated earnings and any other addition to the trust after its establishment (except that it excludes any earnings or addition in the month in which the earnings or addition is credited or otherwise transferred to the trust). 42 U.S.C. 1382b(e)(6)(B).

(c) Any other payments from the trust must be considered an improper disposition of assets and makes the applicant or recipient ineligible for Medicaid for a certain period of time.[117]

The Governor vetoed a provision that would have specified that an applicant's or recipient's home (including the land that appertains the home) is not subject to the provisions described in (a) – (c), above, is not a resource available to the applicant or recipient, and must be excluded from the computation of spousal share determined under federal Medicaid provisions. (Under those federal provisions, a certain amount of a couple's combined resources is counted when determining the institutionalized spouse's Medicaid eligibility; however, depending on how much of his or her own income the community spouse actually has, a certain amount of income belonging to the institutionalized spouse can be set aside for the community spouse's use so that the community spouse is not impoverished.[118]) Federal law already specifies that the home is not to be counted as a resource.[119]

The Governor also vetoed a provision that would have prohibited the transfer of a Medicaid applicant's or recipient's home from a revocable self-settled trust to the applicant or recipient or that individual's spouse from being considered an improper disposition of assets or a disposal of assets for less than fair market value. A Medicaid applicant or recipient may be subject to a period of Medicaid ineligibility if ODM makes one of those two determinations.

Personal needs allowance

(R.C. 5163.33)

The act increases the monthly personal needs allowance for Medicaid recipients residing in ICFs/IID. Beginning January 1, 2016, the personal needs allowance is to be at least $50 per month for an individual resident and at least $100 for a married couple if both spouses are residents of an ICF/IID and their incomes are considered available to each other rather than $40 or an amount determined by ODM. This personal needs allowance is the same that applies to residents of nursing facilities.

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[117] R.C. 5163.30.

[118] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Spousal Impoverishment*, available at medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/spousal-impoverishment-page.html.

[119] 42 U.S.C. 1382b(a)(1).

Independent provider study

(Section 751.10)

The act states that it is the intent of the General Assembly to study the issue of Medicaid provider agreements with independent providers and to resolve the issue not later than December 31, 2015. The act defines "independent provider" as an individual who personally provides one or more of the following services on a self-employed basis and does not employ, directly or through contract, another individual to provide any of those services:

(1) The following aide services: home health aide services available under the Medicaid program's home health services benefit, home care attendant services available under a Medicaid waiver program covering HCBS, and personal care aide services available under Medicaid waiver program covering HCBS;

(2) The following nursing services: nursing services available under the Medicaid program's home health services benefit, private duty nursing services, and nursing services available under a Medicaid waiver program covering HCBS;

(3) Services covered by a Medicaid waiver program covering HCBS;

(4) Services covered by the Helping Ohioans Move, Expanding (HOME) choice demonstration program.

The U.S. Department of Labor (DOL) recently adopted a regulation extending federal minimum wage and overtime protection to most home care workers, including independent providers who provide certain services to Medicaid recipients.[120] DOL has stated that it will not bring enforcement actions against employers for violations before July 1, 2015. From July 1, 2015 to December 31, 2015, DOL will exercise prosecutorial discretion in determining whether to bring enforcement actions, with particular consideration given to good faith efforts to bring home care programs into compliance with the regulation;[121] however, a federal trial court recently found the regulation to be invalid and vacated it. That decision is currently on appeal.[122] If the regulation is determined to be valid, employers of home care workers, which could include states or

[120] 29 C.F.R. 552.6.

[121] Application of the Fair Labor Standards Act to Domestic Service; Announcement of Time-Limited Non-Enforcement Policy, 79 Fed. Reg. 60,974 (October 9, 2014).

[122] *Home Care Ass'n of Am. v. Weil,* Case No. 14-cv-967, 2014 WL 7272406 (December 22, 2014); *Home Care Ass'n of Am. v. Weil,* Case No. 14-cv-967, 2015 WL 181712 (January 14, 2015).

state agencies overseeing Medicaid programs, will be responsible for ensuring the federal requirements are met.[123]

Medicaid expansion group report

(Section 751.20)

The act requires ODM to submit a report to the General Assembly evaluating the Medicaid program's effect on clinical care and outcomes for individuals included in the Medicaid expansion group (also referred to as Group 8). The report is to be submitted by January 1, 2017, and is to include information on the Medicaid program's effects on physical and mental health, health care utilization and access, and financial hardship.

Pre-enrollment provider screenings and reviews

(Section 327.280)

The act states the General Assembly's recommendation that ODM, during fiscal years 2016 and 2017, perform pre-enrollment screenings and reviews of Medicaid providers designated as moderate or high risks to the Medicaid program under the categorical risk levels established pursuant to federal Medicaid regulations.

Medicaid rates for medical transportation services (VETOED)

(R.C. 5164.78; Section 327.300)

The Governor vetoed a provision that would have required that the Medicaid payment rate for medical transportation services include a component that pays for providers' fuel costs. ODM would have been required to revise the rate for the fuel component each month. The rate for the fuel component for a month would have to have been at least 5% higher than the national average for fuel prices for the preceding month as reported by the U.S. Energy Information Administration.

The Governor also vetoed a provision that would have required that the Medicaid payment rates for ambulette services provided during fiscal years 2016 and 2017 be at least 10% higher than the rates for the services in effect on June 30, 2015.

[123] Joint letter from the U.S. Department of Justice and U.S. Department of Health and Human Services, December 15, 2014, available at: www.hhs.gov/ocr/civilrights/resources/specialtopics/community/2014hhsdojdearcolleagueletter.pdf.

Nursing facilities' Medicaid rates (PARTIALLY VETOED)

(R.C. 5165.15 (primary), 173.47, 5165.151, 5165.152, 5165.157, 5165.16, 5165.17, 5165.19, 5165.192, 5165.23, and 5165.25 (new); R.C. 5165.25 and 5165.26 (repealed); Sections 327.270 and 812.10)

Nursing facilities' peer groups

Nursing facilities are placed into various peer groups for determining their Medicaid rates for ancillary and support costs, capital costs, and direct care costs. Continuing law requires ODM to revise the peer groups by placing facilities located in Mahoning County or Stark County in different peer groups beginning with the first rebasing of nursing facilities' Medicaid rates. 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 rates for certain costs using information from Medicaid cost reports for a calendar year that is more recent than the calendar year used for the previous determination of the costs.

The act requires ODM to further revise the peer groups by also placing nursing facilities located in Allen County or Trumbull County in the peer groups in which the nursing facilities located in Mahoning County or Stark County are to be placed with the first rebasing.

For the purpose of determining nursing facilities' Medicaid rates for ancillary and support costs and capital costs, a nursing facility located in Allen County or Trumbull County is placed before the first rebasing in either peer group five or six, depending on how many beds it has. This also applies to a nursing facility located in Mahoning County or Stark County. If the nursing facility 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, 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, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot.

Beginning with the first rebasing, nursing facilities located in Allen County or Trumbull County are to be placed in peer group three or four. These are the peer groups that continuing law requires ODM to place nursing facilities located in Mahoning County or Stark County when the first rebasing occurs. Peer group three is for nursing facilities with fewer than 100 beds. Peer group four is for nursing facilities with 100 or more beds. Before the first rebasing, 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 rates for direct care costs, a nursing facility located in Allen County or Trumbull County is placed before the first rebasing in peer group three. This is the same peer group that a nursing facility located in Mahoning County or Stark County is in before the first rebasing. Peer group three also consists of nursing facilities located in any of the following counties: Adams, 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, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot.

Beginning with the first rebasing, nursing facilities located in Allen County or Trumbull County are to be placed in peer group two for the purpose of direct care costs. This is the same peer group that nursing facilities located in Mahoning County or Stark County are to be placed with the first rebasing. Before the first rebasing, 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.

Quality payments (PARTIALLY VETOED)

Under law in effect until July 1, 2016, a nursing facility's regular total Medicaid payment rate is the sum of (1) each of its rates for the cost centers (ancillary and support costs, capital costs, direct care costs, and tax costs), (2) its critical access incentive payment (if applicable), and (3) its quality incentive payment. ODM is also required until July 1, 2016, to pay a qualifying nursing facility a quality bonus in addition to its regular total rate under certain circumstances. Effective July 1, 2016, the act replaces the quality incentive payment with a quality payment and eliminates the quality bonus. The act retains the rates for cost centers. The Governor apparently vetoed changes that would have been made to the law governing critical access incentive payments.[124]

[124] R.C. 5165.23 governs nursing facilities' critical access incentive payments. The Governor's vetoes remove R.C. 5163.23 from the body of the act but not from the act's title, amending clause, existing

Until July 1, 2016, the maximum quality incentive payment is $16.44 per Medicaid day. A nursing facility can receive the maximum payment if it meets at least five accountability measures, including at least one accountability measure regarding moderate pain, pressure ulcers, physical restraints, urinary tract infections, hospital admissions, and vaccinations.

As part of the provision that replaces the quality incentive payment with a quality payment, the act provides for the amount of the maximum quality incentive payment ($16.44) to be added to the sum of a nursing facility's rates for the cost centers and, if applicable, its critical access incentive payment when determining the nursing facility's regular total Medicaid payment rate. From that amount, $1.79 is to be subtracted. ODM is required to use all of the funds made available by this reduction to determine the amount of each nursing facility's quality payment. These changes result in the following formula that is to be used to determine a nursing facility's regular total per Medicaid day payment rate beginning on July 1, 2016:

(1) Determine the sum of the nursing facilities' rates for each cost center and, if applicable, its critical access incentive payment;

(2) Add $16.44 to the amount determined under (1);

(3) Subtract $1.79 from the amount determined under (2);

(4) Add the nursing facility's quality payment to the amount determined under (3).

To qualify for a quality payment under the act, a nursing facility must meet at least one of five quality indicators. The largest quality payment is to be paid to nursing facilities that meet all of the quality indicators for the measurement period. The following is the measurement period:

(1) For fiscal year 2017, the period beginning July 1, 2015, and ending December 31, 2015;

(2) For each subsequent fiscal year, the calendar year immediately preceding the fiscal year.

The act establishes the following quality indicators for the purpose of the quality payment:

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repeals, and special effective dates. The Governor's veto message does not expressly indicate an intent to repeal the act's changes to the critical access incentive payments.

(1) Not more than a target percentage of a nursing facility's short-stay residents (residents who have resided in the nursing facility for less than 100 days) had new or worsened pressure ulcers and not more than a target percentage of long-stay residents (residents who have resided in the nursing facility for at least 100 days) at high risk for pressure ulcers had pressure ulcers. ODM is required to specify the target percentages and the amount specified for short-stay residents may differ from the amount specified for long-stay residents.

(2) Not more than a target percentage of the nursing facility's short-stay residents newly received antipsychotic medication and not more than a target percentage of the nursing facility's long-stay residents received an antipsychotic medication. ODM is to specify the target percentages. The amount specified may differ for short-term residents and long-term residents. The amount specified also may be different from the target percentages specified for the quality indicator regarding pressure ulcers.

(3) The number of the nursing facility's residents who had avoidable inpatient hospital admissions did not exceed a target rate that ODM is to specify.

(4) The nursing facility's employee retention rate is at least a target rate that ODM is to specify.

(5) The nursing facility utilized the nursing home version of the Preferences for Everyday Living Inventory for all of its residents.

The act provides that if a nursing facility undergoes a change of operator during a fiscal year, the amount of the quality payment rate to be paid to the new operator for the period beginning on the effective date of the change of operator and ending on the last day of the fiscal year is to be the same as the amount of the quality payment rate in effect on the day immediately preceding the effective date of the change of operator. For the immediately preceding fiscal year, the quality payment rate is to be the following:

(1) If the effective date of the change of operator is on or before the first day of October of the calendar year immediately preceding the fiscal year, the amount determined pursuant to the normal method discussed above;

(2) If the effective date of the change of operator is after the first day of that October, the mean quality payment rate for all nursing facilities for the fiscal year.

To qualify for a critical access incentive payment, a nursing facility must (1) be located in an area that, on December 31, 2011, was designated an empowerment zone under federal law, (2) have an occupancy rate of at least 85%, (3) have a Medicaid utilization rate of at least 65%, and (4) have met at least five accountability measures for the purpose of the quality incentive payment, including at least one of the

accountability measures regarding moderate pain, pressure ulcers, physical restraints, urinary tract infections, and vaccinations. The Governor apparently vetoed a provision that would have eliminated the fourth requirement to qualify for a critical access incentive payment. The Governor also apparently vetoed a provision that would have revised how the amount of the critical access incentive payment was to be determined. Under ongoing law, a nursing facility's critical access incentive payment is to equal 5% of the sum of its rates for each of the cost centers and quality incentive payment. If not for the apparent veto, a nursing facility's critical access incentive payment would have equaled 5% of the sum of its rates for each of the cost centers.

A new nursing facility is not paid the regular Medicaid rate for the first fiscal year (or part thereof) that it participates in Medicaid. For example, a new nursing facility is paid the mean quality incentive payment for all nursing facilities instead of a quality incentive payment determined specifically for the new nursing facility. As part of the provision that replaces the quality incentive payment with a quality payment, the act provides for a new nursing facility to be paid a quality payment that is the mean quality payment rate determined for nursing facilities and that $14.65 be added to a new nursing facility's initial total rate.

Case-mix scores (VETOED)

ODM is required to determine case-mix scores for nursing facilities as part of the process of determining their Medicaid payment rates. When determining case-mix scores, ODM must use certain data and, except as provided in ODM's rules, the case-mix values established by the U.S. Department of Health and Human Services (USDHHS). Under ongoing law, ODM also must use, except as modified in ODM's rules, the grouper methodology used on June 30, 1999, by the USDHHS for the prospective payment of skilled nursing facilities under the Medicare program. The Governor vetoed a provision that would have required, beginning July 1, 2016, that ODM instead use, except as modified in ODM's rules, the grouper methodology designated by the USDHHS as the resource utilization group (RUG)-IV, 48 group model.

Low resource utilization residents

The regular Medicaid rate is not paid for nursing facility services provided to low resource utilization residents. A low resource utilization resident is a Medicaid recipient residing in a nursing facility who, for purposes of calculating the nursing facility's Medicaid payment rate for direct care costs, is placed in either of the two

lowest resource utilization groups, excluding any resource utilization group that is a default group used for residents with incomplete assessment data.[125]

Until July 1, 2016, the total per Medicaid day payment rate for nursing facility services provided to low resource utilization residents is $130. The act provides, beginning July 1, 2016, that the per Medicaid day rate is to be the following:

(1) $115 if ODM is satisfied that the nursing facility is cooperating with the Long-Term Care Ombudsman Program in efforts to help the nursing facility's low resource utilization residents receive the services that are most appropriate for such residents' level of care needs;

(2) $91.70 if ODM is not so satisfied.

Alternative purchasing model for nursing facility services

The Medicaid Director is authorized to establish an alternative purchasing model for nursing facility services provided to Medicaid recipients with specialized health care needs by designated discrete units of nursing facilities. The Medicaid rates paid under the alternative purchasing model are in lieu of the regular Medicaid rates for nursing facility services.

Prior law permitted the Director to establish the alternative purchasing model. The act requires it to be established.

Nursing facility demonstration project

The act requires ODM to submit to the U.S. Secretary of Health and Human Services a request for a federal Medicaid waiver to operate a two-year demonstration project under which Medicaid recipients receive nursing facility services in participating nursing facilities in lieu of hospital inpatient services in freestanding long-term care hospitals.[126] The request must be submitted July 30, 2015. It must specify a January 1, 2016, starting date for the project.

ODM is to select four nursing facilities to participate in the project. To be selected, a nursing facility must (1) be held out to the public as providing short-term rehabilitation services, (2) have a hydrotherapy pool, (3) have a Medicaid-certified

[125] R.C. 5165.01, not in the act.

[126] A hospital is a freestanding long-term care hospital if (1) it meets the definition of that term in federal regulations, (2) it has a Medicaid provider agreement to provide inpatient hospital services, and (3) pursuant to ODM rules, it is exempt from the patient refined diagnosis related groups (APR-DRG) and prospective payment methodology ODM uses to determine Medicaid payment rates for inpatient services provided by other types of hospitals not also excluded from the methodology.

capacity that includes at least ten single-occupancy sleeping rooms that will be used for Medicaid recipients admitted to the nursing facility under the project, and (4) have been initially constructed, licensed for operation, and certified for participation in Medicaid on or after January 1, 2010. In selecting four nursing facilities, ODM must select one located in Cuyahoga County, one located in Franklin County, one located in Hamilton County, and one located in Lucas County. However, ODM may select a nursing facility located in another county if necessary to find four facilities that meet the selection requirements.

Each nursing facility selected for participation in the project is required to develop admission criteria that Medicaid recipients must meet to be admitted to the nursing facility under the project. A nursing facility is to give the criteria to each hospital that is located within 50 miles and routinely refers Medicaid recipients to freestanding long-term care hospitals. A hospital that receives the criteria must consider it when determining where to refer a Medicaid recipient who needs the types of services freestanding long-term care hospitals provide.

The act permits a Medicaid recipient to refuse a referral to a nursing facility participating in the project and instead seek admission to a freestanding long-term care hospital. If a Medicaid recipient seeks admission to a nursing facility participating in the project, the nursing facility's staff must ensure that the recipient meets the nursing facility's admission criteria before admitting the recipient.

A nursing facility is required to notify ODM each time it admits a Medicaid recipient under the project. A recipient's admission is not subject to prior authorization from ODM or ODM's designee.

The act requires that the Medicaid payment rate for nursing facility services that a Medicaid recipient receives from a nursing facility participating in the project not exceed the Medicaid payment rate for comparable hospital inpatient services provided by freestanding long-term care hospitals in effect at the time the services are provided.

Each nursing facility participating in the project is required to report to ODM certain information not later than 30 days after the end of each quarter of the project. Specifically, a nursing facility must report all of the following information about each Medicaid recipient residing in the nursing facility under the project during the quarter:

(1) The cost of the nursing facility services provided to the recipient that quarter;

(2) The number of days the recipient resided in the nursing facility that quarter;

(3) The recipient's health outcomes;

(4) The recipient's satisfaction with the nursing facility as reported to the nursing facility's staff;

(5) All other information ODM requires the nursing facilities to include in the reports.

ODM is required by the act to complete a report about the project not later than three months after the project ends. The report must include an analysis of the information nursing facilities submit to ODM under the project. It also must include recommendations about resuming the project's operation and selecting nursing facilities from additional counties to participate. The report is to be submitted to the Governor, General Assembly, and the Joint Medicaid Oversight Committee (JMOC).

Medicaid rate for home health aide services

(Section 327.250)

The act requires that the Medicaid payment rate for home health aide services provided during the period beginning January 1, 2016, and ending June 30, 2017, other than such services provided by independent providers, be at least 5% higher than the rate in effect on October 1, 2015, for the services. An independent provider is a provider who personally provides home health aide services and is not employed by, under contract with, or affiliated with another entity that provides those services.

Medicaid care management system (PARTIALLY VETOED)

Continuing law requires ODM to establish a care management system as part of the Medicaid program. Medicaid managed care is part of the care management system.

Elimination of requirements regarding groups that must participate

(R.C. 5167.03)

The act repeals a requirement that ODM designate for participation in the care management system individuals who receive Medicaid on the basis of being included in the eligibility category identified as covered families and children and, with certain exceptions, individuals who receive Medicaid on the basis of being aged, blind, or disabled. The act also repeals a requirement to ensure the individuals mentioned above are enrolled in Medicaid managed care organizations that are health insuring corporations.

Adding behavioral health services

(R.C. 5167.04 (primary), 103.42, and 5167.03)

The act repeals a prohibition against ODM including in the care management system alcohol, drug addiction, and mental health services for which a board of alcohol, drug addiction, and mental health services or a state agency other than ODM pays the nonfederal share.

ODM must begin to include alcohol, drug addiction, and mental health services in the care management system by January 1, 2018.

During the period beginning July 1, 2015, and ending June 30, 2018, JMOC must monitor on a quarterly basis ODM's actions in preparing to implement and implementing inclusion of the services in the system. Any ODM proposal to include all or part of the services in the system before January 1, 2018, is subject to JMOC's review. In conducting its review, JMOC is to consider all of the following for each service to be included:

(1) The proposed timeline for including the service;

(2) Any issues related to Medicaid recipients' access to the service;

(3) The adequacy of the network of providers of the service;

(4) Payment levels for the service.

JMOC members must vote on whether to approve or disapprove a proposal. If a majority of members approve the proposal, JMOC is to notify ODM, which may implement the proposal.

On and after January 1, 2018, any ODM proposal to include all or part of the services in the system is subject to JMOC's monitoring but not its approval. Beginning July 1, 2018, JMOC on a periodic basis must monitor ODM's inclusion of the services in the system.

Integrity strategies

(R.C. 5167.32)

The act requires ODM to implement, by July 1, 2016, strategies to improve the integrity of the care management system, including strategies to do both of the following:

(1) Increase ODM's oversight of Medicaid MCOs;

(2) Provide incentives for identifying fraud, waste, and abuse in the care management system.

Value-based provider payments

(R.C. 5167.33)

The act requires Medicaid MCOs to implement, by July 1, 2018, strategies that base payments to providers on the value received from the providers' services, including their success in reducing waste in the provision of services. Not later than July 1, 2020, each Medicaid MCO must ensure that at least 50% of the aggregate net payments it makes to providers is based on the value received from the providers' services.

ODM is permitted by the act to measure a Medicaid MCO's compliance with these requirements based on the actions of the MCO, the providers in the MCO's provider panel, the MCO's subcontractors, or any combination of the MCO, providers, and subcontractors.

The ODM Director is required to adopt rules as necessary to implement this provision of the act, including rules that specify all of the following:

(1) The value received from a provider's services;

(2) A provider's success in reducing waste in the provision of services;

(3) The percentage of a Medicaid MCO's aggregate net payments to providers that is based on the value received from the providers' services.

Community health worker services (VETOED)

(R.C. 3701.142 and 5167.15)

The Governor vetoed provisions that would have required Medicaid managed care organizations (MCOs) to provide certain Medicaid recipients, or arrange for those recipients to receive, services provided by community health workers certified by the Board of Nursing. A Medicaid recipient would have been eligible to receive the services if she (1) was pregnant or capable of becoming pregnant, (2) resided in a community with high infant mortality specified in rules the ODH Director is required to adopt under the act, (3) was recommended to receive the services by a physician or another licensed health professional specified in rules the ODH Director would have been required to adopt (see below), and (4) was enrolled in the Medicaid MCO.

The Governor also vetoed associated provisions that would have required (1) the ODH Director to adopt rules specifying healthy behaviors to be promoted and

facilitated by certified community health workers and (2) the ODH Director, in consultation with the Medicaid Director, to adopt rules specifying the licensed health professionals (in addition to physicians) who could recommend that a Medicaid recipient receive community health worker services.

A detailed description of the vetoed provisions is available on pages 405-407 of LSC's analysis of the Senate version of H.B. 64. The analysis is available online at www.lsc.ohio.gov/budget/agencyanalyses131/passedsenate/h0064-ps-131.pdf.

Enhanced care management

(R.C. 3701.142 and 5167.17)

The act requires the ODH Director, in consultation with the ODM Director, to adopt rules specifying the urban and rural communities, identified by zip code or portions of zip codes that are contiguous, that have the highest infant mortality rates in this state. The rules must be adopted in accordance with the Administrative Procedure Act (R.C. Chapter 119.).

The act requires ODM, when it contracts with a Medicaid MCO, to require the MCO to provide enhanced care management services for pregnant women and women capable of becoming pregnant who reside in an identified community. The contract must specify that the services are to be provided in a manner intended to decrease the incidence of prematurity, low birth weight, and infant mortality, as well as improve the overall health status of women capable of becoming pregnant for the purpose of ensuring optimal future birth outcomes.

Help Me Grow home visits

(R.C. 5167.16)

The act requires Medicaid MCOs to provide to certain Medicaid recipients (or arrange for those recipients to receive) home visits, including depression screenings, and cognitive behavioral therapy. The Medicaid recipients who are to receive those services are recipients who are (1) enrolled in the Help Me Grow program and a Medicaid MCO and (2) pregnant or the birth mother of a child under three years of age. Help Me Grow is a program established by the Department of Health to encourage early prenatal and well-baby care, provide parenting education to promote the comprehensive health and development of children, and provide early intervention services for individuals with disabilities.[127]

[127] R.C. 3701.61, not in the act.

A Medicaid MCO is to provide or arrange for the provision of home visits for which federal financial participation is available under the federal targeted case management benefit. ("Federal financial participation" is that portion of the cost of a Medicaid service that is paid for from federal funds.) Cognitive behavioral therapy is to be provided or arranged for if it is determined to be medically necessary through a depression screening conducted as part of a home visit. The cognitive behavioral therapy must be provided by a community mental health services provider.

If requested, a Medicaid recipient who is eligible for the cognitive behavioral therapy is entitled to have that therapy provided at her home. The act requires the Medicaid MCO to inform the recipient of the right to make such a request and how to make it.

Enrollment preferences – MCOs that reduce infant mortality rates

(Section 327.340)

The act requires ODM to modify, for the period from January 1, 2016, to June 30, 2017, the default enrollment process under which ODM enrolls in a Medicaid MCO a recipient who is designated for participation in managed care but fails to select an MCO during the enrollment period. Under the modifications, ODM must give preference to Medicaid MCOs that have demonstrated to ODM's satisfaction success in reducing the infant mortality rates among children born to women enrolled in the MCOs. In determining success in reducing infant mortality rates, ODM may consider direct and indirect measures of infant mortality and factors that differ from the performance standards for the Managed Care Performance Payment Program.

A determination of whether to give preference to a Medicaid MCO under this provision is to have no effect on an MCO's eligibility for a performance payment under the Managed Care Performance Payment Program or on the amount of the performance payment.

Study – self-selection of Medicaid MCOs

(Section 327.330)

The act requires ODM to complete, by December 27, 2015, a study of the feasibility and potential savings to the state of delaying an individual's Medicaid coverage until the individual self-selects a Medicaid managed care organization in which to enroll (if the individual is required to participate in the care management system). As part of the study, ODM must both:

(1) Examine the feasibility of obtaining any necessary federal waivers, including a waiver of the default enrollment process that federal law requires states to use when a Medicaid recipient fails to timely select a managed care organization; and

(2) Contract with an actuary to determine the effect that the delay on coverage would have on the amount of premiums to be paid Medicaid managed care organizations under the care management system.

ODM is required to prepare a report about the study and submit it to the Governor, General Assembly, and JMOC.

Healthy Ohio Program

(R.C. 5166.40 to 5166.409 and 5167.03)

HOP established

The act requires the ODM Director to establish a Medicaid waiver program to be known as the Healthy Ohio Program (HOP). An adult, unless a ward of the state, must participate in HOP if eligible for Medicaid on the basis of being included in the eligibility group identified by ODM as covered families with children or in the expansion eligibility group authorized by the Patient Protection and Affordable Care Act (i.e., Group VIII). With certain exceptions, a HOP participant is not to receive Medicaid services under the fee-for-service system or participate in Medicaid managed care. (See "**Exhausting payout limits**" below.)

Comprehensive health plan

A HOP participant must enroll in a comprehensive health plan offered by a managed care organization under contract with ODM. All of the following apply to the health plan:

(1) It must cover physician, hospital inpatient, hospital outpatient, pregnancy-related, mental health, pharmaceutical, laboratory, and other health care services the ODM Director determines necessary.

(2) It must not begin to pay for any services it covers until the amount of the noncore portion of the participant's Buckeye account is zero. (See "**Buckeye accounts**" and "**Core and noncore portions of Buckeye accounts**" below.)

(3) It must require copayments for services covered by the health plan, except that a participant's copayments are to be waived whenever the amount of the core portion of the participant's Buckeye account is zero.

(4) It must have a $300,000 annual payout limit and a $1 million lifetime payout limit.

Buckeye accounts

The act requires that a Buckeye account be established for each HOP participant. A participant's Buckeye account is to consist of (1) Medicaid funds deposited into the account each year and (2) contributions made by and on behalf of the participant. (See "**Deposits of Medicaid funds**" and "**Participants' contributions**" below.) However, a Buckeye account is not to have more than $10,000 in it at one time.

Deposit of Medicaid funds

Each year, $1,000 of Medicaid funds is to be deposited into a HOP participant's Buckeye account. The Medicaid funds are not to be deposited until after the initial contribution to the Buckeye account is made by the participant or on the participant's behalf unless the participant is not required to make contributions. (See "**Participants' contributions**" below.) Additional Medicaid funds are to be deposited based on points the participant earns under HOP for providing for the participant's contributions to be made by electronic funds transfers and satisfying certain health care goals and benchmarks. (See "**Amounts awarded to HOP debit swipe cards**" below.)

Participants' contributions

With certain exceptions, a HOP participant must contribute each year to the participant's Buckeye account the lesser of the following:

(1) 2% of the participant's monthly countable family income;

(2) $99.[128]

A participant's contributions may be made in monthly installments. A monthly installment is to be considered an initial contribution.

The following are permitted to make contributions to a participant's Buckeye account on the participant's behalf:

(1) The participant's employer, but only up to 50% of the contributions the participant is required to make;

(2) A not-for-profit organization, but only up to 75% of the contributions the participant is required to make;

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[128] A HOP participant is not to begin to receive benefits under HOP until the initial contribution to the Buckeye account is made, unless the participant is not required to make a contribution.

(3) The managed care organization that offers the health plan in which the participant enrolls under HOP, but such contributions (a) are to be used only to pay for the participant to participate in a health-related incentive available under the health plan (such as completion of a risk assessment or participation in a smoking cessation program) and (b) cannot reduce the amount the participant is required to contribute.

Contributions made on behalf of a participant by an employer or not-for-profit organization must be coordinated in a manner so that the participant makes at least 25% of the contributions the participant is required to make.

Core and noncore portions of Buckeye accounts

The act distinguishes between the core and noncore portions of a HOP participant's Buckeye account. The core portion consists of the contributions made by or on behalf of the participant and amounts awarded to the account when the participant satisfies certain health care goals and benchmarks. (See "**Amounts awarded to HOP debit swipe cards**" below.) The remaining portion of the Buckeye account is the noncore portion.

Amounts in Buckeye account to carry forward to next year

The act provides for a portion of the amount that remains in a participant's Buckeye account at the end of a year to carry forward in the account the next year. If the participant satisfies requirements regarding preventative health services the ODM Director is to establish in rules, the entire amount is to carry forward.[129] If the participant does not satisfy the requirements regarding preventative health services, only the amount representing the contributions made by or on behalf of the participant is to carry forward. The amount of contributions that must be made to the participant's Buckeye account for a year are to be reduced by the amount that is carried forward. If the amount carried forward is at least the amount of contributions that would otherwise have been required to be made by or on behalf of the participant for the year, no contributions are required to be made for the participant that year.

Use of Buckeye accounts

The act provides that a Buckeye account is to be used only for the following:

(1) To pay for the expenses for which a HOP debit swipe card may be used (see "**HOP debit swipe card**" below);

[129] The rules may establish different requirements regarding preventative health services for HOP participants of different ages and genders.

(2) Other purposes the ODM Director is to specify in rules.[130]

Monthly statements

ODM is required to provide for a HOP participant to receive monthly statements showing the current amount in the participant's Buckeye account and the previous month's expenditures from the account. The statement must specify how much of the amount in the account is the core portion and how much is the noncore portion. ODM is permitted to arrange for the statements to be provided in an electronic format.

HOP debit swipe card

The act requires a managed care organization that offers a health plan in which a HOP participant enrolls to issue a debit swipe card to be used to pay only for the following:

(1) Until the amount of the noncore portion of the participant's Buckeye account is zero, the costs of health care services that are covered by the health plan and provided to the participant by a provider participating in the health plan;

(2) The participant's copayments under the health plan;

(3) Subject to rules the ODM Director is to adopt, the costs of health care services that are medically necessary for the participant but not covered by the health plan.

A HOP participant's debit swipe card is to be credited one point for each of the following:

(1) Each dollar of Medicaid funds deposited into the participant's Buckeye account;

(2) Each dollar that is contributed to the account by or on behalf of the participant;

(3) Each point awarded to the participant for providing for the participant's contributions to the account to be made by electronic funds transfers and satisfying certain health care goals and benchmarks. (See "**Amounts awarded to HOP debit swipe cards**" below.)

Each time a HOP participant uses the debit swipe card, the amount for which the card is used must be deducted from the number of points on the card as follows:

[130] The rules must also establish the means for using a Buckeye account for the additional purposes.

(1) If the card is used for the costs of health care services that are covered by the participant's health plan, the deduction is to come from the points representing the noncore portion of the participant's Buckeye account.

(2) If the card is used for the other allowable purposes, the deduction is to come from the points representing the core portion of the participant's account.

The act requires that a HOP participant's debit swipe card do all of the following:

(1) Verify the participant's eligibility for HOP;

(2) Determine whether the service the participant seeks is covered by the participant's health plan;

(3) Determine whether the provider is a participating provider under the health plan;

(4) Be linked to the participant's Buckeye account in a manner that enables the participant to know at the point of service what will be deducted from the noncore portion and core portion of the account for the service and how much will remain in each portion after the deduction.

Amounts awarded to HOP debit swipe cards

The act requires the ODM Director to establish a system under which points are awarded to HOP participants' debit swipe cards. One dollar of Medicaid funds is to be deposited into a participant's Buckeye account for each point awarded.

The ODM Director must provide a one-time award of 20 points to a HOP participant who provides for the participant's contributions to his or her Buckeye account to be made by electronic funds transfers from the participant's checking or savings account. Twenty points are to be deducted if the participant terminates the electronic funds transfers.

The ODM Director is permitted to award up to 200 points annually to a HOP participant who achieves health care goals. The points must be awarded in accordance with rules the Director is to adopt. The rules must specify the goals that qualify for points and the number of points each goal is worth. The number of points may vary for different goals. A participant is not to be awarded more than 200 points per year regardless of the number of goals the participant achieves that year.

Up to 100 points may be awarded annually to a HOP participant by one or more primary care physicians who verify that the participant has satisfied health care benchmarks set by the physicians. A participant is not to be awarded more than 100

points per year regardless of how many primary care physicians award points to the participant that year and the number of points the primary care physicians award the participant that year.

Suspension and termination of participation

A HOP participant's participation is to cease if any of the following applies:

(1) Unless the participant is pregnant, a monthly installment payment to the participant's Buckeye account is 60 days late.

(2) The participant fails to submit documentation needed for a Medicaid eligibility redetermination before the 61st day after the documentation is requested.

(3) The participant becomes eligible for Medicaid on a basis other than being included in the covered families and children eligibility group or Group VIII.

(4) The participant becomes a ward of the state.

(5) The participant ceases to be eligible for Medicaid.

(6) The participant exhausts the $300,000 annual or $1 million lifetime payout limit.

(7) The participant requests that the participant's participation be terminated.

A participant who ceases to participant because of a late monthly installment payment or failure to timely submit documentation needed for an eligibility redetermination cannot resume participation in HOP until the former participant pays the full amount of the monthly installment payment or submits the documentation needed for the former participant's Medicaid eligibility redetermination. The former participant is not to be transferred to the fee-for-service component of Medicaid or the care management system as a result of ceasing to participate in HOP for either of these reasons.

Except when a transfer to a bridge account is to be made, a participant is to be provided the contributions that are in the participant's Buckeye account when the participant ceases to participate in HOP. (See "**Buckeye account transferred to bridge account**" below.)

Exhausting payout limits

If a HOP participant exhausts the $300,000 annual or $1 million lifetime payout limits, the participant is to be transferred to the fee-for-service component of Medicaid or the care management system. A participant who exhausts the annual payout limit for

a year is to resume participation at the beginning of the immediately following year if the participant continues to meet the conditions for participation.

Buckeye account transferred to bridge account

If a HOP participant ceases to qualify for Medicaid due to increased family countable income and purchases a health insurance policy or obtains health care coverage under an eligible employer-sponsored health plan, the amount remaining in the participant's Buckeye account is to be transferred to a bridge account. The amount transferred may be used only to pay for the following:

(1) If the participant has purchased a health insurance policy, the participant's costs in purchasing the policy and paying for the participant's out-of-pocket expenses under the policy for health care services and prescription drugs covered by the policy;

(2) If the participant obtained health care coverage under an eligible employer-sponsored health plan, the participant's out-of-pocket expenses under the plan for health care services and prescription drugs covered by the plan.

Only the amount remaining in a participant's Buckeye account at the time the participant ceases to participate in HOP is to be deposited into a bridge account. The bridge account must be closed once the amount transferred is exhausted.

The ODM Director is required to notify a participant when a bridge account is established for the participant.

Referrals to workforce development agencies

The act requires each CDJFS to offer to refer to a workforce development agency each HOP participant who resides in the county served by the CDJFS and is either unemployed or employed for less than an average of 20 hours per week. The referral must include information about the workforce development activities available from the workforce development agency. A participant is permitted to refuse to accept the referral and to participate in the workforce development activities without any effect on the participant's eligibility for, or participation in, HOP.

HCAP

(R.C. 5168.01, 5168.06, 5168.07, 5168.10, 5168.11, and 5168.12 (repealed); Sections 610.10 and 610.11)

The act continues the Hospital Care Assurance Program (HCAP) for two additional years. HCAP was scheduled to end October 16, 2015, but under the act, is to continue until October 16, 2017. 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.

The act eliminates a requirement for a portion of the money generated by the HCAP assessments and intergovernmental transfers to be deposited into the Legislative Budget Services Fund and repeals the law creating the fund. Under prior law, ODM was required to deposit into that fund an amount equal to the amount by which the biennial appropriation from the fund exceeded the amount of unexpended, unencumbered money in the fund. The money for the deposits was to come from the first installment of the HCAP assessments and intergovernmental transfers made during a year.

The act requires that any money remaining in the Legislative Budget Services Fund on September 29, 2015, be used solely for the purpose stated in that law. The law states that the fund can be used solely to pay the expenses of LSC's Legislative Budget Office. The act abolishes the fund when all the money in it has been spent.

Hospital franchise permit fees

(R.C. 5168.23 and 5168.26; Sections 610.10 and 610.11)

The act continues the assessments imposed on hospitals for two additional years, ending October 1, 2017, rather than October 1, 2015. The assessments are in addition to HCAP, but like HCAP, they raise money to help pay for the Medicaid program. To distinguish the assessments from HCAP, the assessments are sometimes called hospital franchise permit fees.

Under prior law and unless ODM adopted rules establishing a different payment schedule, each hospital was required to pay its assessment for a year in accordance with the following schedule:

(1) 28% was due on the last business day of October;

(2) 31% was due on the last business day of February;

(3) 41% was due on the last business day of May.

The act eliminates this payment schedule and instead requires ODM to establish a payment schedule for each year. ODM is required to consult with the Ohio Hospital

Association before establishing the payment schedule for a year and to include the payment schedule in each preliminary determination notice of the assessment that continuing law requires ODM to mail to hospitals.

Nursing homes' and hospital long-term care units' franchise permit fees

(R.C. 5168.40, 5168.44, 5168.45, 5168.47, 5168.48, 5168.49, and 5168.53)

The act revises the law governing the annual franchise permit fees that nursing homes and hospital long-term care units are assessed. The fees are a source of revenue for nursing facility services and HCBS covered by the Medicaid program and the Residential State Supplement program.

Bed surrenders

Under continuing law, ODM is required to redetermine each nursing home's and hospital long-term care unit's franchise permit fee for a year if one or more bed surrenders occur during the period beginning on the first day of May of the preceding calendar year and ending on the first day of January of the calendar year in which the redetermination is made. The act revises what constitutes a bed surrender. In the case of a nursing home, a bed surrender does not occur unless a bed's removal from its licensed capacity is done in a manner that, in addition to reducing the total licensed capacity of all nursing homes, makes it impossible for the bed to ever be a part of any nursing home's licensed capacity. In the case of a hospital long-term care unit, a bed surrender does not occur unless a bed's removal from registration as a skilled nursing facility bed or long-term care bed is done in a manner that, in addition to reducing the total number of hospital beds registered as such, makes it impossible for the bed to ever be registered as a skilled nursing facility bed or long-term care bed.

Notices of fees and redeterminations

Under continuing law, ODM is required to notify each nursing home and hospital long-term care unit of the amount of its franchise permit fee for a year not later than the first day of each October. ODM must notify each nursing home and hospital long-term care unit of its redetermined franchise permit fee due to bed surrenders not later than the first day of each March. If a nursing home or hospital long-term care unit requests an appeal regarding its franchise permit fee, ODM must notify the nursing home or hospital of the date, time, and place of the hearing.

Prior law required ODM to mail these notifications to nursing homes and hospital long-term care units. The act requires that these notices be provided electronically or by the U.S. Postal Service.

Home care services contracts (VETOED)

(R.C. 121.36)

The Governor vetoed a provision that would have added ODM to a provision of law that requires, for contracts for home care services paid for with public funds, that the provider of those services have a system for monitoring the delivery of the services by the provider's employees. Law unchanged by the act requires the departments of Developmental Disabilities, Aging, Job and Family Services, and Health to ensure that this requirement is met. ODM did not exist at the time that provision was originally enacted.[131]

Annual report on Medicaid effectiveness

(R.C. 5162.13)

The act requires additional information to be included in an annual report that ODM must complete under continuing law on Medicaid's effectiveness in meeting the needs of low-income pregnant women, infants, and children. The additional information to be included is:

--The actual number of enrolled pregnant women categorized by estimated gestational age at time of enrollment; and

--The rates at which enrolled pregnant women receive addiction or mental health services, progesterone therapy, and any other service ODM specifies.

Graduate Medical Education Study Committee

(Section 327.320)

The act creates the Graduate Medical Education Study Committee for the purpose of studying the issue of Medicaid payments to hospitals for the costs of graduate medical education. The Committee must include in its study the feasibility of targeting the payments in a manner that rewards graduates of medical schools of colleges and universities located in Ohio who practice medicine and surgery or osteopathic medicine and surgery in this state for at least five years after graduation.

The Committee is to consist of all of the following:

(1) The Executive Director of the Office of Health Transformation;

[131] See H.B. 59 of the 130th General Assembly.

(2) The ODM Director;

(3) The Chancellor of Higher Education;

(4) Four deans of medical schools of Ohio colleges and universities, appointed by the President of the Senate;

(5) Four presidents of Ohio colleges and universities that have medical schools, appointed by the Speaker of the House;

(6) The chief executive officers of the Ohio State Medical Association, the Ohio Osteopathic Association, the Ohio Hospital Association, and the Ohio Children's Hospital Association.

The appointments must be made by July 15, 2015. A member of the Committee may designate an individual to serve in the member's place for one or more meetings. Members are to serve without compensation or reimbursement, except to the extent that serving on the Committee is part of their usual job duties.

The Executive Director of the Office of Health Transformation is to serve as the Committee's chairperson. ODM must provide the Committee all support services it needs.

The Committee must complete a report about its study by December 31, 2015. Copies of the report must be submitted to the Governor, General Assembly, and JMOC. The Committee ceases to exist on submission of the report.

Medicaid waiver for married couple to retain eligibility (VETOED)

(R.C. 5166.33 (primary) and 5166.01)

The Governor vetoed a provision that would have required ODM to establish a Medicaid waiver program under which Medicaid recipients who are married to each other would have retained eligibility for Medicaid despite one of the recipients having earnings from employment that cause the recipients to have countable family income exceeding the income eligibility threshold for the eligibility group, or groups, under which the recipients qualify for Medicaid. To retain Medicaid eligibility, both of the following would have to have applied:

(1) One of the recipients would have had to qualify to participate in the Medicaid Buy-In for Workers with Disabilities Program (Buy-In Program) if not for a disability that, according to a physician's written evaluation, is too severe for the recipient to have earnings from employment or to be an employed individual with a medically improved disability.

(2) The other recipient's earnings from employment could not have caused the recipients to have countable family income, determined in the same manner as income is determined for the Buy-In Program, exceeding 250% of the federal poverty line.

The Buy-In Program is the component of Ohio's Medicaid program under which Medicaid covers (1) individuals who are at least 16 but not more than 65 years of age and would be considered to be receiving Supplemental Security Income benefits if not for earnings that exceed a certain amount and (2) employed individuals with a medically improved disability.[132]

Medicaid Recipients' ID and Benefits Cards Workgroup

(Section 751.30)

The act creates the Workgroup to Study the Feasibility of Medicaid Recipients' ID and Benefits Cards, consisting of the following 11 members:

(1) The Director of Public Safety or the Director's designee;

(2) The Medicaid Director or the Director's designee;

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

(4) The Director of Development Services or the Director's designee;

(5) The Director of Developmental Disabilities or the Director's designee;

(6) The Superintendent of Public Instruction or the Superintendent's designee;

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

(8) The Director of Insurance or the Director's designee;

(9) The Director of Job and Family Services or the Director's designee;

(10) The Director of Mental Health and Addiction Services or the Director's designee; and

(11) The Executive Director of Opportunities for Ohioans with Disabilities or the Executive Director's designee.

[132] 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and (XVI).

The Director of Public Safety or the Director's designee must serve as chairperson of the Workgroup, and the Department of Public Safety is required to provide staff and all other support functions for the Workgroup.

In order to reduce enrollee and provider fraud and abuse, the Workgroup is required to evaluate the feasibility of using state-issued licenses and identification cards to establish an individual's eligibility for all state public assistance programs and benefits under them, such as Medicaid, the Home Energy Assistance Program, the Supplemental Nutrition Assistance Program, the Temporary Assistance for Needy Families program, and child care. Upon conclusion of the evaluation, the Workgroup must develop findings and formulate recommendations.

Not later than July 1, 2018, the Workgroup is required to submit to the General Assembly a report that contains its findings and recommendations. The Workgroup must submit the report in accordance with the provisions of continuing law that govern the submission of reports to the General Assembly. Upon submission of the report, the Workgroup ceases to exist.

Health and Human Services Fund

(Section 751.40)

The act creates the Health and Human Services Fund in the state treasury, consisting of money appropriated and transferred to it. The Fund is to be used to pay any costs associated with programs or services provided by the state to enhance the public health and overall health care quality of citizens of this state. The act requires the Director of Budget and Management to transfer any unexpended, unobligated cash that remains in the Fund as of June 30, 2017, to the Budget Stabilization Fund.