DEPARTMENT OF MEDICAID

Coverage of optional eligibility groups (VETO OVERRIDDEN)

- Eliminates the Medicaid program's authority to cover an optional eligibility group if state statutes do not address whether the program may cover the group, but permits the program to cover an optional eligibility group that is currently covered (VETO OVERRIDDEN).

- Prohibits the Medicaid program from covering an optional eligibility group that it does not currently cover unless state statutes either require the group or expressly permit the group to be covered (VETO OVERRIDDEN).

Eligibility for expansion group (PARTIALLY VETOED)

- Would have prohibited new enrollment in the Medicaid expansion group beginning July 1, 2018 (VETOED).

- Would have prohibited continuing enrollment in the expansion group if an individual ceased to meet eligibility requirements or the federal government reduced its share of Medicaid expenditures (VETOED).

- Would have exempted from the two prohibitions described above individuals who have a mental illness or drug addiction (VETOED).

- Requires the Medicaid Director to establish a waiver program under which an individual included in the Medicaid expansion group must satisfy additional requirements to be eligible for Medicaid.

Medicaid provider enrollment system

- Requires the Ohio Department of Medicaid (ODM) to revise, by December 31, 2018, the system by which government and private entities become and remain Medicaid providers.

Ohio Access Success Project

- Abolishes the Ohio Access Success Project on January 1, 2019.

- Requires ODM, before that date, to transfer Medicaid recipients enrolled in the project to the Helping Ohioans Move, Expanding (HOME) Choice program or another Medicaid waiver program that provides home and community-based services.

State plan home and community-based services

- Permits the Medicaid program to continue to cover state plan home and community-based services beyond July 1, 2017.

Payment rates (PARTIALLY VETOED)

- Would have prohibited the implementation of a proposal to increase a Medicaid payment rate if (1) the proposal was not submitted to the Joint Medicaid Oversight Committee (JMOC), (2) JMOC voted to prohibit implementation, or (3) the General Assembly adopted a concurrent resolution prohibiting implementation (VETOED).

- Repeals a provision prohibiting Medicaid payments for services provided by a noninstitutional provider from exceeding the payment limits for the same services under Medicare.

- Requires ODM to rebase nursing facilities' cost centers at least once every five state fiscal years, instead of no more than once every ten years, and requires each cost center to be rebased for the same state fiscal years (VETO OVERRIDDEN).

- Allows, instead of prohibiting, the use of the index maximizer element of the grouper methodology used in determining nursing facilities' case-mix scores (VETO OVERRIDDEN).

- Changes the quality indicators used for the quality portion of nursing facilities' rates (VETO OVERRIDDEN).

- Requires that a new nursing facility's initial rate for tax costs be determined by dividing its projected tax costs for the calendar year in which it begins to participate in Medicaid by a 100% imputed occupancy rate if the facility submits the projected tax costs to ODM (VETO OVERRIDDEN).

- Adjusts, beginning in FY 2020, nursing facilities' rates by an amount equal to the difference between the Medicare skilled nursing facility market basket index and a budget reduction adjustment factor (VETO OVERRIDDEN).

- States the General Assembly's intent to enact laws that specify the budget reduction adjustment factor for each state fiscal year (VETO OVERRIDDEN).

- Sets the budget reduction adjustment factor at zero for a state fiscal year if the General Assembly fails to enact such a law for that year (VETO OVERRIDDEN).

- Caps the total payments for nursing facility services provided under Medicaid fee-for-service and the Integrated Care Delivery System (i.e., MyCare Ohio) at $2,659,167,368 for FY 2018 and $2,664,485,703 for FY 2019.

- Requires that nursing facilities' rates be decreased as necessary to ensure that the total payments equal those capped amounts (VETO OVERRIDDEN).

- Provides for the default Medicaid rate for nursing facility services determined under the alternative purchasing model to be 34%, instead of 60%, of the statewide average of the Medicaid rate for long-term acute care hospital services.

- Would have required the Medicaid payment rates for hospital services provided during FYs 2018 and 2019 to equal the rates that were in effect for those services on January 1, 2017 (VETOED).

- Requires that the Medicaid rates for certain neonatal and newborn services equal 75% of the Medicare rates for the services (VETO OVERRIDDEN).

- Requires that Medicaid rates for other services selected by the Medicaid Director be reduced to avoid an increase in Medicaid expenditures that would otherwise result from the requirements regarding the rates for neonatal and newborn services (VETO OVERRIDDEN).

- Requires ODM to establish a maximum Medicaid rate for vision care services provided during the period beginning January 1, 2018, and ending July 1, 2019, unless there are no claims data available to ODM needed to establish the rate.

- Prohibits a payment methodology for vision care services provided during that period from relying on a vision care service provider's charged amount.

- Reduces the Medicaid rates for noninstitutional laboratory, radiology, and pathology services by 5% for the period beginning January 1, 2018, and ending July 1, 2019.

Delayed implementation of behavioral health redesign

- Requires ODM and the Department of Mental Health and Addiction Services to conduct a beta test before implementing updates to Medicaid billing codes or payment rates for community behavioral health services as part of the behavioral health redesign.

- Prohibits certain elements of the behavioral health redesign from being implemented before the later of January 1, 2018, or the date the beta test requirement is satisfied.

- Requires the departments, by October 1, 2017, as part of implementing those elements of the redesign, to adopt rules and make available to the public provider manuals, claims instructions, information technology resources, and other educational and training documents.

Medicaid managed care (PARTIALLY VETOED)

- Would have prohibited home and community-based waiver services and nursing facility services from being included in the Medicaid managed care system (VETOED).

- Establishes a temporary study committee to examine the merits of including such services in the system.

- Would have required the General Assembly to consider and vote, on legislation that would authorize the inclusion of such services in the system (VETOED).

- Would have provided for an ongoing advisory committee to be established to advise the Joint Medicaid Oversight Committee on projects concerning the delivery of such services if the General Assembly enacts the legislation (VETOED).

- Prohibits alcohol, drug addiction, and mental health services from being included in the system before July 1, 2018 (VETO OVERRIDDEN).

- Requires ODM, if it adds to the system during FYs 2018 and 2019 more Medicaid recipients who are aged, blind, disabled, or also enrolled in Medicare, to take certain actions regarding the duties of area agencies on aging relative to home and community-based waiver services.

- Exempts from Medicaid managed care prior authorization requirements certain psychiatric drugs that are prescribed by an advanced practice registered nurse who is certified in psychiatric mental health by a national certifying organization.

- Modifies the definition of "qualified community hub" for purposes of law governing required services that Medicaid managed care organizations must provide to pregnant women or women capable of becoming pregnant.

- Authorizes the services described above to be provided by a public health nurse in lieu of or in addition to community health worker services provided by certified community health workers.

- Authorizes a public health nurse (in addition to a physician or licensed health professional specified in rules adopted by the Medicaid Director) to recommend that a Medicaid recipient receive the services described above.

- Increases to 5% (from 2%) the maximum amount of Medicaid managed care organization premiums that may be withheld by ODM for purposes of the Managed Care Performance Payment Program for FY 2018 and thereafter.

- Would have provided for 1% to be withheld for FY 2019 (VETOED).

- Prohibits ODM from implementing during the FY 2018-2019 biennium a program under which Medicaid managed care organizations receive incentives for helping Medicaid recipients attending low-performing primary schools to improve their academic performance.

Waiver for services at institutions for mental diseases (VETOED)

- Would have required ODM to create a Medicaid waiver component to provide services to eligible individuals between the ages of 21 and 64 at hospitals and other facilities larger than 16 beds that are primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases (VETOED).

- Would have required ODM to participate in the federal Innovation Accelerator Program to determine where, when, and how services are to be provided under the waiver component (VETOED).

Retention or collection of federal financial participation

- Permits, rather than requires, ODM to retain or collect a portion of the federal financial participation obtained by a state agency or political subdivision for administering a component of the Medicaid program that was federally approved on or after January 1, 2002.

Third-party liability

- Requires a liable third party to respond to an ODM request for payment of a claim within 90 business days of receiving written proof of the claim.

- Clarifies that the amount owed for care rendered to a Medicaid recipient enrolled in a Medicaid managed care organization with a provider capitation agreement is the amount the organization would have paid in the absence of an agreement.

- Authorizes ODM, when it has assigned its right of recovery to a Medicaid managed care organization, to recoup from a liable third party (beginning one year from the date the organization paid the claim) the amount the organization has not collected.

Franchise fee on health insuring corporation plans (PARTIALLY VETOED)

- Imposes, for the purpose of raising revenues to pay Medicaid providers and Medicaid managed care organizations, a franchise fee on health insuring corporation plans that make basic health care services available.

- Would have required the Medicaid Director to seek federal approval to increase the amount of the franchise fee for the purpose of mitigating the effects to counties and transit authorities of Medicaid health insuring corporation transactions ceasing to be sales for the purpose of state sales tax laws (VETOED).

Hospital Care Assurance Program and hospital franchise permit fee

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

Drug dispensing fees

- Permits the Medicaid Director to establish dispensing fees that vary by terminal distributor of dangerous drugs.

Recovery of overpayments (VETOED)

- Would have reduced from five to three the number of years ODM had to notify a nursing facility or intermediate care facility for individuals with intellectual disabilities of certain Medicaid overpayments (VETOED).

Fraud, waste, and abuse

- Requires a contract between ODM and a Medicaid managed care organization to address issues of fraud, waste, and abuse in the Medicaid program.

- Provides civil immunity for a Medicaid managed care organization that furnished information to ODM regarding potential fraud, waste, and abuse in the Medicaid program.

- Requires ODM to collect information from other government agencies regarding fraud, waste, and abuse in the Medicaid program.

Retained Applicant Fingerprint Database

- Permits ODM to participate in the Bureau of Criminal Identification and Investigation's Retained Applicant Fingerprint Database system ("Rapback") to receive notices about the arrests, convictions, and guilty pleas of independent Medicaid providers of home and community-based services.

- Eliminates a requirement that such an independent provider annually undergo a Bureau-conducted criminal records check if ODM participates in the system.

Controlling Board authority, Medicaid expenditures (PARTIAL VETO OVERRIDDEN)

- Provides for the Health and Human Services Fund to continue to exist for the FY 2018-2019 biennium.

- Permits the Medicaid Director to request that the Controlling Board authorize expenditures from the Fund in an amount necessary to pay for the Medicaid program's costs during the FY 2018-2019 biennium (VETO OVERRIDDEN).

- Permits the Controlling Board to authorize the expenditure unless Congress amends federal law to reduce the federal match for the expansion eligibility group (also known as Group VIII) (VETO OVERRIDDEN).

Residents Protection Fund

- Requires that fines imposed by the federal government against home health agencies for failure to comply with Medicaid participation requirements be deposited into the Residents Protection Fund when disbursed to ODM on or after July 1, 2017 and used to improve the quality of certain Medicaid services.

Refunds and Reconciliation Fund

- Provides for the continued deposit into the Refunds and Reconciliation Fund refunds and reconciliations for which ODM does not initially know the appropriate fund or that are to go to another government entity.

Health Care Services Administration Fund

- Abolishes the Health Care Services Administration Fund and provides for money that would otherwise be deposited into it be deposited instead into the Health Care/Medicaid Support and Recoveries Fund.

Integrated Care Delivery System performance payments

- For FYs 2018 and 2019, requires ODM to make performance payments to Medicaid managed care organizations that provide care to participants of the Integrated Care Delivery System, and requires ODM to withhold a percentage of their premium payments for the purpose of providing the performance payments.

Nursing facility demonstration project

- Extends until June 30, 2019, a Medicaid demonstration project under which recipients receive nursing facility services in lieu of hospital inpatient services in a freestanding long-term care hospital.

- Provides for one nursing facility in Brown County, and another nursing facility in Sandusky County, to be added to the demonstration project.

- Eliminates a requirement that a nursing facility have been initially constructed, licensed to operate, and certified to participate in Medicaid after 2009 to participate in the demonstration project.

Nursing facility bed conversion pilot

- Requires ODM to operate a pilot program during FYs 2018 and 2019 under which nursing facility beds located in Cuyahoga County may voluntarily be converted for use for substance use disorder treatment services.

Care Innovation and Community Improvement Program

- Requires the Medicaid Director to establish the Care Innovation and Community Improvement Program for the FY 2018-2019 biennium.

- Permits a nonprofit hospital agency affiliated with a state university and a public hospital agency to participate in the Program if it operates a hospital that has a Medicaid provider agreement.

- Provides for each participating agency to receive supplemental Medicaid payments for physician and other professional services.

Healthy Ohio Program (PARTIALLY VETOED)

- Declares the General Assembly's intent to use the Healthy Ohio Program as a model if Congress transforms the Medicaid program into a federal block grant.

- Would have required the Medicaid Director to resubmit not later than January 31, 2018, a request for a federal Medicaid waiver needed to implement the Healthy Ohio Program (VETOED).

State agency collaboration

- Extends to FYs 2018 and 2019 pre-existing provisions that authorize the Office of Health Transformation Executive Director to facilitate collaboration between certain

state agencies for health transformation purposes and authorize the exchange of personally identifiable information regarding a health transformation initiative.

Temporary authority regarding employees

- Extends through July 1, 2019, the Medicaid Director's authority to establish, change, and abolish positions for ODM and to assign, reassign, classify, reclassify, transfer, reduce, promote, or demote employees who are not subject to collective bargaining.

Coverage of optional eligibility groups (VETO OVERRIDDEN)

(R.C. 5163.03 (primary) and 5162.021)

Federal Medicaid law requires states' Medicaid programs to cover certain eligibility groups (mandatory eligibility groups) and permits states' Medicaid programs to cover certain other groups (optional eligibility groups).

The act restricts the Medicaid program's authority to cover additional optional eligibility groups. The Medicaid program is no longer permitted to cover any optional eligibility group that state statutes do not address whether the program may cover. Instead, it is permitted to cover only optional eligibility groups that it already covers. Also, it is prohibited from covering any optional eligibility group not already covered unless state statutes either require or expressly permit the group to be covered. The General Assembly overrode the Governor's veto of this provision.

Eligibility for expansion group (PARTIALLY VETOED)

(R.C. 5163.01, 5163.15, 5166.01, 5166.37, 5166.40, and 5166.405; Section 333.271)

The Governor vetoed a provision that would have prohibited, with certain exceptions, the Medicaid program from covering the expansion eligibility group on or after July 1, 2018. An individual enrolled on June 30, 2018, in Medicaid on the basis of being included in the expansion eligibility group would have been permitted to continue to be enrolled until the earlier of (1) the date the individual ceased to meet Medicaid eligibility requirements or (2) the date, if any, that a reduction in the federal match for the expansion eligibility group took effect if federal legislation enacted on or after July 1, 2018, reduced the federal match. Neither provision would have applied to an individual with a mental illness or drug addiction.

The act requires the Medicaid Director to establish a Medicaid waiver that establishes additional eligibility requirements for members of the Medicaid expansion

group. Under the waiver, a member of the expansion group also must satisfy at least one of the following requirements to be eligible for Medicaid:

(1) Be at least age 55;

(2) Be employed;

(3) Be enrolled in school or an occupational training program;

(4) Be participating in an alcohol and drug addiction treatment program;

(5) Have intensive physical health care needs or serious mental illness.

Medicaid provider enrollment system

(R.C. 5164.29)

The act requires the Department of Medicaid (ODM) to develop and implement revisions to the system by which government and private entities become and remain Medicaid providers. The revisions must be developed and implemented not later than December 31, 2018. ODM must create a single system of records for the Medicaid provider system and enable government and private entities to become and remain Medicaid providers for any part of the Medicaid program, including parts administered by other state or local agencies, without having to submit duplicate data to the state. The departments of Aging, Developmental Disabilities, and Mental Health and Addiction Services must participate in the development of the revisions and use the revised system.

Ohio Access Success Project

(R.C. 5166.35; Section 333.200)

The act abolishes the Ohio Access Success Project on January 1, 2019. The project helps Medicaid recipients transition from residing in nursing facilities to residing in community settings. ODM must transfer all Medicaid recipients enrolled in the project to the HOME Choice program or, if that program is integrated into a Medicaid waiver program covering home and community-based services, to the same or another Medicaid waiver program. The transfers must be made before January 1, 2019.

State plan home and community-based services

(R.C. 5164.10 with conforming changes in R.C. 5164.01; Section 333.160)

The act permits the Medicaid program to continue to cover one or more state plan home and community-based services. Prior authority to cover these state plans services expired July 1, 2017.[112] These state plan services are optional under federal law and, unlike the other home and community-based services that Medicaid covers, do not require a federal waiver.[113] To make this authority ongoing, the act codifies it (i.e., places the authority in the Revised Code). The act also makes revisions. The codification and revisions take effect September 29, 2017. Until then, the act permits Medicaid to continue to cover the state plan services in the same manner that it covered the services during FYs 2016 and 2017.

Under the act's revisions, ODM must select which state plan home and community-based services that Medicaid will cover. A Medicaid recipient may receive a state plan service if the recipient has countable income not exceeding 225% of the federal poverty line, has a medical need for the service, and meets all other eligibility requirements to be specified in rules. In contrast, the authority to cover the state plan services that expired July 1, 2017 limited eligibility to Medicaid recipients who had behavioral health issues and countable incomes not exceeding 150% of the federal poverty line. As under the expired authority, a Medicaid recipient is not required to undergo a level of care determination.

Legislative oversight of Medicaid rate increases (VETOED)

(R.C. 5164.69 (primary), 103.41, 103.417, 5162.021, 5164.02, and 5164.021)

The Governor vetoed a provision that would have prohibited ODM and other state agencies that administer part of the Medicaid program on ODM's behalf from increasing the Medicaid payment rate for a service, by rule or otherwise, under certain circumstances.[114]

A proposal to increase the rate for a service would have been prohibited from being implemented if ODM or the other state agency failed to submit the proposal to the Joint Medicaid Oversight Committee (JMOC). If a proposal was to be implemented in part or whole by rule, ODM or the other state agency would have been required to

---

[112] Section 327.190 of Am. Sub. H.B. 64 of the 131st General Assembly.

[113] 42 U.S.C. 1396n(i).

[114] On July 6, 2017, the House voted to override the Governor's veto of this item. The Senate had not acted on the override when this analysis was published.

include with the proposal a copy of the proposed rule as filed in final form under the Administrative Procedure Act (R.C. Chapter 119.). JMOC would have been required, not later than 30 days after receiving the proposal, to conduct a public hearing on the proposal and vote on whether to permit or prohibit the proposal's implementation. The proposal could not have been implemented if JMOC voted by the deadline to prohibit implementation. The proposal also could not have been implemented if the General Assembly, not later than 90 days after JMOC's deadline, adopted a concurrent resolution prohibiting implementation. The General Assembly's authority to adopt the concurrent resolution would have applied regardless of whether JMOC voted to permit the proposal's implementation or failed to vote before its deadline. These prohibitions would have applied to a proposal to increase a Medicaid payment rate regardless of whether it involved a change to the method by which the rate was to be determined or specified the actual amount of the rate increase.

To give JMOC and the General Assembly time to prohibit implementation of a proposed Medicaid rate increase, the effective date for a rule increasing a Medicaid rate could not be earlier than the 121st day after the rule was filed in final form under the Administrative Procedure Act.

Medicaid payment limits for noninstitutional providers

(R.C. 5164.70; Section 333.180)

The act repeals a provision prohibiting Medicaid payments for services provided by a noninstitutional provider from exceeding the payment limits for the same services under Medicare. For purposes of this provision, a noninstitutional provider is a Medicaid provider other than a hospital, nursing facility, or ICF/IID.

Medicaid rates for nursing facility services (VETO OVERRIDDEN)

(R.C. 5165.01, 5165.106, 5165.15, 5165.151, 5165.153, 5165.154, 5165.16, 5165.17, 5165.19, 5165.192, 5165.21, 5165.23, 5165.25, 5165.34, 5165.36, 5165.361, 5165.37, 5165.41, 5165.42, and 5165.52)

The act revises the formula to determine Medicaid payment rates for nursing facility services. The General Assembly overrode the Governor's veto of the revisions.

The formula has several components. There are four separate cost centers (ancillary and support costs, capital costs, direct care costs, and tax costs) and a quality payment. For nursing facilities that qualify as critical access nursing facilities, there is also a critical access incentive payment. Specific dollar amounts are added and subtracted to the sum of the amounts determined for the different components.

Rebasings

A rebasing is a redetermination of nursing facilities' cost centers using information from Medicaid cost reports for a calendar year that is later than the calendar year used for the previous rebasing. Under prior law, ODM was not required to conduct a rebasing more than once every ten years. The act instead requires ODM to conduct a rebasing at least once every five fiscal years. It also requires ODM, when conducting a rebasing for a fiscal year, to conduct the rebasing for each cost center.

Index maximizer element

Determining a nursing facility's Medicaid payment rate for direct care costs includes a process under which case-mix scores are determined for the nursing facility. As part of the process, ODM must use a modified version of the grouper methodology used on June 30, 1999, by the U.S. Department of Health and Human Services for prospective payment of skilled nursing facilities under the Medicare program. Prior law prohibited ODM from using the methodology's index maximizer element. The act permits ODM to use it.

Quality payments

Nursing facilities earn quality payments by meeting quality indicators. The amount of a nursing facility's quality payment depends on the number of quality indicators the nursing facility meets. A nursing facility must meet at least one quality indicator to get a quality payment and the nursing facilities that meet all of the quality indicators receive the largest quality payments.

The act revises the quality indicators. There were five quality indicators under prior law. There are seven under the act.

Under prior law, a nursing facility met one of the quality indicators if not more than a target percentage of its short-stay residents had new or worsened pressure ulcers, and not more than a target percentage of long-stay (more than 100 days) residents at high risk for pressure ulcers had pressure ulcers. The act separates this single indicator into two quality indicators.

The act also separates into two quality indicators an indicator concerning antipsychotic medication. Under prior law, a nursing facility met this indicator if not more than a target percentage of its short-stay residents newly received an antipsychotic medication *and* not more than a target percentage of long-stay residents received that medication. In determining whether a nursing facility meets these quality indicators, the act requires ODM to exclude residents receiving hospice care.

Whereas prior law gave ODM the authority to specify the target percentage to be used for the quality indicators discussed above, the act sets the target percentage at the 40th percentile of nursing facilities that have data for the quality indicators.

The act eliminates a quality indicator concerning the number of residents who had avoidable inpatient hospital admissions, and adds an indicator concerning the percentage of long-stay residents who had an unplanned weight loss. ODM must set the target percentage at the 40th percentile of nursing facilities that have data for the quality indicators. Two other quality indicators are unchanged by the act.

Critical access nursing facilities

The act eliminates provisions of the law governing critical access nursing facilities that were intended to be eliminated by the main operating budget act for the FY 2016-2017 biennium, H.B. 64 of the 131st General Assembly, but were apparently inadvertently line-item vetoed by the Governor. The eliminated provisions referenced other provisions of law that no longer exist.

New nursing facilities' initial rate for tax costs

The method used to determine the initial Medicaid payment rates for new nursing facilities differs from the method used to determine the rates for other nursing facilities, because ODM does not have Medicaid cost reports and certain other information for the new nursing facilities. The initial rate is adjusted at the beginning of the next fiscal year to reflect new rate calculations for all nursing facilities.

The act provides for a new nursing facility's initial rate for tax costs to be determined by dividing its projected tax costs for the calendar year in which it begins to participate in Medicaid by a 100% imputed occupancy rate *if the nursing facility submits the projected tax costs to ODM*. If a nursing facility does not submit the projected tax costs, its initial rate for tax costs is the median rate for tax costs for the peer group in which it is placed for determining its rates for ancillary and support costs. Under prior law, all new nursing facilities' initial rates for tax costs were those median rates.

Market basket index and budget reduction adjustment factor

One of the revisions the act makes to the formula concerns a $16.44 add-on, which became part of the formula on July 1, 2016. The act maintains the add-on for FYs 2018 and 2019. Beginning with the first fiscal year in a group of consecutive fiscal years for which a rebasing is conducted after FY 2020, the add-on is the amount of the add-on for the preceding fiscal year. (See "**Rebasings**" above.) For other fiscal years beginning with 2020, the add-on is the sum of the following:

(1) The amount of the add on for the immediately preceding fiscal year;

(2) The difference between (a) the Medicare skilled nursing facility market basket index determined for the federal fiscal year that began during the state fiscal year preceding the state fiscal year for which the rate is being determined and (b) the budget reduction adjustment factor for the fiscal year for which the rate is being determined.

The act states that it is the General Assembly's intent to specify in statute the factor to be used for a fiscal year as the budget reduction adjustment factor. That factor cannot exceed the Medicare skilled nursing facility market basket index determined for the federal fiscal year that begins during the state fiscal year preceding the fiscal year for which the factor is being determined. If the General Assembly fails to specify the factor in statute, the budget reduction adjustment factor is zero.

The act also provides for the difference between the Medicare skilled nursing facility market basket index and the budget reduction adjustment factor to be part of the manner in which the rates for the cost centers are determined beginning with FY 2020, other than the first fiscal year in a group of consecutive fiscal years for which a rebasing is conducted.

Caps on nursing facility payments

(Section 333.165)

Amount of caps

The act provides that the total amount of payments made by ODM under the fee-for-service component of the Medicaid program and by Medicaid managed care organizations under the Integrated Care Delivery System (i.e., MyCare Ohio) for nursing facility services provided during FYs 2018 and 2019 cannot exceed the following:

(1) For FY 2018, $2,659,167,368;

(2) For FY 2019, $2,664,485,703.

Possible rate reductions (VETO OVERRIDDEN)

ODM must do all of the following in conjunction with LeadingAge Ohio, the Academy of Senior Health Sciences, and the Ohio Health Care Association:

(1) Monitor the payments made under Medicaid fee-for-service and the Integrated Care Delivery System for nursing facility services provided during those fiscal years;

(2) Beginning with the calendar quarter ending December 31, 2017, and each calendar quarter thereafter during FY 2018 and FY 2019, project whether the total payments to be made for the fiscal year will exceed the cap the act sets for the fiscal year;

(3) If the total payments to be made for FY 2018 or FY 2019 are projected to exceed the cap for the fiscal year, determine the percentage by which each nursing facility's rate under Medicaid fee-for-service and the Integrated Care Delivery System need to be reduced for the following calendar quarter to ensure that the total payments for the fiscal year will equal the cap for the fiscal year.

If a rate reduction has to be made, each nursing facility's rate must be reduced by the percentage so determined. The reduction is to take effect on the first day of the following calendar quarter and ODM must notify LeadingAge Ohio, the Academy of Senior Health Sciences, and the Ohio Health Care Association of the percentage reduction at least 30 days before it is to take effect.

The General Assembly overrode the Governor's veto of these requirements.

Alternative purchasing model for nursing facility services

(R.C. 5165.157)

The act modifies the alternative method for determining the Medicaid rate for nursing facility services provided to Medicaid recipients with specialized health care needs by discrete units of nursing facilities. ODM must set the alternative rate at either a certain percentage of the statewide average Medicaid rate for long-term acute care hospital services or another amount determined in accordance with a methodology that includes improved health outcomes as a factor. Prior law set the percentage at 60%. The act lowers the percentage to 34%.

Medicaid rates for hospital services (VETOED)

(Section 333.240)

The Governor vetoed a provision that generally would have required the Medicaid payment rate for a hospital service provided between July 1, 2017, and June 30, 2019, to equal the rate for the same type of service that was in effect on January 1, 2017. An exception would have applied for any rate change resulting from a hospital payment rate rebasing or recalibration by ODM on July 1, 2017.

Medicaid rates for neonatal and newborn services (VETO OVERRIDDEN)

(R.C. 5164.78)

The act requires that the Medicaid payment rates for certain neonatal and newborn services equal 75% of the Medicare payment rates for the services in effect on the date the services are provided to Medicaid recipients eligible for them. This requirement applies to the following neonatal and newborn services:

(1) Initial care for normal newborns;

(2) Subsequent day, hospital care for normal newborns;

(3) Same day, initial history and physical examination and discharge for normal newborns;

(4) Initial neonatal critical care for children not more than 28 days old;

(5) Subsequent day, neonatal critical care for children not more than 28 days old;

(6) Subsequent day, pediatric critical care for children at least 29 days old but less than two years old;

(7) Initial neonatal intensive care;

(8) Subsequent day, neonatal intensive noncritical care for children weighing less than 1,500 grams;

(9) Subsequent day, neonatal intensive noncritical care for children weighing at least 1,500 grams but not more than 2,500 grams; and

(10) Subsequent day, neonatal care for children weighing more than 2,500 grams but not more than 5,000 grams.

Payment rates for other Medicaid services selected by the Medicaid Director must be less than the amount of the rates in effect on September 29, 2017, so that the cost of the rates for the neonatal and newborn services listed above do not increase Medicaid expenditures. The Director is prohibited from selecting for rate reduction any Medicaid service for which the rate is determined in accordance with state statutes.

The General Assembly overrode the Governor's veto of these requirements.

Vision Care Services

(Section 333.184)

The act requires ODM to establish a maximum Medicaid rate for vision care services provided during the period beginning January 1, 2018, and ending July 1, 2019, unless there are no claims data available to ODM needed to establish the rate. The act prohibits a payment rate for the services from relying only on a vision care service provider's charged amount.

Noninstitutional laboratory, radiology, and pathology services

(Section 333.300)

The act requires that the Medicaid rates for noninstitutional laboratory, radiology, and pathology services provided during the period beginning January 1, 2018, and ending July 1, 2019, be 5% lower than the rates for the services in effect on December 31, 2017.

Delayed implementation of behavioral health redesign

(R.C. 5164.761 (primary) and 5164.01; Section 333.260)

ODM, in collaboration with the Governor's Office of Health Transformation and the Department of Mental Health and Addiction Services, developed proposals to revise the Medicaid program's coverage of community behavioral health services, including revisions to Medicaid billing codes and payments rates. This is commonly known as the behavioral health redesign. Community behavioral health services are alcohol and drug addiction services and mental health services provided by community providers.

The act requires ODM and the Department of Mental Health and Addiction Services to conduct a beta test before they update Medicaid billing codes or payment rates for community behavioral health services as part of the redesign. Any Medicaid provider of community behavioral health services may volunteer to participate in the beta test. An update may not be implemented outside of the beta test until at least half of the Medicaid providers participating in the test are able to submit a clean claim that is properly adjudicated within 30 days after it is submitted. Clean claim is a term defined in a federal Medicaid regulation as a claim that can be processed without obtaining additional information from the service provider or a third party. It includes a claim with errors originating in a state's claims system. It does not include a claim from

a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.[115]

The act prohibits any of the following changes to Medicaid coverage of community behavioral health services from being implemented before January 1, 2018, or the date the beta test requirement is satisfied:

(1) Aligning billing codes for the services to national standards;

(2) Redefining mental health pharmacologic management and substance use disorder medical/somatic services as medical services;

(3) Separating and repricing the services and providing for lower acuity service coordination and support services;

(4) Requiring practitioners who are employed by a community behavioral health services provider and render the services to obtain a Medicaid provider agreement and be reported on Medicaid claims for the services;

(5) Requiring community behavioral health services providers to submit claims for the services to a third party responsible for some or all of the costs of the services before the providers submit Medicaid claims for the services.

The Medicaid Director and Director of Mental Health and Addiction Services must do both of the following by October 1, 2017, as part of the changes discussed above: (1) adopt rules and (2) complete and make available to the public provider manuals, claims instructions, information technology resources, and other educational and training documents.

Medicaid managed care

Continuing law requires ODM to establish a care management system, which is more commonly called the Medicaid managed care system. The act makes a number of changes to the law governing the system.

Elimination of requirement to include certain services

(R.C. 5162.70)

The Medicaid Director is required by continuing law to limit the growth in the per recipient per month cost of the Medicaid program. The Director must achieve the growth limit through certain actions. The act eliminates one of these actions: the

[115] 42 C.F.R. 447.45(b).

Director is no longer required to integrate in the Medicaid managed care system the delivery of physical health, behavioral health, nursing facility, and home and community-based services.

Including long-term care services (PARTIALLY VETOED)

(R.C. 5167.03 (primary), 103.43, and 5167.01; Sections 333.270, 333.283, and 333.284)

The Governor vetoed a provision that would have prohibited home and community-based waiver services and nursing facility services from being included in the Medicaid managed care system.[116] The provision would not have prohibited (1) participants of the Integrated Care Delivery System (i.e., MyCare Ohio) from being required or permitted to obtain such services under the system or (2) Medicaid recipients who receive such services from being designated for voluntary or mandatory participation in the system in order to receive other health care services included in the system.

The act establishes the Patient-Centered Medicaid Managed Care Long-Term Services and Supports Study Committee to examine the merits of including in home and community-based waiver services and nursing facility services in the Medicaid managed care system. The study committee must include the following members:

(1) The chair of the House Finance Subcommittee on Health and Human Services;

(2) The chair of the House Aging and Long-Term Care Committee;

(3) The chair of the Senate Finance Health and Medicaid Subcommittee;

(4) The chair of the Senate Health, Human Services, and Medicaid Committee;

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

(6) The Medicaid Director or Director's designee;

(7) The Director of Aging or Director's designee;

(8) The Director of Health or Director's designee;

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

[116] On July 6, 2017, the House voted to override the Governor's veto of this item. The Senate had not acted on the override when this analysis was published.

(10) One representative of each of the following organizations, as appointed by the organization's chief executive: LeadingAge Ohio, the Academy of Senior Health Sciences, the Ohio Aging Advocacy Coalition, the Ohio Assisted Living Association, the Ohio Association of Health Plans, the Ohio Association of Area Agencies on Aging, the Ohio Council for Home Care and Hospice, the Ohio Health Care Association, the Ohio Olmstead Task Force, the Universal Health Care Action Network Ohio, AARP Ohio, and the Center for Community Solutions.

Appointments to the study committee must be made by July 29, 2017. Members are to serve without compensation or reimbursement, except to the extent that serving on the committee is part of their usual duties. The Speaker and Senate President must appoint co-chairpersons from among the committee's legislative members. ODM must provide the committee any needed administrative assistance.

When examining the merits of including the services in the system, the study committee must:

(1) Consider available information about the Medicaid waiver created as part of the Integrated Care Delivery System and the Medicaid program's coverage of nursing facility services;

(2) Estimate the costs that the state, Medicaid managed care organizations, providers, and Medicaid recipients would incur;

(3) Address any redundancies in rules governing the services and the terms and conditions of contracts with Medicaid managed care organizations;

(4) Estimate the projected benefits that Medicaid recipients would realize;

(5) Consider policies and procedures that are intended to promote efficient implementation and administration of including the services in the system;

(6) Recommend systems that can be used in either Medicaid managed care long-term care services or supports or fee-for-services Medicaid to reward providers of long-term care services and supports that meet specified quality measures.

The study committee must complete a report by December 31, 2018. The report must include the committee's recommendations regarding costs, benefits, and policies. The committee must submit its report to the Governor, General Assembly, and JMOC and make it available to the public. On the report's submission, the committee ceases to exist.

The Governor vetoed a provision that would have required the General Assembly to consider and vote on legislation authorizing the inclusion of home and community-based waiver services and nursing facility services in the Medicaid managed care system beyond their inclusion in the Integrated Care Delivery System.[117] If the General Assembly enacted such legislation, the Patient-Centered Medicaid Long-Term Care Delivery System Advisory Committee would have been created effective on the date that the legislation took effect.

In contrast to the temporary study committee discussed above, the advisory committee would have been ongoing. It would have had the same type of membership as the temporary study committee. JMOC staff would have been required to provide administrative assistance and ODM would have been required to provide updates about the inclusion of home and community-based waiver services and nursing facility services in the Medicaid managed care system. The ongoing advisory committee would have been required to advise JMOC on projects that measure improvements to the delivery of the services and periodically recommend to the Medicaid Director policy changes to make additional improvements. It also would have been required to complete quarterly reports regarding its work. The reports would have had to be submitted to the General Assembly and JMOC.

Including behavioral health services (PARTIAL VETO OVERRIDDEN)

(R.C. 5167.04 (primary), 103.41, and 103.416)

Under prior law, ODM was required to begin including alcohol, drug addiction, and mental health services in the Medicaid managed care system *not later than* January 1, 2018. Before that date, any proposal by ODM to include all or part of the services in the system was subject to review by JMOC and ODM was permitted to implement the proposal only if JMOC approved it. JMOC was required to monitor ODM's actions in preparing to implement and implementing such a proposal until June 30, 2018. Beginning January 1, 2018, any such proposal was subject to JMOC's monitoring, but not JMOC's approval.

The act generally eliminates these provisions. The requirement that alcohol, drug addiction, and mental health services be included in the Medicaid managed care system is retained, but they are prohibited from being included before July 1, 2018. The General Assembly overrode the Governor's veto of this prohibition. JMOC must monitor on a quarterly basis ODM's preparations to include the services in the system and

[117] On July 6, 2017, the House voted to override the Governor's veto of this item. The Senate had not acted on the override when this analysis was published.

periodically monitor ODM's inclusion of the services in the system once they begin to be included.

Duties of area agencies on aging

The act requires ODM, if it expands the inclusion of the aged, blind, and disabled Medicaid eligibility group or Medicaid recipients who are also eligible for Medicare in the Medicaid managed care system during the FY 2018-2019 biennium, to do both of the following for the remainder of the biennium:

(1) Require area agencies on aging to be the coordinators of home and community-based waiver services that the recipients receive and permit Medicaid managed care organizations to delegate to the agencies full-care coordination functions for those and other health care services;

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

Prior authorization for psychiatric drugs

(R.C. 5167.12)

The act exempts from Medicaid managed care prior authorization requirements certain psychiatric drugs that are prescribed by either a certified nurse practitioner or a clinical nurse specialist who is certified in psychiatric mental health by a national organization approved by the Nursing Board. Under prior law, these drugs were exempt from prior authorization requirements only if they were prescribed by (1) a physician who was, through the Medicaid managed care organization's credentialing process, allowed to provide care as a psychiatrist or (2) a psychiatrist who practiced at a community mental health services provider whose services were certified by the Department of Mental Health and Addiction Services.

Local boards of health as community hubs; public health nurses

(R.C. 5167.173)

Law modified in part by the act requires Medicaid managed care organizations to provide or arrange for female Medicaid recipients who are pregnant or capable of becoming pregnant to receive services by certified community health workers who work for, or are under contract with, a qualified community hub. Under prior law, a "qualified community hub" was defined as a central clearinghouse for a network of community care coordination agencies that met the following criteria:

(1) Demonstrated that it used an evidence-based, pay-for-performance community care coordination model endorsed by the federal Agency for Healthcare Research and Quality, the National Institutes of Health, and the Centers for Medicare and Medicaid Services (or their successors) to connect at-risk individuals to health, housing, transportation, employment, education, or other social services;

(2) Demonstrated that it had achieved, or was engaged in achieving, certification from a national hub certification program; and

(3) Had a plan, approved by the Medicaid Director, specifying how the community hub ensured that children received specified developmental screenings.

The act modifies all three criteria necessary to be a qualified community hub:

--First, a central clearinghouse may use certified community health workers or public health nurses in lieu of being endorsed by the national organizations and agencies;

--Second, a central clearinghouse may be a local board of health instead of having achieved, or being engaged in achieving, certification from a national hub certification program; and

--Third, as a result of local boards of health being authorized by the act to serve as central clearinghouses, a board may submit a plan approved by the Medicaid Director specifying how it ensures that the children served by it receive the appropriate developmental screenings.

The act also authorizes Medicaid managed care organizations to provide or arrange for eligible female Medicaid recipients to receive services provided by a public health nurse (in lieu of or in addition to community health worker services, as provided for under prior law). Moreover, it authorizes a public health nurse to recommend that a Medicaid recipient receive the services. (Under prior law, only a physician or other licensed health professional specified in rules was authorized to make that recommendation.) For conforming purposes, the act makes other changes related to the authority of public health nurses and the provision of services to eligible female Medicaid recipients.

Premium payment withholdings (PARTIALLY VETOED)

(R.C. 5167.30; Section 333.50)

The act increases to 5% (from 2%) the maximum amount of a Medicaid managed care organization's premium payments that ODM may withhold for the Managed Care

Performance Payment Program, under which Medicaid managed care organizations receive payments for meeting performance standards. The Governor vetoed a provision that would have limited the amount withheld during FY 2019 to 1%.

Managed care academic performance incentives

(Section 333.223)

The act prohibits ODM from implementing during the FY 2018-2019 biennium a program under which Medicaid managed care organizations receive incentives for helping its Medicaid enrollees who attend low-performing primary schools to improve their academic performance.

Waiver for services at institutions for mental diseases (VETOED)

(R.C. 5166.38)

The Governor vetoed a provision that would have required the Department to administer a Medicaid waiver component to provide services to eligible individuals between the ages of 21 and 64 at institutions for mental diseases, which are hospitals and other facilities of more than 16 beds primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. The provision would have required the Department to participate in the Centers for Medicare and Medicaid Services' Innovation Accelerator Program to determine where, when, and how the waiver services were to be provided.

Retention or collection of federal financial participation

(R.C. 5162.40)

The act modifies ODM's authority to retain or collect a portion of the federal financial participation obtained by a state agency or political subdivision that administers one or more components of the Medicaid program that was federally approved on or after January 1, 2002. Prior law required ODM to retain or collect between 3% and 10% of the federal financial participation. Under the act, ODM is permitted, instead of required, to retain or collect up to 10% of the federal financial participation, which matches continuing law with respect to Medicaid components that were federally approved before January 1, 2002.

Third-party liability

Federal law[118] generally provides that Medicaid is the payer of last resort for a Medicaid recipient's medical costs. Accordingly, if a Medicaid recipient has one or more additional sources of coverage for health care services (insurance, recovery from a tortfeasor, or coverage from another program), that other source must be billed before Medicaid. This concept is known as "third-party liability." Ohio law reflects this policy.

Deadline for third-party payments

(R.C. 5160.40)

The act requires a liable third party to respond to an ODM request for payment of a claim not later than 90 business days after receipt of written proof of the claim, either by paying the claim or issuing a written denial to ODM. A business day is any day of the week excluding Saturday, Sunday, or a legal holiday.

Medicaid managed care

Amount of recovery

(R.C. 5160.37, with a conforming change in R.C. 5160.401)

Under continuing law not modified by the act, an individual who receives medical assistance (from Medicaid, the Children's Health Insurance Program, or the Refugee Medical Assistance Program) gives an automatic right of recovery to ODM or a county department of job and family services against the liability of a third party for the cost of medical assistance paid on the recipient's behalf. In the case of a recipient who receives medical assistance through a Medicaid managed care organization, continuing law specifies that ODM's or the county department's claim is the amount the managed care organization pays for medical assistance rendered to the recipient (even if that amount exceeds the amount that ODM or the county department pays to the organization for the recipient's medical assistance). The act clarifies that this provision applies only to a Medicaid managed care organization that does not have a capitation agreement with a provider. For a Medicaid managed care organization with a capitation agreement, the act specifies that ODM's or the county department's claim is the amount the managed care organization would have paid in the absence of a capitation agreement.

[118] 42 U.S.C. 1396a(a)(25).

Right of recoupment

(R.C. 5160.40)

Continuing law unchanged by the act requires a liable third party to treat a Medicaid managed care organization as ODM for a claim if the Medicaid recipient received a medical item or service through the organization and ODM assigned its right of recovery for the claim to the organization. The act authorizes ODM, even if it assigned its right of recovery to the managed care organization, to recoup from the third party the amount that was assigned to the organization but was not collected. ODM may initiate recoupment beginning one year after the managed care organization paid the claim.

Health insuring corporation franchise fee (PARTIALLY VETOED)

(R.C. 5168.75, 5168.76, 5168.761, 5168.77, 5168.78, 5168.79, 5168.80, 5168.81, 5168.82, 5168.83, 5168.84, 5168.85, and 5168.86)

Imposition of franchise fee

The act imposes a monthly franchise fee on health insuring corporation plans (policies, contracts, certificates, or agreements of a health insuring corporation under which the corporation pays for, reimburses, provides, delivers, arranges for, or otherwise makes available basic health care services).[119] A plan is exempt from the franchise fee if it (1) covers only supplemental health care services or specialty health care services, (2) is a health benefits plan for federal government employees and subjecting the plan to the franchise fee would violate federal law, or (3) is a Medicare Advantage Plan.

The franchise fee is to have a component based on Ohio Medicaid member months and another component based on other Ohio member months. Ohio Medicaid member months are months in which a state resident who is a Medicaid recipient is enrolled in a health insuring corporation plan. Other Ohio member months are months in which a state resident who is not a Medicaid recipient is enrolled in a health insuring corporation plan.

---

[119] Continuing law defines "basic health care services" as the following when medically necessary: physician's services (except when such services are supplemental), inpatient hospital services, outpatient medical services, emergency health services, urgent care services, diagnostic laboratory services, diagnostic and therapeutic radiologic services, diagnostic and treatment services (other than prescription drug services) for biologically based mental illnesses, preventive health care services (including voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care), and routine patient care for patients enrolled in an eligible cancer clinical trial. Experimental procedures are not basic health care services. (R.C. 1751.01, not in the act.)

The franchise fee is to be first imposed for the month of July 2017.

The franchise fee may not be imposed, however, unless there is a federal waiver authorizing it issued by the U.S. Secretary of Health and Human Services. The waiver is needed because of federal law that places restrictions on states' use of health care-related taxes to raise revenues for the nonfederal share of Medicaid costs.[120] If the federal government determines that the franchise fee is an impermissible health care-related tax, ODM must do either of the following as appropriate:

(1) Modify the imposition of the franchise fee, including, if necessary, the amount of the fee, in a manner needed for the federal government to reverse its decision;

(2) Take all necessary actions to stop imposing the franchise fee until the determination is reversed.

Amount of the franchise fee

Default amount

The act provides for separate calculations to be made in determining a default amount of a health insuring corporation plan's franchise fee. The first calculation concerns the number of a plan's Ohio Medicaid member months and the second calculation concerns the number of its other Ohio member months.

The act does not establish the specific formula to determine the part of the franchise fee that is based on Ohio Medicaid member months. Instead, it requires ODM to determine the amount as part of the process of determining the annual capitated payments rates to be paid to Medicaid managed care organizations. It also requires that the following rates be used as part of the determination:

Cumulative Monthly Total Number of Medicaid Recipient Enrollees as of the Portion of a Fiscal Year That Has Ended	Applicable Rate
For the first 250,000	$56
For 250,001 to 500,000	$45
For 500,001 and above	$26

The act establishes the formula to determine the part of the franchise fee that is based on other Ohio member months. This part is to be determined by multiplying the number of other Ohio member months that the health insuring corporation plan had for the month by the applicable rate or rates. The applicable rate or rates depends on the

[120] 42 U.S.C. 1396b(w).

cumulative total number of other Ohio member months the health insuring corporation plan had for all of a fiscal year's months that ended before the beginning of the month in which the franchise fee is due. The following table shows the applicable rate or rates:

Cumulative Monthly Total Number of Other Enrollees as of the Portion of a Fiscal Year That Has Ended	Applicable Rate
For the first 150,000	$2
For 150,001 and above	$1

Higher amount if CMS grants formal approval (VETOED)

The Governor vetoed a provision that would have required the Medicaid Director to ask the U.S. Centers for Medicare and Medicaid Services (CMS) whether the franchise fee may be increased above the default amount in a manner to raise up to an additional $207 million per fiscal year without causing it to be an impermissible health care-related tax under federal law.[121] The Director would have been required to collaborate with the County Commissioners Association of Ohio and the Director of Budget and Management in preparing the question, and submit it to CMS by October 1, 2017.

If CMS informed the Director that the franchise fee may be so increased, the Director would have been required to request that CMS provide formal approval as soon as possible. On receipt of the formal approval, the Director would have been required to increase the franchise fee as needed to raise as much of the additional $207 million per fiscal year as CMS specified in the formal approval. The increase would have gone into effect on the later of July 1, 2018, or the earliest date the formal approval permitted. It would have had to be applied proportionately across health insuring corporation plans. The increase was not to be applied on or after July 1, 2024.

Cap

The total revenue raised by the franchise fee during a fiscal year is subject to a cap that may result in ODM refunding a portion of the fee. If the total franchise fees imposed on all health insuring corporations during a fiscal year exceeds a certain amount of the net patient revenue for all health insuring corporations for that fiscal year, and 75% or more of all health insuring corporations receive enhanced Medicaid payments or other state payments equal to 75% or more of their total franchise fees, ODM must refund the excess amount of the fees to the health insuring corporations.

[121] On July 6, 2017, the House voted to override the Governor's veto of this item. The Senate had not acted on the override when this analysis was published.

The percentage used for this calculation is set by federal law. Currently, it is 6%.[122] If the percentage changes during a fiscal year, the percentage in effect before the change is to be used for the part of the fiscal year before the change takes effect, and the new percentage is to be used for the remainder of the fiscal year.

Due dates

The part of the franchise fee based on Ohio Medicaid member months is to be paid monthly. It is due on the fifth business day of the month following the month for which it is imposed. The other part is to be paid in one annual payment, which is due on September 30 of the calendar year in which the fiscal year for which it is imposed ends.

If a health insuring corporation administers multiple plans, it must pay the total amount due for all of the plans under the part of the franchise fee based on Ohio Medicaid member months in one payment, and pay the total amount due for all of the plans under the other part in one payment, too.

Submission of information and access to documentation

ODM may request that a health insuring corporation provide it documentation it needs to verify the amount of the franchise fees imposed on the corporation's plans and to ensure the corporation's compliance with state law governing the franchise fee. On receipt of the request, the health insuring corporation must provide ODM the requested documentation. ODM also may review relevant documents possessed by other entities for the purpose of making the verifications.

Recovering underpayments

ODM must notify a health insuring corporation if it determines that the franchise fee the corporation paid is less than the amount it should have paid. The corporation must pay the amount due. However, the corporation may request a reconsideration of ODM's determination. A reconsideration may be requested solely on the grounds that the Department made a material error in making the determination. The request must be received by ODM not later than 15 days after it notifies the corporation of the determination, and must include written materials setting forth the basis for the reconsideration. If the request is timely made, ODM must reconsider the determination and issue a final decision within 30 days after it receives the request.

---

[122] 42 U.S.C. 1396b(w)(4)(C)(ii).

Penalty for late payment

ODM may impose a penalty on a health insuring corporation that fails to pay the full amount of a franchise fee when due. The amount of the penalty is 10% of the amount due for each month or fraction thereof that the franchise fee is overdue.

Use of funds raised by the franchise fee (PARTIALLY VETOED)

The act creates in the state treasury the Health Insuring Corporation Franchise Fee Fund. All payments and associated penalties paid by health insuring corporations must be deposited into the Fund. Money in the Fund must be used to make Medicaid payments to Medicaid providers and Medicaid managed care organizations. Any interest or other investment proceeds earned on the money must be credited to the Fund and used to make those payments.

The vetoed provision that would have required the Medicaid Director to seek CMS approval to increase the amount of the franchise fee also would have required the Director of Budget and Management to have the additional funds periodically transferred from the Health Insuring Corporation Franchise Fee Fund to the Permissive Tax Distribution Fund. The transfers' purpose would have been to mitigate the reduced sales tax revenues of counties and transit authorities caused by Medicaid health insuring corporation transactions being removed from the sales tax (see "**Medicaid provider sales tax cessation and transition payments**" in the **DEPARTMENT OF TAXATION** section of this analysis). The Tax Commissioner would have been required to provide for the equitable distribution of the transferred amounts to each county and transit authority that levied a permissive sales tax on such transactions on July 1, 2017.

Rules

The Medicaid Director is permitted to adopt rules as necessary to implement the franchise fee on health insuring corporation plans. The rules are to be adopted in accordance with the Administrative Procedure Act (R.C. Chapter 119.).

Hospital Care Assurance Program and hospital franchise permit fee

(Sections 610.40 and 610.41 (amending Sections 125.10 and 125.11 of H.B. 59 of the 130th G.A.))

The act continues the Hospital Care Assurance Program for two additional years. The program was scheduled to end October 16, 2017, but under the act is to continue until October 16, 2019. Under the program, 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 them. A hospital compensated under the program must provide (without charge) basic, medically necessary, hospital-level services to Ohio residents who are not recipients of Medicare or Medicaid and whose income does not exceed the federal poverty line.

The act also continues for two additional years another assessment imposed on hospitals. The assessment is to end October 1, 2019, rather than October 1, 2017. The assessment is in addition to the Hospital Care Assurance Program, but like that program, it raises money to help pay for the Medicaid program. To distinguish the assessment from the Hospital Care Assurance Program, it is sometimes called a hospital franchise permit fee.

Drug dispensing fees

(R.C. 5164.752 and 5164.753)

In July of every even-numbered year, ODM is required by continuing law to initiate a confidential survey of the cost of dispensing drugs incurred by terminal distributors of dangerous drugs in Ohio. Each terminal distributor that is a Medicaid provider of drugs must participate in the survey. The act extends the deadline for the survey to be completed and its results published from October 31 of the year in which it is conducted to November 30.

The act also permits the Medicaid Director to establish dispensing fees that vary by terminal distributor, taking into consideration the volume of drugs a terminal distributor dispenses under Medicaid or any other criteria the Director considers relevant. Prior law required the Director to establish a single dispensing fee for all terminal distributors.

Recovery of overpayments (VETOED)

(R.C. 5164.57)

ODM has statutory authority to recover a Medicaid payment from a provider if ODM notifies the provider of the overpayment during the five-year period following the state fiscal year in which the overpayment was made. The Governor vetoed a provision that would have reduced the recovery period to three years, in the case of an overpayment made to a nursing facility or intermediate care facility for individuals with intellectual disabilities that ODM determined from data in its possession, or in the possession of another state agency, at the time ODM made the determination.

Fraud, waste, and abuse

Managed care organizations

(R.C. 5167.18 and 5167.34)

The act requires each contract ODM enters into with a managed care organization to require the organization to comply with federal and state efforts to identify fraud, waste, and abuse in the Medicaid program.

The act provides civil immunity to a Medicaid managed care organization, and its officers, employees, or other associated persons, in a civil action for damages for furnishing information to ODM regarding potential Medicaid fraud, waste, or abuse.

Collection of information

(R.C. 5162.16)

The act requires each government entity that administers a component of the Medicaid program to inform ODM if it has reasonable cause to believe that an instance of fraud, waste, or abuse has occurred in the Medicaid program. The Department must collect the information in the Medicaid data warehouse system.

Retained Applicant Fingerprint Database

(R.C. 109.5721, 5164.34 and 5164.341 with conforming changes in R.C. 4749.031, 5101.32, 5160.052, and 5164.37)

The act permits ODM to participate in the Bureau of Criminal Identification and Investigation's Retained Applicant Fingerprint Database to receive notices about the arrests, convictions, and guilty pleas of independent Medicaid providers of home and community-based services under a Medicaid program the Department administers. The database, commonly known as "Rapback," notifies participating public offices and private parties when an individual the office or party employs, licenses, or approves for adoption is arrested for, is convicted of, or pleads guilty to any offense.

If ODM participates in the database, the independent providers will no longer be required to undergo annual criminal records checks conducted by the Bureau. Despite not undergoing the annual check, an independent provider may still lose the provider's Medicaid provider agreement if a notice from database indicates that the provider has been convicted of, or pleaded guilty to, an offense that disqualifies individuals from holding Medicaid provider agreements as independent providers. An individual seeking an initial Medicaid provider agreement as an independent provider still must undergo a Bureau-conducted criminal records check.

Controlling Board authorization, Medicaid expenditures (PARTIAL VETO OVERRIDDEN)

(Sections 333.33 and 333.34)

The act provides for the Health and Human Services Fund to continue during the FY 2018-2019 biennium. The Fund was originally created by the main operating budget act for the FY 2016-2017 biennium, H.B. 64 of the 131st General Assembly.

The act permits the Medicaid Director to request the Controlling Board to authorize expenditures from the Fund in an amount necessary to pay for the costs of the Medicaid program during the FY 2018-2019 biennium. The General Assembly overrode the Governor's veto of this authority. The Controlling Board may authorize the expenditure if Congress has not amended the federal law governing the federal match for the expansion eligibility group (also known as Group VIII).

Residents Protection Fund

(R.C. 5162.66)

The act requires that the following be deposited into the existing Residents Protection Fund: the portions of fines and corresponding interest that are imposed by the federal government against home health agencies for failure to comply with Medicaid participation requirements and dispersed to ODM on or after July 1, 2017. The money must be used to improve the quality of Medicaid services provided by Medicare-certified home health agencies.

Refunds and Reconciliation Fund

(R.C. 5162.65 and 5101.074)

The act codifies (i.e., places in the Revised Code) the Refunds and Reconciliation Fund. The Fund was originally created for the FY 2014-2015 biennium and was extended for the FY 2016-2017 biennium.[123] Codifying the Fund provides for its ongoing existence.

The act specifies that the Fund is in the state treasury and requires that money ODM receives from a refund or reconciliation be deposited into the Fund if ODM does not know the appropriate fund for the money at the time it receives the money, or if the money is to go to another government entity. The act also requires that the Department

[123] Section 323.400 of Am. Sub. H.B. 59 of the 130th General Assembly and Section 327.170 of Am. Sub. H.B. 64 of the 131st General Assembly.

of Job and Family Services transfer for deposit into the Fund money it receives from a refund or reconciliation related to the Medicaid program.

Money in the Fund, including money transferred by the Department of Job and Family Services, must be transferred to the appropriate fund once the appropriate fund is identified or, if the money is supposed to go to another government entity, transferred to the other government entity.

Health Care Services Administration Fund

(R.C. 5162.52 with conforming changes in R.C. 5162.12, 5162.40, 5162.41, 5164.31, 5165.1010, 5168.01, 5168.06, 5168.07, 5168.10, 5168.11, and 5168.99; repealed R.C. 5162.54)

The act abolishes the Health Care Services Administration Fund. Money that would otherwise have been deposited into that fund instead must be deposited into the Health Care/Medicaid Support and Recoveries Fund. This includes the following:

(1) Fees charged for Medicaid recipient or claims payment data, data from reports of nursing facility audits, or extracts or analyses of such data, other than the portion of the fees used to pay a contractor to receive and process requests for the data, extracts, or analyses;

(2) ODM's share of federal funds that a state agency or political subdivision obtains for administering a part of the Medicaid program on ODM's behalf;

(3) ODM's share of federal supplemental Medicaid payments to a provider owned or operated by a state agency or political subdivision;

(4) Application fees charged to entities seeking to enter into, or revalidate, a Medicaid provider agreement;

(5) Fines imposed on nursing facilities when an audit includes certain adverse findings; and

(6) Assessments imposed on hospitals, and intergovernmental transfers made by governmental hospitals, under the Hospital Care Assurance Program.

The act revises one of the purposes for which money in the Health Care/Medicaid Support and Recoveries Fund is to be used. Instead of using the money for contracts, ODM is to use the money for costs associated with the administration of the Medicaid program. Additionally, ODM is to continue to use the money to pay for Medicaid services.

Integrated Care Delivery System performance payments

(Section 333.60)

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.[124] It may be better known, however, as MyCare Ohio.

For FYs 2018 and 2019, the act requires ODM to provide performance payments to Medicaid managed care organizations that provide care under the Integrated Care Delivery System. If participants receive care through Medicaid managed care organizations under the system, ODM must both:

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

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

For purposes of the amount to be withheld from premium payments, ODM must establish a percentage amount and apply the same percentage to all Medicaid managed care organizations providing care to participants of the Integrated Care Delivery System. Each organization must agree to the withholding as a condition of receiving or maintaining its Medicaid provider agreement. The act provides that a Medicaid managed care organization providing care under the system is not subject to withholdings under the Medicaid Managed Care Performance Payment Program for premium payments attributed to participants of the system during FYs 2018 and 2019.

Nursing facility demonstration project

(Sections 610.38 and 610.39 (amending Section 327.270 of H.B. 64 of the 131st G.A.))

The act requires that ODM request federal approval to extend until June 30, 2019, a 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. The demonstration project was established by H.B. 64 of the 131st General Assembly, the main operating budget act for the FY 2016-2017 biennium, and was to be operated for two years ending January 1, 2018, but had not been implemented when this act passed.

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

The act also requires ODM to seek federal approval to modify the demonstration project. Under prior law, ODM had to select four nursing facilities to participate. To the extent possible, the four nursing facilities had to be located in Cuyahoga, Franklin, Hamilton, and Lucas counties. The act requires ODM to add two additional nursing facilities. To the extent possible, one must be located in Brown County and the other must be located in Sandusky County. Continuing law permits ODM to select a nursing facility located in another county if necessary to find nursing facilities that meet the requirements for participation.

Another modification concerns the requirements that nursing facilities must meet to participate in the demonstration project. The act eliminates the requirement that a nursing facility must have been initially constructed, licensed to operate, and certified to participate in Medicaid after 2009.

Nursing facility bed conversion pilot program

(Section 333.230)

The act requires ODM to operate a pilot program during FYs 2018 and 2019 under which owners of nursing facilities located in Cuyahoga County may voluntarily cease to use one or more beds for nursing facility services and instead use them for substance use disorder treatment services. To convert the use of a bed, the following requirements must be met:

(1) The bed cannot be occupied by an individual receiving nursing facility services or be needed for an individual seeking such services.

(2) The Department of Health must (a) reduce the nursing facility's Medicaid certified capacity and corresponding nursing home licensed capacity by the bed being converted if other beds in the nursing facility will continue to be used for nursing facility services after the conversion or (b) terminate the nursing facility's Medicaid certification and nursing home license if no beds in the facility will continue to be used for nursing facility services.

(3) The substance use disorder treatment services for which the bed is to be used must satisfy the standards for certification by the Director of Mental Health and Addiction Services and, if the owner of the bed seeks state or federal funds or funds administered by a board of alcohol, drug addiction, and mental health services to pay for the services, be certified by the Director.

The Department of Health and the Department of Mental Health and Addiction Services must assist ODM with the pilot program. ODM must complete a report about the pilot program by October 1, 2019. The report must include recommendations about

making the pilot program a permanent and statewide program. It must be submitted to the Governor, General Assembly, and JMOC. It also must be made available to the public.

Care Innovation and Community Improvement Program

(Section 333.320)

The act requires the Medicaid Director to establish the Care Innovation and Community Improvement Program for the FY 2018-2019 biennium. Any nonprofit hospital agency affiliated with a state university and any public hospital agency may volunteer to participate if it operates a hospital that has a Medicaid provider agreement. The nonprofit and public hospital agencies that participate in the program are responsible for the state share of the program's costs and must make or request the appropriate government entity to make intergovernmental transfers to pay for the costs. The Director must establish a schedule for making the transfers.

Each participating hospital agency must undertake at least one of the following tasks in accordance with strategies, and for the purpose of meeting goals designed to benefit Medicaid recipients, the Medicaid Director is to establish:

(1) Sustain and expand community-based patient centered medical home models;

(2) Expand access to community-based dental services;

(3) Improve the quality of community care by creating and sharing best practice models for emergency department diversions, care coordination at discharge and during transitions of care, and other matters related to community care;

(4) Align community health improvement strategies and goals with the State Health Improvement Plan and local health improvement plans;

(5) Expand access to ambulatory drug detoxification and withdrawal management services;

(6) Train medical professionals on evidence-based protocols for opioid prescribing and drug addiction risk assessments;

(7) In collaboration with other nonprofit and public hospital agencies that also do this task, create and implement a plan to assist rural areas to (a) expand access to cost-effective detoxification, withdrawal management, and prevention services for opioid addiction and (b) disseminate evidence-based protocols for opioid prescribing and drug addiction risk assessment.

If a hospital agency chooses the task to expand access to ambulatory drug detoxification and withdrawal management services, or the task to create and implement a plan to assist rural areas, it must give priority to the areas of the community it serves with the greatest concentration of opioid overdoses and deaths. Regardless of the task chosen, a hospital agency must submit annual reports to JMOC summarizing its work on the task and progress in meeting the program's goals.

Each participating hospital agency is to receive supplemental Medicaid payments for physician and other professional services that are covered by Medicaid and provided to Medicaid recipients. The payments must equal the difference between the Medicaid rate and average commercial rates for the services. The Director may terminate, or adjust the amount of, the payments if funding for the program is inadequate.

The Director must establish a process to evaluate the work done under the program by nonprofit and public hospital agencies and their progress in meeting the program's goals. The process must be established by January 1, 2018. The Director may terminate a hospital agency's participation if the Director determines that it is not performing at least one of the tasks discussed above or making progress in meeting the program's goals.

The act establishes in the state treasury the Care Innovation and Community Improvement Program Fund and requires that all intergovernmental transfers made under the program to be deposited into it. Money in the Fund and the corresponding federal funds must be used to make the supplemental payments to hospital agencies under the program.

Healthy Ohio Program (PARTIALLY VETOED)

(Sections 333.273 and 333.280)

The act declares the General Assembly's intent to use the Healthy Ohio Program as a model for making medical assistance available to the state's qualifying residents if Congress transforms the Medicaid program into a federal block grant. The Healthy Ohio Program is a Medicaid waiver proposal under which certain Medicaid eligibility groups would enroll in comprehensive health plans and contribute to Buckeye accounts. The main operating budget act for the 131st General Assembly, H.B. 64, required ODM to seek federal approval for the waiver, but the U.S. Centers for Medicare and Medicaid Services (CMS) denied the waiver request in September 2016.

The Governor vetoed a provision that would have required the Medicaid Director to resubmit to CMS a request for a federal waiver needed to implement the Healthy Ohio Program.[125] The request would have had to be made by January 31, 2018.

State agency collaboration for health transformation initiatives

(R.C. 191.04 and 191.06; Section 803.20)

The act extends through FYs 2018 and 2019 the Office of Health Transformation's authority to facilitate the coordination of operations and exchange of information between certain state agencies ("participating agencies"). Originally granted for FY 2013, and since extended through FY 2017, the specified purpose of this authority is to support agency collaboration for health transformation purposes, including modernization of Medicaid, streamlining health and human services programs, and improving the quality, continuity, and efficiency of health care and health care support systems. The Office's Executive Director, or the Executive Director's designee, must identify each health transformation initiative in Ohio that involves two or more participating agencies and that permit or require an interagency agreement. For each health transformation initiative identified, the Executive Director or the designee, in consultation with each participating agency, must adopt one or more operating protocols.

As a result of the extension, participating agencies may continue to exchange, through FY 2019, personally identifiable information for purposes related to or in support of a health transformation initiative that has been identified as described above. If a participating agency uses or discloses personally identifiable information, it must do so in accordance with all operating protocols adopted as described above that apply to the use or disclosure.

Temporary authority regarding employees

(Section 333.20)

The act extends until July 1, 2019, the Medicaid Director's authority to establish, change, and abolish positions for ODM, and to assign, reassign, classify, reclassify, transfer, reduce, promote, or demote employees who are not subject to the state's public employees collective bargaining law.

[125] On July 6, 2017, the House voted to override the Governor's veto of this item. The Senate had not acted on the override when this analysis was published.

H.B. 59 of the 130th General Assembly granted the Director this authority from July 1, 2013, to June 30, 2015. H.B. 64 of the 131st General Assembly extended it until June 30, 2017.

The authority includes assigning or reassigning an exempt employee to a bargaining unit classification if the Director determines that the bargaining unit classification is the proper classification for that employee.[126] The Director's actions must comply with a federal regulation establishing standards for a merit system of personnel administration. If an employee in the E-1 pay range is assigned, reassigned, classified, reclassified, transferred, reduced, or demoted to a position in a lower classification, the Director, or in the case of a transfer outside ODM, 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 either Director takes under this provision are not subject to appeal to the State Personnel Board of Review.

[126] An exempt employee is a permanent full-time or permanent part-time employee paid directly by warrant of the Director of Budget and Management 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, not in the act.)