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## DEPARTMENT OF MEDICAID

### Medicaid managed care contracting entities (VETOED)

- Would have required the Department of Medicaid to contract with Medicaid managed care organizations (MCOs) that (1) are domiciled in Ohio, (2) are currently Medicaid MCOs, and (3) have a proven history of providing quality services and customer satisfaction.
- Would have required any Medicaid MCO to participate, at minimum, in the geographic regions of Ohio where it is already providing services.
- Would have required the Department to establish an appeals process under which applicants can appeal the Department's award of Medicaid MCO contracts.

### Duties of area agencies on aging

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

### Medicaid coverage of women postpartum

- Expands Medicaid coverage for pregnant women to include the maximum period permitted under federal law, instead of for 60 days after giving birth.

### Medicaid eligibility

- Requires the Department to take certain actions in the event that it receives federal funding for the Medicaid program that is contingent upon a restriction that limits the Department's ability to disenroll ineligible Medicaid recipients.

### Post-COVID Medicaid redetermination

- Requires the Department to seek controlling board approval to permit ODM to use third-party data to conduct an eligibility redetermination of all Ohio Medicaid recipients within 90 days after the conclusion of the COVID-19 emergency period.
- Requires the Department to conduct an expedited eligibility review of those recipients identified as likely ineligible for the program based on that verification and (to the extent permitted under federal law) to disenroll those recipients who are no longer eligible.
- Requires the Department to conduct an expedited eligibility review of those recipients who were newly enrolled in Medicaid for three or more months during the COVID-19 emergency period and (to the extent permitted under federal law) to disenroll those recipients who are no longer eligible.
- Requires the Department to complete a report containing its findings from the verification and submit it to various state agencies.

- Provides that any third-party vendor expenses incurred by the verification is entirely contingent on the Department realizing cost savings, and limits vendor expenses to 20% of those savings.

### **Medicaid waiver component definition**

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

### **Voluntary community engagement program**

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

### **Medicaid Cost Assurance Pilot Program**

- Establishes the Medicaid Cost Assurance Pilot Program to be available to the Medicaid expansion eligibility group population during the FY 2022-FY 2023 biennium.
- Requires the Department to implement the pilot program initially to the expansion eligibility group population, with future expansion to be determined based on success criteria.
- By December 31, 2022, requires the Department to submit a report to the Speaker of the House, the Senate President, and the Joint Medicaid Oversight Committee (JMOC) outlining clinical outcome data and cost impacts of the program.

### **Care Innovation and Community Improvement Program**

- Requires the Medicaid Director to continue the Care Innovation and Community Improvement Program for the FY 2022-FY 2023 biennium.

### **Ohio Invests in Improvements for Priority Populations**

- Establishes the Ohio Invests in Improvements for Priority Populations Program as a directed payment program for inpatient and outpatient hospital services provided to Medicaid managed care recipients.
- Provides that, under the program, state university-owned hospitals with fewer than 300 beds can directly receive payment for program services.
- Requires participating hospitals to remit to the Department, through intergovernmental transfer, the nonfederal share of payment for those services.

## **Hospital Care Assurance Program, franchise permit fee**

- Continues, until October 2023, the Hospital Care Assurance Program and the franchise permit fee imposed on hospitals under Medicaid.

## **Medicaid rates for community behavioral health services**

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

## **Home and community-based services payment rates (VETOED)**

- Would have earmarked \$5 million to increase the payment rates during FY 2022 and FY 2023 for adult day care services provided under the PASSPORT, Ohio Home Care, MyCare Ohio, and Assisted Living waivers.
- Would have increased the payment rates for providers of certain services under the PASSPORT program, the Ohio Home Care waiver program, the MyCare Ohio Waiver program, and the Assisted Living waiver by 4% in FY 2022 and another 2% in FY 2023.

## **Value-based purchasing supplemental rebate**

- Requires the Department to submit to the U.S. Centers for Medicare and Medicaid Services (CMS) a Medicaid state plan amendment to allow the Department to enter into value-based purchasing supplemental rebate agreements with pharmaceutical manufacturers.

## **Medicaid reports**

- Requires the Director to notify JMOC and be available to testify to JMOC before making any Medicaid payment rate increases greater than 10%.
- Requires the Director to report quarterly to JMOC the fee rates and the aggregate total of certain Medicaid program fees and if there is a rate increase pending before CMS for any of those fees.

## **Pharmacy supplemental dispensing fee (PARTIALLY VETOED)**

- Requires the Department to establish for the FY 2022-FY 2023 biennium a supplemental dispensing fee with three payment levels for retail pharmacies under the care management system.
- Would have required the payment levels to be based on (1) the ratio of Medicaid prescriptions filled compared to total prescriptions filled for each pharmacy and (2) the number of retail pharmacies participating in the care management system (VETOED).
- Would have prohibited the supplemental dispensing fee from causing a reduction in other payments made to the pharmacy (VETOED).

## **Nursing facilities**

### **Critical access nursing facilities**

- For calculating the occupancy and utilization rates to determine if a nursing facility is a critical access nursing facility, provides that “as of the last day of the calendar year” refers to the rates during the calendar year identified in the nursing facility’s cost report.

### **Medicaid payment formula**

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

### **Resident assessment data**

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

### **Special Focus Facility Program**

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

### **Quality payments – repealed**

- Repeals the quality payments nursing facilities received under former law for meeting at least one of five quality indicators.

### **Quality incentive payments (PARTIALLY VETOED)**

- Extends the nursing facility quality incentive payments from FY 2021 through the FY 2022-FY 2023 biennium.
- Clarifies that the data used to calculate a nursing facility’s quality score is based on CMS data from the most recent month of the calendar year during which the fiscal year for the rate begins, instead of May of the calendar year during which the fiscal year begins.
- Provides that a nursing facility receives zero quality points if its total number of points for FY 2022 or FY 2023 for the quality metrics is less than the number equal to the bottom 25% of all nursing facilities.
- Replaces the previous disqualifications from the quality incentive payments with a new disqualification for a nursing facility that is on CMS’s SFF list in that fiscal year.

- Would have defined SFF Table A, Table B, and Table C, for purposes of the above disqualification (VETOED).
- Suspends, after FY 2023, a provision of continuing law that disqualifies a nursing facility from receiving a quality incentive payment if its licensed occupancy percentage is below 80% for the applicable fiscal year, unless certain exceptions are met.
- Subtracts \$1.79 from the nursing facility's base rate calculation, which is used to determine the total amount to be spent on quality incentive payments.
- Modifies the calculation used to determine the total amount to be spent on quality incentive payments in a fiscal year by (1) adding \$1.79 to the step of the calculation using the number that is 5.2% of each nursing facility's base rate and (2) including a \$25 million add-on in FY 2022 and \$125 million in FY 2023 to the total in each fiscal year.
- Clarifies that if a nursing facility is new or undergoes a change of operator during FY 2022 or FY 2023, it receives no quality incentive payment for that fiscal year.

### **Nursing facility rebasing**

- Requires the Department to rebase only the direct care, ancillary and support, and tax cost centers when conducting a rebasing.
- Requires a nursing facility to spend money received from the rebasing conducted in FY 2022 on those cost centers only.
- Requires a nursing facility operator to spend 70% of additional dollars received as a result of a rebasing on direct care costs, including employee salaries, and permits the Department to recover any amounts that do not comply with this requirement.
- Requires the Medicaid Director to adopt rules to ensure that nursing facility operators comply with this requirement.
- Requires the Department to conduct its next nursing facility rebasing on June 30, 2021, using nursing facility calendar year 2019 data.
- Earmarks \$125 million in each fiscal year during FYs 2022 and 2023 for that rebasing and requires the rebasing determinations to be paid in the following order: (1) direct care costs, (2) ancillary and support costs, and (3) tax costs.
- Requires nursing facility payments based on the rebasing calculations to be prorated in order to stay within that earmark.
- Requires nursing facility operators to submit quarterly reports to the Department identifying the amounts spent on each cost center.
- Permits the Department to review the quarterly reports and requires an operator to reimburse to the Department any amounts, plus interest, not spent in accordance with these requirements.

## **Nursing Facility Payment Commission**

- Requires the Department to establish the Nursing Facility Payment Commission to analyze the efficacy of the current nursing facility quality incentive payment formula, base rate calculation, and cost centers and submit a report of its findings to the General Assembly by August 31, 2022.

## **Medicaid managed care contracting entities (VETOED)**

(R.C. 5167.10)

The Governor vetoed provisions that would have imposed additional requirements on the Department of Medicaid's contracts with Medicaid managed care organizations (MCOs) to provide health care services to Medicaid enrollees under the care management system. To the extent permitted under federal law, beginning September 30, 2021, the act would have required the Department to include contracts with Medicaid MCOs that:

- Were domiciled in Ohio, including their parent entities;
- Were currently Medicaid MCOs; and
- Had a proven history of providing quality services and customer satisfaction, as reported by (1) the Department's Medicaid Managed Care Plans Report Card and (2) the National Committee for Quality Assurance (NCQA) Medicaid health insurance plan ratings.

Additionally, beginning on that date, any organization included as a Medicaid MCO would have been required to participate, at minimum, in the geographic regions of Ohio where they were already providing services.

The act would have exempted from these requirements a behavioral health managed care plan selected to assist the Department in implementing the Ohio Resilience Through Integrated Systems and Excellence (OhioRISE) Program for children and youth involved in multiple state systems or children and youth with complex behavioral health needs.

The Department would have been required to establish an appeals process under which applicants could appeal an adverse decision by the Department regarding an application for up to 30 days after the decision date.

## **Duties of area agencies on aging**

(Section 333.170)

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

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

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

## **Medicaid coverage of women postpartum**

(R.C. 5163.06 and 5163.061; Section 333.253)

The act expands Medicaid coverage to women postpartum from 60 days after giving birth to the maximum postpartum period permitted by federal law. If federal law provides Medicaid coverage for a postpartum period longer than 60 days, the act requires the Medicaid Director to amend the Medicaid state plan and seek any necessary waiver from the U.S. Centers for Medicare and Medicaid Services (CMS) to provide Medicaid coverage for this extended period.

The federal American Rescue Plan Act of 2021 established an option under which states may extend Medicaid coverage for pregnant women for one year after giving birth. This option will take effect on April 1, 2022, and remain in effect for five years.<sup>96</sup>

## **Medicaid eligibility**

(R.C. 5163.52; Section 812.10)

Effective January 1, 2022, the act establishes requirements the Department must follow if it receives federal funding for Medicaid that is contingent upon a temporary maintenance of effort restriction or otherwise restricts the Department's ability to disenroll ineligible Medicaid recipients (such as the requirements under the Families First Coronavirus Response Act).<sup>97</sup> First, the Department must continue to conduct eligibility redeterminations for the Medicaid program and act on those redeterminations to the fullest extent permitted under federal law. Second, within 60 days of the expiration of the restriction or limitation, the Department must complete an audit that does both of the following:

- Completes and acts on all eligibility redeterminations for Medicaid recipients for whom an eligibility redetermination has not been conducted in the past 12 months; and
- Requests approval from CMS to conduct and act on eligibility redeterminations for all Medicaid recipients who were enrolled for a period of at least three months, or other period of time consistent with federal law or guidelines, during a period of restriction or limitation. If approved by CMS, the Department must conduct and act on any redetermination within 90 days of receiving approval.

Any county department of job and family services assisting ODM with conducting the redeterminations described above may request from the Department of Job and Family

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<sup>96</sup> American Rescue Plan Act of 2021, Pub. L. No. 117-2, Section 9812.

<sup>97</sup> Section 6008, Pub. L. No. 116-127.



Services, in consultation with the Department of Medicaid, an additional 30 days to act on any redetermination.

The Department must submit a report to the Speaker of the House and the President of the Senate summarizing the results of this audit.

## **Post-COVID Medicaid redetermination**

(Section 333.255)

Not later than 90 days after the expiration of the federal COVID-19 emergency period,<sup>98</sup> the act requires the Department or its designee to use third-party data sources and systems to conduct eligibility redeterminations of all Medicaid recipients. The act requires the Department, not later than November 1, 2021, to seek Controlling Board approval to permit the Department or its designee to use the third-party data sources and systems. To the extent permitted by state and federal law, the Department or its designee must verify each Medicaid recipient's enrollment records against all of the following: (1) information and databases available to the Department under federal law, (2) identity records, (3) death records, (4) employment and wage records, (5) lottery winning records, (6) residency checks, (7) household composition and asset records, and (8) any other records the Department considers appropriate to strengthen program integrity, reduce costs, and reduce fraud, waste, and abuse in the Medicaid program.

Following this verification and not later than 120 days after the expiration of the federal COVID-19 emergency period, the Department must prepare and submit a report regarding its findings from the verification, including any findings regarding fraud, waste, or abuse in the Medicaid program. The Department must submit the report to all of the following:

- The Governor and Lieutenant Governor;
- The members of JMOC;
- The Senate President and Speaker of the House;
- The chairpersons of the House and Senate finance committees; and
- The chairpersons of any other standing committees of the House and Senate that have jurisdiction over the Department.

Within 90 days after the expiration of the federal COVID-19 emergency period, the act requires the Department or its designee to conduct an expedited eligibility review of Medicaid recipients that are identified as likely ineligible for continued participation in the Medicaid program based on the verification described above to determine whether or not a recipient remains eligible for Medicaid. To the extent permitted by federal law, the Department must disenroll those Medicaid recipients who are determined to no longer be eligible based on this expedited review.

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<sup>98</sup> See 42 U.S.C. 1320b-5(g)(1)(B).



Additionally, not later than six months after the expiration of the federal COVID-19 emergency period, the act requires the Department or its designee to conduct an expedited eligibility review of Medicaid recipients who were newly enrolled in the Medicaid program for three or more months during the emergency period, but who were not newly enrolled during the last six months of the emergency period, to determine whether or not a recipient remains eligible for Medicaid. To the extent permitted by federal law, the Department must disenroll those Medicaid recipients who are determined to no longer be eligible based on this expedited review.

The act provides that any third-party vendor expenses incurred from conducting the verification procedures described above are entirely contingent on validated cost savings realized by the Department. Any vendor expenses paid related to the verification procedures may not exceed 20% of the cost savings realized by the Department.

### **Medicaid waiver component definition**

(R.C. 5166.01)

The act specifies that the definition of a “Medicaid waiver component” does not include services that are delivered under a prepaid inpatient health plan.<sup>99</sup> Medicaid waiver component means a component of the Medicaid program authorized by a waiver granted by the U.S. Department of Health and Human Services and does not include the care management system.

### **Voluntary community engagement program**

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

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

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

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<sup>99</sup> Federal law defines a “prepaid inpatient health plan” as an entity that provides limited services to Medicaid enrollees through a limited-benefit risk-based plan. (42 Code of Federal Regulations (C.F.R.) 438.2.)

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

Ohio law requires the Director to establish a Medicaid waiver component under which an individual eligible for Medicaid on the basis of being included in the expansion eligibility group (also known as “Group VIII”) – adults under age 65 with no dependents and incomes at or below 138% of the federal poverty level – must meet one of a list of enumerated criteria to enroll in Medicaid. The criteria include (1) being at least age 55, (2) being employed, (3) being enrolled in a school or occupational training program, (4) participating in an alcohol and drug addiction treatment program, or (5) having intensive physical health care needs or serious mental illness.<sup>100</sup> Pursuant to this requirement, the Department submitted a waiver request to CMS to implement a Work Requirement and Community Engagement Section 1115 Demonstration waiver program. CMS approved the waiver on March 15, 2019; however, the program was never implemented because the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act prohibits state Medicaid programs from imposing additional eligibility criteria on Medicaid enrollees during the COVID-19 public health emergency.

## Medicaid Cost Assurance Pilot Program

(Section 333.217)

The act requires the Department to establish the Medicaid Cost Assurance Pilot Program to operate during the FY 2022-FY 2023 biennium. The Department must open the program to Medicaid enrollees in the expansion eligibility group, initially. It may expand the program based on the program outcome data and cost findings in its report (see “**Report**” below).

The pilot program must do all of the following:

- Identify eligible Medicaid enrollees who are members of the expansion eligibility group to participate in the program;
- Provide Medicaid services to pilot program participants at a rate of 95% of current Medicaid MCO capitation rates;
- Use technology to (1) utilize automation and artificial intelligence to provide Medicaid program savings by avoiding traditional cost structures, (2) diversify care management system programs to achieve better health outcomes at better value, (3) enable seamless communication between providers and care management entities, and (4) improve the Medicaid program experience for providers and enrollees;

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<sup>100</sup> R.C. 5166.37, not in the act.

- Develop and implement strategies to provide opportunities for pilot program participants to rise above the poverty level criteria for Medicaid eligibility;
- Enable care management entities under the program to take the risks incidental to the practice of insurance, as a health insuring corporation licensed in Ohio; and
- Include 90-day study periods to determine whether to expand, sustain, or terminate the pilot program.

### **Care management entity**

The Department must contract with a care management entity to administer Medicaid benefits under the pilot program. The care management entity must:

- Be a health insuring corporation licensed in Ohio;
- Be a start-up company domiciled in Ohio; and
- Meet the solvency requirements under Ohio law for health insuring corporations.

### **Report**

The Department must submit a report outlining pilot program clinical outcome data and cost impacts and submit the report to the Speaker of the House, the Senate President, and the members of JMOC by December 31, 2022.

### **Rules**

The Medicaid Director must adopt rules as necessary to implement the pilot program, including (1) the geographic area where the program will occur, (2) program participant eligibility requirements, and (3) program demonstrated success criteria.

## **Care Innovation and Community Improvement Program**

(Section 333.60)

The act requires the Medicaid Director to continue the Care Innovation and Community Improvement Program for the FY 2022-FY 2023 biennium. The Director was originally required to establish it for the FY 2018-FY 2019 biennium.<sup>101</sup>

Any nonprofit hospital agency affiliated with a state university and any public hospital agency may volunteer to participate in the program if the hospital has a Medicaid provider agreement. The agencies that participate are responsible for the state share of the program's costs and must make or request that appropriate government entity to make intergovernmental transfers to pay for the costs. The Director must establish a schedule for making the transfers.

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<sup>101</sup> Section 333.320 of H.B. 49 of the 132<sup>nd</sup> General Assembly and Section 333.220 of H.B. 166 of the 133<sup>rd</sup> General Assembly.

Rather than being required to perform specific tasks delineated for the program in prior budget acts, the act requires each participating hospital agency to jointly participate in quality improvement initiatives that align with and advance the goals of the Department's quality strategy.

Under the program, each participating hospital agency receives 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 the average commercial payment 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 maintain 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 Director may terminate a hospital agency's participation if the Director determines that it is not participating in required quality improvement initiatives or making progress in meeting the program's goals.

The act does not include the requirement that existed in prior budget acts for participating agencies to report information to JMOC; however, it includes a new requirement that, not later than December 31 of each year, the Director must submit a report to the Speaker of the House, the Senate President, and JMOC that details the efficacy, trends, outcomes, and number of hospital agencies enrolled in the program. The report must include the total amount of supplemental Medicaid payments made through the program. All data contained in the report must be aggregated.

All intergovernmental transfers made under the program must be deposited into the existing Care Innovation and Community Improvement Program Fund. Money in the fund and the corresponding federal funds must continue to be used to make the supplemental payments to hospital agencies under the program.

## **Ohio Invests in Improvements for Priority Populations**

(Section 333.175)

The act establishes the Ohio Invests in Improvements for Priority Populations (OIPP) Program as a directed payment program for inpatient and outpatient hospital services provided to Medicaid managed care recipients receiving care at state university-owned hospitals with less than 300 inpatient beds.

Under the program, participating hospitals receive payments directly (instead of through the contracted Medicaid MCO) for inpatient and outpatient hospital services provided under the program and remit to the Department the nonfederal share of payment for those services. The hospital must pay the Department through intergovernmental transfer. Funds transferred under the program must be deposited into the Hospital Directed Payment Fund.

In general, under federal law, states are prohibited from (1) directing Medicaid MCO expenditures or (2) making payments directly to providers for Medicaid MCO services (“directed payments”) unless permitted under federal law or subject to federal authorization.<sup>102</sup> Therefore, the act requires the Medicaid Director to seek approval from CMS to operate the program.

## **Hospital Care Assurance Program, franchise permit fee**

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

The act continues the Hospital Care Assurance Program (HCAP) for two additional years. The program had been scheduled to end October 16, 2021. The act extends it to October 16, 2023. Under HCAP, hospitals are annually assessed an amount based on their total facility costs, and government hospitals make annual intergovernmental transfers. The Department distributes to hospitals money generated by the assessments and intergovernmental transfers along with federal matching funds. A hospital compensated under the program must provide (without charge) basic, medically necessary, hospital-level services to Ohio residents who are not recipients of Medicare or Medicaid and whose income does not exceed the federal poverty line.

The act also continues for two additional years another assessment imposed on hospitals; that assessment is to end on October 1, 2023, rather than October 1, 2021. The assessment is in addition to HCAP, but like that program, it raises money to help pay for the Medicaid program. To distinguish the assessment from HCAP, the assessment is sometimes called a hospital franchise permit fee.

## **Medicaid rates for community behavioral health services**

(Section 333.160)

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

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<sup>102</sup> Centers for Medicare and Medicaid Services, *Letter Re: Additional Guidance on State Directed Payments in Medicaid Managed Care*, January 8, 2021, <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf>.

## **Home and community-based services provider payment rates (VETOED)**

### **Adult day care services (VETOED)**

(Section 333.165)

The Governor vetoed a \$5 million earmark to increase the payment rates during the FY 2022 – FY 2023 biennium for adult day care services provided under the PASSPORT, Ohio Home Care, MyCare Ohio, and Assisted Living waivers. The increase would have applied to both Medicaid waiver-funded and state plan-funded providers. The Department would have been required to establish a methodology for calculating the rate increase from those funds.

### **Other services (VETOED)**

(Section 333.166)

The Governor vetoed a provision that would have increased the payment rates under the PASSPORT program, the Ohio Home Care waiver program, the MyCare Ohio Waiver program, and the Assisted Living waiver for waiver- and state plan-funded providers of the following services:

- Private duty nursing;
- Nursing;
- Home health aide;
- Personal care;
- Home care attendant and homemaker;
- Assisted living;
- Speech therapy;
- Occupational therapy; and
- Physical therapy.

For FY 2022, the payment rates for those services would have been 4% higher than the rates in effect on June 30, 2021. For FY 2023, the payment rates for those services would have been 2% higher than the rates in effect on June 30, 2022.

## **Value-based purchasing supplemental rebate**

(Section 333.215)

Not later than August 30, 2021, the act requires the Department to submit to CMS a Medicaid state plan amendment to authorize the Department to enter into value-based purchasing supplemental rebate agreements with pharmaceutical manufacturers. The agreements must establish criteria for the payment of supplemental rebates. The rebates can be calculated and paid in a single year or over multiple years.

The Department must use its best efforts to ensure that the agreement form submitted to CMS permits rebates to be calculated on many different bases at the discretion of the Department with the approval of the drug manufacturer, including under (1) outcome-based models, (2) shared savings models, (3) subscription or modified subscription models, (4) risk-sharing models, or (5) guarantees.

The act provides that the Department is not required to enter into these supplemental rebate agreements.

## **Medicaid reports**

### **Payment rate increase report to JMOC**

(R.C. 5162.82)

The act requires the Director to notify JMOC and be available to testify before JMOC before making any payment rate increases of greater than 10% under the Medicaid program.

### **Franchise permit fees report to JMOC**

(R.C. 5168.90)

The act requires the Director to submit a quarterly report to the members of JMOC and the executive director of JMOC with the fee rates and the aggregate total of the following fees:

- The hospital assessment fee;
- The nursing home and hospital long-term care unit franchise permit fee;
- The ICF/IID franchise permit fee; and
- The health insuring corporation franchise fee.

The Director also must report if there is a rate increase pending before the CMS for any of the above-listed fees.

The Director can adopt rules related to compiling and submitting the quarterly reports, including adopting rules specifying the information that must be submitted to the Director by the Department of Developmental Disabilities regarding the ICF/IID franchise permit fee.

## **Pharmacy supplemental dispensing fee (PARTIALLY VETOED)**

(Section 333.245)

The act requires the Department to establish a supplemental dispensing fee for retail pharmacies under the care management system for the FY 2022-FY 2023 biennium. The fee is being continued from last biennium's main operating budget. The Governor vetoed provisions in the act that would have required the three payment levels for the fee to be based on (1) the ratio of Medicaid prescriptions compared to total prescriptions a pharmacy location fills and (2) the number of pharmacy locations participating in the care management system in the geographic area, as determined by the Department. Also vetoed is a provision specifying that the supplemental dispensing fee cannot cause a reduction in other payments made to a pharmacy for providing prescribed drugs under the care management system.



The act provides that the Medicaid Director must adjust the fee if the Department receives reduced federal funds for the supplemental dispensing fee.

## **Nursing facilities**

### **Critical access nursing facilities**

(R.C. 5165.01)

The act clarifies terminology relating to the critical access incentive payment received by nursing facilities that qualify as critical access nursing facilities. To qualify as a critical access nursing facility, a nursing facility must meet certain occupancy and Medicaid utilization rate metrics. For purposes of calculating the occupancy and utilization rates, the act clarifies that “as of the last day of the calendar year” refers to the rates during the calendar year identified in the nursing facility’s annual cost report filed with the Department, rather than the entire reporting period.

### **Medicaid payment formula**

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

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

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

### **Resident assessment data**

(R.C. 5165.191)

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

### **Special Focus Facility Program**

(R.C. 5165.771)

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

Services SFF Program for nursing facilities identified as having substantially failed to meet federal requirements.<sup>103</sup>

### **SFF tables**

The act removes effective date references regarding the SFF tables. As a result, the Department must terminate a nursing facility's Medicaid participation if:

1. The nursing facility is placed in Table A or Table B and fails to be placed in Table C within 12 months after being placed in Table A or Table B;
2. The nursing facility is placed in Table A, Table B, or Table C and fails to be placed in Table D within 24 months after being placed in Table A, Table B, or Table C;
3. The nursing facility is placed in Table A and fails to be placed in Table C within 12 months after being placed in Table A;
4. The nursing facility is placed in Table A and fails to be placed in Table D within 24 months after the nursing facility is placed in Table A.

The act requires a nursing facility to take all necessary steps to avoid having its Medicaid participation terminated. As part of that requirement, the act provides that technical assistance and quality improvement initiatives to help a nursing facility are available through the Nursing Home Quality Initiative (NHQI) and through a quality improvement organization under the NHQI. Former law required the Department of Aging to provide assistance through the NHQI at least four months before the Department was required to terminate the facility's Medicaid participation.

The act permits nursing facilities to appeal, under the Administrative Procedure Act, the length of time a facility is listed on a SFF table. The Director may adopt rules to provide for an expedited process for those appeals, notwithstanding the Administrative Procedure Act's time limits. Under former law, an order terminating a nursing facility's Medicaid participation was not subject to appeal under the Administrative Procedure Act (R.C. Chapter 119).<sup>104</sup>

### **Quality payments – repealed**

(R.C. 5165.25, repealed)

The act repeals the quality payments nursing facilities received under former law. Those payments were made to nursing facilities for meeting at least one of five quality indicators. The largest quality payment was paid to nursing facilities that met all of the quality indicators for the measurement period (the calendar year preceding the year in which the fiscal year begins).

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<sup>103</sup> 42 U.S.C. 1396r(f)(10).

<sup>104</sup> In October 2020, the Ohio Tenth District Court of Appeals found that the prior version of R.C. 5165.771 violates the due process protections of the U.S. and Ohio Constitutions due to a lack of procedural protections and upheld a permanent injunction prohibiting its enforcement. *CT Ohio Portsmouth, LLC v. Ohio Dept. of Medicaid*, 2020-Ohio-5091 (10<sup>th</sup> Dist.).

The act repeals the quality payments; therefore, after FY 2021, nursing facilities will no longer receive quality payments.

### **Quality incentive payments (PARTIALLY VETOED)**

(R.C. 5165.26 and 5165.15)

The act modifies the calculations for quality incentive payments that are added to a nursing facility's Medicaid payment rates. The payment amount is based on the score the nursing facility receives for meeting certain quality metrics regarding its residents who have resided in the nursing facility for at least 100 days (long-stay residents). With certain adjustments, a nursing facility's quality score is the total number of points that CMS assigned to it under its nursing facility five-star quality rating system, based on the most recent four-quarter average data in its Nursing Home Compare, for the following:

- The percentage of the nursing facility's long-stay residents at high risk for pressure ulcers who had pressure ulcers;
- The percentage of the facility's long-stay residents who had a urinary tract infection;
- The percentage of the facility's long-stay residents whose ability to move independently worsened;
- The percentage of the facility's long-stay residents who had a catheter inserted and left in their bladder.

First, the act extends the payments through the FY 2022 – FY 2023 biennium. Under former law, the payments were scheduled to end after FY 2021.

Second, the act provides that the nursing facility data from CMS used to determine a nursing facility's quality incentive payment amount is the data from the most recent month of the calendar year during which the fiscal year begins, instead of May of the calendar year during which the fiscal year begins, as under former law.

Third, the act adds an additional circumstance under which a nursing facility is to receive zero quality points. Under the act, a nursing facility receives zero quality points for a fiscal year if its total number of points for FY 2022 or FY 2023 for all of the quality metrics is less than the bottom 25% of all nursing facilities. Continuing law, unchanged by the act, also provides that a nursing facility receives zero quality points for a quality metric if CMS assigned the nursing facility to the lowest percentile for that quality metric.

Fourth, the act replaces two former law disqualifications from the quality incentive payments with a new disqualification. Under the act, a nursing facility is ineligible for a quality incentive payment in a fiscal year if the Department of Health assigned the nursing facility to the SFF list on May 1 of the applicable calendar year. The Governor vetoed a provision that would have defined SFF "Table A," "Table B," and "Table C," for purposes of this provision, because the definitions contained terminology that was inconsistent with the federal table designations. Under former law, a nursing facility was disqualified from receiving a quality incentive payment if it is receiving its initial per Medicaid day payment rate or it underwent a change of operator.

Fifth, the act suspends after FY 2023 a provision of former law that disqualified a nursing facility from receiving quality incentive payments in FY 2021 if its licensed occupancy percentage is below 80%.

This disqualification does not apply if:

- The nursing facility has a quality score of at least 15 points;
- The nursing facility was initially certified for participation in Medicaid after January 1, 2019;
- One or more of the beds counted in the licensed occupancy percentage could not be used for resident care due to causes beyond the control of the facility operator, such as a force majeure event; or
- The nursing facility underwent a renovation involving capital expenditures of at least \$50,000 that directly impacted the part of the facility in which the beds counted in the licensed capacity were located.

Sixth, the act subtracts \$1.79 from the base rate used as part of the calculation for the total amount to be spent on quality incentive payments. Under the act, the base rate is calculated by determining the sum of the following:

1. The nursing facility's per Medicaid day payment rate for each of the four cost centers (ancillary and support costs, capital costs, direct care costs, and tax costs) and, if the nursing facility qualifies as a critical access nursing facility, its critical access incentive payment;
2. To that sum, add \$16.44;
3. From that sum, subtract \$1.79.

Former law did not include step (3) as part of the base rate calculation.

Seventh, the act modifies the calculation used to determine the total amount to be spent on quality incentive payments in a fiscal year. Under the act, the total to be spent is calculated as follows:

1. For each nursing facility, determine the amount that is 5.2% of the nursing facility's base rate (described above) on the first day of the fiscal year plus \$1.79;
2. Multiply that amount by the number of the nursing facility's Medicaid days for the calendar year preceding the fiscal year for which the rate is determined;
3. Determine the sum of (1) and (2) above for all nursing facilities for which the product was determined for the state fiscal year;
4. To that sum, add \$25 million in FY 2022 and \$125 million in FY 2023.

Current law does not add \$1.79 as part of the calculation in (1) above or include the add-ons to the total to be spent on the payments in each fiscal year in (4) above.

Finally, the act disqualifies a new nursing facility or a nursing facility that undergoes a change of operator during FY 2022 or FY 2023 from receiving a quality incentive payment for the fiscal year in which the new facility obtains an initial provider agreement or the change of

operator occurred. In the following fiscal year, the nursing facility is to receive a quality incentive payment under the normal calculation.

The above provisions take effect on June 30, 2021.

### **Nursing facility rebasing**

(R.C. 5165.36; Section 333.240)

The act makes changes to the nursing facility rebasing process, which must be conducted at least once every five state fiscal years as a redetermination of the cost components (called “cost centers”) used to calculate a nursing facility’s per Medicaid day payment rate.<sup>105</sup> The act requires the Department to conduct a rebasing of the direct care, ancillary and support, and tax cost centers only. Former law required the Department to rebase all four cost centers (the above three plus the capital costs center).

The act requires a nursing facility provider to spend 70% of any additional dollars received as the result of a rebasing on direct care costs, including employee salaries, and permits the Department to recover any amounts that are not spent in accordance with that requirement. This requirement applies to the Department’s FY 2022 rebasing and all subsequent rebasings. The act requires the Medicaid Director to adopt rules to ensure that nursing facility operators spend at least 70% of the additional dollars on direct care costs.

#### **Current rebasing**

The act requires the Department to conduct its next rebasing on June 30, 2021, based on calendar year 2019 nursing facility data. The act earmarks \$125 million in each fiscal year during FY 2022 and FY 2023 for the rebasing calculation and requires the Department to pay nursing facilities based on the rebasing calculations in the following order:

1. Direct care costs;
2. Ancillary and support costs; and
3. Tax costs.

The Department must prorate the rebasing determinations as necessary to stay within the earmark.

The act requires nursing facility providers to submit quarterly reports to the Department during FY 2022 and FY 2023 identifying the amounts spent by the provider on each cost center included in the FY 2022 rebasing. The Department can conduct a review of the reports to determine whether the reported amounts comply with the act’s requirements. If a nursing facility provider spends any amounts on cost centers in a manner that violates these requirements, the act requires the provider to reimburse those amounts to the Department, plus interest. The act permits the Medicaid Director to adopt rules to implement the above requirements.

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<sup>105</sup> 42 U.S.C. 1396r(f)(10).

## **Nursing Facility Payment Commission**

(R.C. 5165.261)

The act requires the Department to establish the Nursing Facility Payment Commission consisting of the following members:

- Four members appointed by the Speaker of the House; and
- Four members appointed by the Senate President.

Appointments must be made by December 31, 2021. In the event of a vacancy, a replacement member must be appointed in the same manner as initial appointments. Members serve without compensation. At the initial meeting, Commission members must elect one member of the majority party of the House and one member of the majority party of the Senate to serve as co-chairpersons.

The Commission must analyze the efficacy of the following:

1. The current quality incentive payment formula;
2. The nursing facility base rate calculation;
3. The nursing facility cost centers used to calculate a nursing facility's per Medicaid day payment rate; and
4. Establishing a bed buyback program under which a nursing facility operator can permanently surrender one or more long-term care beds due to a decrease in bed utilization.

By August 31, 2022, the Commission must submit a report to the General Assembly with its recommendations and determinations regarding those items.