DEPARTMENT OF MEDICAID

Medicaid eligibility

Medicaid coverage for workers with a disability

- Requires the Medicaid program to cover the optional eligibility group consisting of certain workers with a disability.
- Declares that the General Assembly's intent in requiring the coverage is to provide coverage consistent with Ohio's existing Medicaid Buy-In for Workers with a Disability program for workers with disabilities age 65 or older.

Continuous Medicaid enrollment for young children

- Requires the Medicaid Director to establish a Medicaid waiver component to provide continuous enrollment for Medicaid-eligible children from birth through age three.

Medicaid presumptive eligibility error rate training (PARTIALLY VETOED)

- Requires each entity or provider qualified to make presumptive eligibility determinations to submit a corrective action plan to ODM and provide training when the entity or provider's error rate exceeds 7.5% in a calendar month.
- Would have disqualified presumptive eligibility determinations for 60 months for any qualified entity or provider that exceeded a presumptive eligibility error rate of 7.5% in six or more months in a 24-month period (VETOED).

Post-COVID Medicaid unwinding

- Requires the Department of Medicaid (ODM) to use third-party data to conduct an eligibility redetermination of all Ohio Medicaid recipients at the conclusion of the COVID-19 emergency period.
- Requires ODM to conduct an eligibility review of all recipients, based on the recipient's eligibility review date, and to disenroll those recipients who are no longer eligible.
- Requires ODM to complete a report containing its findings from the verification and submit it to the Joint Medicaid Oversight Committee (JMOC).
- Repeals requirements ODM must follow if it receives federal Medicaid funding contingent on a temporary maintenance of effort restriction or otherwise limiting its ability to disenroll ineligible recipients.

Nursing facilities

Special Focus Facility Program

- Aligns statutory language regarding the Special Focus Facility (SFF) Program with federal changes to the program and prohibits a nursing facility provider from appealing an order

issued by ODM terminating a nursing facility's participation in Medicaid based on the facility's participation in the SFF program.

Nursing facility case-mix scores

- Updates the terminology used to calculate nursing facility case-mix scores to correspond to the new federal Patient Driven Payment Model.

Debt summary reports; debts related to exiting operators

- Regarding determining the actual amount of debt an exiting operator of a nursing facility owes ODM, requires ODM to issue a final debt summary report instead of having an initial or revised debt summary report become the final debt summary report.
- Eliminates various provisions related to debts an exiting operator owes to the federal Centers for Medicare and Medicaid Services (CMS).

Nursing facility field audit manual and program

- Eliminates the requirement that ODM establish a program and manual for field audits of nursing facilities.
- Eliminates certain required procedures for auditors that must be included in the manual.
- Requires audits conducted by ODM to be conducted by an audit plan developed before audit begins, and audits conducted by auditors contracted with ODM be conducted by procedures agreed upon by the auditor and ODM, subject to certain continuing requirements.

Alternative purchasing model – ventilator services

- Beginning on July 1, 2023, prohibits the Director from approving an application for an alternative purchasing model for ventilator services in a discrete unit of a nursing facility if the facility is listed on Table A or Table D of the SFF list or has a one-star overall rating in CMS's Care Compare database.
- Requires ODM to pay pursuant to the alternative purchasing model for services provided on or after the date the facility's is removed from the SFF list or no longer has a one-star overall rating.
- Permits the Director to waive the above requirements if the Director determines that the waiver is necessary to ensure access to ventilator services in the geographic area of the unit.

Nursing facility per Medicaid day payment rate

- Modifies the nursing facility per Medicaid day payment rate calculation by removing a $1.79 deduction, including a deduction for low occupancy nursing facilities, and increasing the add-on to the initial rate for new nursing facilities.

Ancillary and support costs and direct care costs

- Determines a nursing facility's direct care costs rates by using the rate at the 70th percentile of the facility's peer group.
- Beginning on January 1, 2024, during the remainder of FY 2024 and all of FY 2025, requires ODM to determine each nursing facility's direct care costs by multiplying the per case-mix unit determined for the peer group by the case-mix score selected by the nursing facility.
- Removes inflationary adjustments to the calculation for a facility's ancillary and support and direct care costs.

Low occupancy deduction

- To the per Medicaid day payment rate formula, adds a low occupancy deduction for a nursing facility that has an occupancy rate below 65%.

Private room incentive payment

- Beginning six months after CMS approval or the effective date of applicable ODM rules, but not later than April 1, 2024, adds a private room incentive payment rate to the per Medicaid day payment rate formula for nursing facilities with private rooms.
- Sets the private room incentive payment at $30 for a Category One private room and $20 for a Category Two private room during FY 2024 and permits ODM to increase the rate in subsequent fiscal years.
- Requires nursing facility providers to apply for approval of their private rooms in the form and manner prescribed by ODM and permits ODM to specify evidence that an applicant must supply to demonstrate that a room is a private room.
- Limits ODM to considering only those private room applications that meet specified criteria.
- Permits ODM to deny an application under certain circumstances.

Quality incentive payments

- Extends nursing facility quality incentive payments indefinitely.
- Adds an occupancy metric to the quality incentive payment rate calculation, beginning in FY 2024, for facilities with specified occupancy thresholds, and adds four new quality incentive metrics beginning in FY 2025.
- Eliminates an exclusion from the quality incentive payment for facilities that have an occupancy percentage of less than 80%, unless certain exceptions are met.
- Requires a facility's number of quality points to be recalculated in the second half of each fiscal year using updated information, and specifies that a facility receives zero quality points if its number of points is in the bottom 25th percentile of all facilities.

- Adds to the calculation of the total amount to be spent on quality incentive payments an additional component based on 60% of the amount the facility's ancillary and support costs and direct care costs changed as a result of the FY 2024 rebasing.
- Caps the add-on to the total amount to be spent on quality incentive payments at $125 million in each fiscal year.
- Grants an operator of a new nursing facility or, under certain circumstances, a facility that undergoes a change in operator, a quality incentive payment.

Rebasing

- Beginning in FY 2024, limits rebasing to only the direct care and tax cost centers.
- Specifies that the costs are measured from the calendar year immediately before the start of the fiscal year in which a rebasing is conducted, instead of two calendar years before.
- In calculating a facility's FY 2024 and FY 2025 base rates, limits any increases in the direct care cost and ancillary and support cost centers from the most recent rebasing to only 40% of the increase.

Medicaid provider payment rates

Payment rates for community behavioral health services

- Permits ODM to establish Medicaid payment rates for community behavioral health services provided during FY 2024 and FY 2025 that exceed the Medicare rates for those services.

Competitive wages for direct care workforce

- Requires certain funds contained in the act for provider rate increases to be used to increase wages and needed workforce supports to ensure workforce stability and greater access to care for Medicaid recipients.

Assisted Living program payment rates (PARTIALLY VETOED)

- Requires ODM, in consultation with the Department of Aging (ODA), to establish both (1) an assisted living services base payment rate, and (2) an assisted living memory care service payment rate for assisted living facilities participating in the Medicaid-funded component of the Assisted Living program.
- Would have required the rules to be adopted by November 1, 2023, and established the payment rates at certain levels (VETOED).
- Would have required the departments to also establish a critical access payment rate for such facilities and adopt associated rules (VETOED).

Direct care provider payment rates (PARTIALLY VETOED)

- Increases direct care wages for certain direct care services provided under the Medicaid home and community-based services waivers administered by ODM or ODA.

- Would have increased the base payment rate to $17 an hour in FY 2024 beginning January 1, 2024, and to $18 an hour for all of FY 2025 (VETOED).

Federally qualified health center payment rates (VETOED)

- Would have appropriated funds to increase payment rates to federally qualified health centers (FQHCs) and FQHC look-alikes (VETOED).

Vision and eye care services provider payment rate (VETOED)

- Would have earmarked funds to increase Medicaid provider payment rates for vision services and medically billed eye care provided to Medicaid recipients during FY 2024 (VETOED).

Dental provider payment rates (VETOED)

- Would have appropriated $122 million in FY 2024 and $244 million in FY 2025 to increase the payment rate to dental providers treating Medicaid enrollees (VETOED).

Medicaid MCO credentialing

- Repeals a requirement that ODM permit Medicaid managed care organizations (MCOs) to create a credentialing process for providers.

Payment of claims by third parties

- Decreases to 60 days (from 90 days) the time period in which specified third parties must respond to a request by ODM for payment of a claim.

Payment rate for neonatal and newborn services

- Specifies that the Medicaid payment rate for certain neonatal and newborn services must be *at least* 75% of the Medicare payment rate for the services, rather than equaling 75% of the rate.

Medicaid providers

Interest on payments to providers

- Limits the time frame when interest is assessed against a Medicaid provider on an overpayment to the time period determined by ODM, instead of from the payment date until the repayment date.

Provider penalties

- Clarifies that when a Medicaid provider agreement is terminated due to a provider engaging in prohibited activities, the provider may not provide Medicaid services on behalf of any other Medicaid provider.

Suspension of provider agreements and payments

- Revises the law governing the suspension of Medicaid provider agreements and payments in cases of credible allegations of fraud or disqualifying indictments against

Medicaid providers or their officers, agents, or owners, including by prohibiting a suspension if the provider or owner can demonstrate good cause.

Criminal records checks

- Revises the law governing the availability of criminal records check reports for Medicaid providers, independent providers, and waiver agencies and their employees, including by authorizing reports to be introduced as evidence at certain administrative hearings and requiring them to be admitted only under seal.

HHA and PCA training

- Prohibits ODM from requiring more hours of pre-service training and annual in-service training than required by federal law for home health aides (HHAs) providing services under the Integrated Care Delivery System (MyCare Ohio).
- Prohibits ODM from requiring more than 30 hours of pre-service training and six hours of annual in-service training for personal care aides (PCAs) providing services under MyCare Ohio.
- Permits a licensed practical nurse to supervise an HHA or PCA providing services under MyCare Ohio.

ICF/IID bed conversion to OhioRISE program

- Prohibits an ICF/IID from reserving or converting a portion of its beds from beds that provide ICF/IID services to beds that provide services to individuals enrolled in the OhioRISE program, if reserving or converting a bed would require the ICF/IID operator to discharge or terminate services to a resident occupying that bed.

Special programs

Care Innovation and Community Improvement Program

- Requires the Director to continue the Care Innovation and Community Improvement Program for the FY 2024-FY 2025 biennium.

Ohio Invests in Improvements for Priority Populations

- Continues 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 ODM, through intergovernmental transfer, the nonfederal share of payment for those services.

Physician directed payment program

- Permits the Medicaid Director to seek federal approval to establish a physician directed payment program for nonpublic hospitals and related health systems under which

participating hospitals receive payments directly for physician services provided to enrollees.

- Caps directed payments under the programs at the average commercial level paid to participating health systems for physician and other covered professional services that are provided to Medicaid MCO enrollees.
- Requires eligible public entities to transfer, through intergovernmental transfer, the nonfederal share of those services.

Ground emergency medical transportation supplemental payment program

- Requires the Director to submit a state plan amendment seeking to establish and administer a supplemental payment program for specified ground emergency medical transportation service providers.

Hamilton County hospital directed payment program

- Permits ODM to establish a hospital directed payment program for directed payments to hospitals in Hamilton County that meet enumerated criteria.
- Permits eligible public entities to transfer funds, through intergovernmental transfer, to ODM for the directed payments, and limits payment amounts to not more than the average commercial level paid for inpatient and outpatient services under the Care Management System.

Hospital Care Assurance Program; franchise permit fee

- Continues, until October 2025, the Hospital Care Assurance Program and the franchise permit fee imposed on hospitals under Medicaid.

ODM doula program (PARTIALLY VETOED)

- Establishes a program to cover doula services provided by a certified doula with a Medicaid provider agreement.
- Would have required the Medicaid Director to complete an annual report regarding program outcomes (VETOED).
- Repeals this program after five years (PARTIALLY VETOED).

General

Coverage of services at outpatient health facilities

- Repeals law that required Medicaid to cover comprehensive primary health services provided by outpatient health facilities that are operated by a city or general health district, another public agency, or certain types of nonprofit private agencies or organizations that receive at least 75% of their operating funds from public sources.

Medicaid program reforms

- When calculating the per member per month growth rate in the Medicaid program for purposes of required Medicaid program reforms, requires the Director to include all Medicaid costs, with the exception of one-time expenses or expenses unrelated to enrollees.
- Requires ODM, not later than October 1 of each year, to submit a report to JMOC detailing Medicaid reforms during the two previous fiscal years.
- In even-numbered years, requires the report to include ODM's historical and projected Medicaid program expenditure and utilization trend rates for each year of the next biennium.

Medicaid program cost savings report

- Requires ODM to conduct an annual cost savings study of the Medicaid program and submit a report to the Governor recommending measures to reduce Medicaid program costs.

HCBS direct care worker wages

- During the fiscal biennium, requires ODM, ODA, and the Department of Developmental Disabilities to jointly submit an annual report outlining the wages paid to direct care staff providing services to enrollees under the Medicaid home and community-based services (HCBS) waivers.

Medicaid work requirements

- Between February 1, 2025, and March 1, 2025, requires the ODM Director to apply to CMS for a new waiver establishing Medicaid work requirements.

Meaningful employment for Medicaid recipients

- Requires ODM, in collaboration with ODJFS, to establish a program to assist individuals enrolled in Medicaid secure meaningful employment.
- Requires each Medicaid MCO to develop a specialized component of their MCO plan to provide referral and support services to identified enrollees to assist in obtaining and maintaining employment.
- Requires ODM and ODJFS to convene a workgroup to assist in the implementation of the program.
- Requires ODM and ODJFS to provide a periodic report to the Governor, Senate Medicaid Committee, and other relevant legislative committees regarding the implementation and operation of the program.

MyCare Ohio expansion

- Requires the Medicaid Director to seek CMS approval to expand MyCare Ohio, or its successor program, to all Ohio counties.

- Requires the Director to select the entities for the expanded program.
- Requires ODM to establish requirements for care management and coordination of waiver services, subject to enumerated requirements.

Coverage of remote ultrasounds and fetal nonstress tests

- Requires Medicaid coverage of remote ultrasound procedures and remote fetal nonstress tests under certain circumstances.

Coverage for donor breast milk and human milk fortifiers

- Requires the Medicaid program to cover medically necessary pasteurized donor human milk and human milk fortifiers for inpatient and home use.

Lockable and tamper-evident containers (PARTIALLY VETOED)

- Requires ODM to reimburse pharmacists for expenses related to dispensing drugs in lockable or tamper-evident containers.
- Would have required that coverage only (1) during FY 2024 and FY 2025 and (2) for drugs used in medication assisted treatment (VETOED).
- Would have required ODM, during FY 2024 and FY 2025, to reimburse prescribers for expenses related to personally furnishing drugs used in medication-assisted treatment in lockable containers or tamper-evident containers (VETOED).

Nursing Home Franchise Permit Fee Fund uses

- Expands the permitted uses of the Nursing Home Franchise Permit Fee Fund.

Obsolete waiver repeal

- Repeals the Unified Long-Term Services and Support Medicaid Waiver component that was never implemented.

Medicaid eligibility

Medicaid coverage for workers with a disability

(R.C. 5163.06 and 5163.063; Sections 333.310 and 812.40)

The act requires the Medicaid program to provide coverage to employed individuals with disabilities whose family income is less than 250% of the federal poverty level. Under federal law, states have the option of extending Medicaid coverage to this group of individuals.[114] The act requires the Director to adopt any rules necessary to provide the coverage.

The act delays implementation of Medicaid coverage for this new group for one year after its October 3, 2023, effective date. Upon approval of a state plan amendment by the federal

[114] 42 U.S.C. 1396a(a)(10)(A)(ii)(XIII).

Centers for Medicare and Medicaid Services (CMS) that authorizes the Medicaid coverage, the Medicaid Director may certify to the OBM Director the amount needed to pay for coverage of the optional eligibility group in FY 2025. Upon this certification, the act appropriates that amount to the Department of Medicaid (ODM).

In requiring the Medicaid program to cover this group of individuals, the act declares that it is the intent of the General Assembly to establish Medicaid coverage for employed individuals with disabilities who are 65 years of age or older in a manner that is consistent with the coverage that is provided to individuals who participate in the Medicaid Buy-In for Workers with Disabilities program.

Continuous Medicaid enrollment for young children

(R.C. 5166.45)

The act requires the Director to establish a Medicaid waiver component to provide continuous Medicaid enrollment for Medicaid-eligible children from birth through age three. A child who is eligible for Medicaid will remain eligible until the earlier of (1) the end of a continuous 48-month period, or (2) the date the child exceeds age four. The waiver does not apply to a child who is deemed presumptively eligible for Medicaid, is eligible for alien emergency medical assistance, or is eligible for the refugee medical assistance program.

Medicaid presumptive eligibility error rate training (PARTIALLY VETOED)

(R.C. 5163.103)

The act imposes requirements related to presumptive eligibility, which is a federal option by which states may elect to grant temporary Medicaid benefits to certain eligible individuals as a result of an initial, simplified eligibility determination while the individual applies for full Medicaid coverage. Related to presumptive eligibility determinations, the act defines the presumptive eligibility error rate as the rate at which entities or providers that are qualified to conduct presumptive eligibility determinations deem an individual presumptively eligible for Medicaid but the individual is ineligible. Under the act, ODM must require qualified entities and providers to take the following steps when they have a presumptive eligibility error rate greater than 7.5% in a calendar month:

1. Submit for ODM's approval a corrective action plan specifying the steps the entity or provider will take to reduce its error rate, including required trainings; and

2. Provide training for all presumptive eligibility determination staff to ensure thorough knowledge of prescreening procedures.

The Governor vetoed provisions that would have imposed penalties when a qualified entity or provider exceeded the 7.5% error rate limit. The penalties would have required ODM to notify a qualified entity or provider that they could no longer make eligibility determinations when the error rate exceeded 7.5% in six or more cumulative months in a 24-month period.

The qualified entity or provider would have remained unable to make presumptive eligibility determinations for 60 months.

Post-COVID Medicaid unwinding

(Section 333.210; repealed R.C. 5163.52)

The act requires ODM or its designee to use third-party data sources and systems to conduct eligibility redeterminations of all Ohio Medicaid recipients given the end of the federal COVID-19 emergency period.[115] The federal COVID-19 emergency period expired May 11, 2023.[116] ODM or its designee must, to the full extent permitted by state and federal law, verify Medicaid recipients' enrollment records against third-party data sources and systems, including any other records ODM considers appropriate to strengthen program integrity, reduce costs, and reduce fraud, waste, and abuse in the Medicaid program.

ODM or its designee must conduct an eligibility review of Medicaid recipients based on the recipient's next eligibility review date. Based on that review, ODM must disenroll those Medicaid recipients who are determined to no longer be eligible based on this expedited review, and must oversee the county determinations and administration to ensure timely and accurate compliance with these requirements.

Additionally, the act requires ODM to complete a report containing its findings from the redetermination, including any findings of fraud, waste, or abuse in the Medicaid program through June, 2024 – 13 months after the expiration of the federal emergency period.

In imposing these requirements, the act repeals law enacted in the last main operating budget that establish requirements ODM must follow if it received federal Medicaid funding contingent on a temporary maintenance of effort restriction or otherwise limited ODM's ability to disenroll ineligible recipients, such as the maintenance of effort requirements under the Families First Coronavirus Response Act.[117]

Nursing facilities

Special Focus Facility Program

(R.C. 5165.771)

The act revises the law regarding the federal Special Focus Facility (SFF) Program to align with federal changes to the program. First, it references standard health surveys, which, under the federal changes, are comprehensive on-site inspections conducted every six months by the state nursing facility licensing agency on behalf of CMS. The act replaces references to the old SFF tables and instead requires ODM to terminate a nursing facility's participation in the Medicaid program if it has not graduated from the SFF program after two standard health surveys, instead of based on the time the facility is listed in SFF tables.

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[115] 42 U.S.C. 1320b-5(g)(1)(B).

[116] See the White House Statement of Administration Policy, January 30, 2023 (PDF), which is available on the Statements of Administration Policy page via keyword "terminate the public health emergency" search on whitehouse.gov.

[117] Section 6008, Pub. L. No. 116-127.

Second, the act prohibits a nursing facility from appealing to ODM an ODM order terminating the facility's participation in the Medicaid program if the appeal challenges (1) standard health findings under the SFF program or (2) a CMS determination to terminate the nursing facility's participation in the Medicare or Medicaid program. Instead, the appeals must be brought to (1) the Department of Health or (2) CMS, respectively.

Nursing facility case-mix scores

(R.C. 5165.01, 5165.152, and 5165.192)

The act updates the terminology used to calculate nursing facility case-mix scores to correspond to a new federal model. Effective October 1, 2019, CMS implemented a new Patient Driven Payment Model. The act updates terminology relating to nursing facility case-mix scores from "low resource utilization resident" to "low case-mix resident" to accord with the new model.

Debt summary reports; debts related to exiting operators

(R.C. 5165.52, 5165.521, 5165.525, 5165.526, and 5165.528)

The act makes several changes related to exiting operators of nursing facilities and various related duties of ODM. Regarding a requirement that ODM determine the actual amount of debt an exiting operator owes ODM, the act requires ODM to issue a final debt summary report. Under prior law, an initial or revised debt summary report could have automatically become the final debt summary report.

Also regarding exiting operators, the act eliminates the following provisions related to debts an operator owes to CMS:

- A requirement that ODM determine other actual and potential debts the exiting operator owes or may owe to CMS;
- Authorization for ODM to withhold from a payment due to an exiting operator the total amount the exiting operator owes or may owe to CMS;
- A requirement that ODM determine the actual amount of debt an exiting operator owes to CMS by completing all final fiscal audits not already completed and performing other appropriate actions;
- Regarding releasing amounts withheld from an exiting operator, authorization for ODM to deduct any amount an exiting operator owes CMS; and
- Authorization for moneys in the Medicaid Payment Withholding Fund to be used to pay CMS amounts an exiting operator owes CMS under Medicaid.

All of the above-described provisions are retained as they relate to debt owed to ODM, and eliminated only with regard to debt owed to CMS. The act, however, eliminates law expressly requiring ODM's debt estimate methodology to address any final civil monetary and other penalties.

Nursing facility field audit manual and program

(R.C. 5165.109)

Under continuing law, ODM may conduct audits for any cost reports filed as either an annual cost report by a nursing home or by an exiting operator of a nursing home. The act removes the requirement that ODM establish a program and publish a manual for those audits conducted in the field. Instead, the act specifies general parameters for field audit procedures. Specifically, ODM must develop an audit plan before the audit begins for any audits it conducts, but the scope of the audit may change during its course based on the observations and findings. Field audits conducted by an auditor under contract with ODM must be conducted by procedures agreed upon between ODM and the auditor.

The act, as a result of eliminating the field manual, eliminates the requirements that all auditors conducting field audits:

- Comply with federal Medicare and Medicaid law;
- Consider standards prescribed by the American Institute of Certified Public Accountants;
- Include a written summary with each audit about whether cost report that is the subject of the audit complied with state and federal laws and the reported allowable costs were documented, reported, and related to patient care;
- Completed each audit within a time period specified by ODM; and
- Provide to the nursing home provider written information about the audit's scope and ODM's policies, including examples of allowable cost calculation.

Alternative purchasing model – ventilator services

(R.C. 5165.157)

The act clarifies the application of ventilator services to ODM's current authority to establish an alternative purchasing model for nursing facility services provided in discrete units of nursing facilities. Beginning in FY 2024, the Director may not approve an application for an alternative purchasing model for ventilator services provided in such a unit if, at the time of application, the facility is listed on Table A or Table D of the SFF list or is designated as having a one-star overall rating in CMS's Care Compare database. For services beginning on January 1, 2024, in such a unit, the facility must be paid for those services pursuant to the facility's regular per Medicaid day payment rate formula, instead of pursuant to the alternative purchasing model. If the facility is removed from the SFF list or no longer has a one-star overall rating, ODM must pay for ventilator services on or after the removal from the SFF list or increase in rating pursuant to the alternative purchasing model. The Director may waive the above requirements if the Director determines that the waiver is necessary to ensure access to ventilator services in the geographic area of the unit.

Nursing facility per Medicaid day payment rate

(R.C. 5165.15 and 5165.151)

The act modifies the formula used to calculate the Medicaid payment amount ODM makes to nursing facilities for Medicaid residents (referred to as the per Medicaid day payment rate in the Revised Code) as follows:

- Removes the $1.79 deduction that is part of calculating a facility's base rate;
- Incudes a deduction for low occupancy nursing facilities; and
- For the initial rate paid to new nursing facilities, increases the add-on to $16.44 from $14.65.

Ancillary and support costs and direct care costs

(R.C. 5165.16 and 5165.19)

The act makes changes to two of the cost center calculations that are used as part of the per Medicaid day payment rate formula. First, it removes inflationary adjustments for the ancillary and support and direct care costs. Additionally, under the act, a nursing facility's direct care costs rates are determined based on the 70th percentile for the peer group, instead of the rate at the 25th percentile.

During FY 2024 and FY 2025, the act adds another modification to the direct care costs calculation. Beginning January 1, 2024, through the end of the biennium, ODM must determine each nursing facility's direct care costs rate by multiplying the per case-mix unit determined for the peer group under the calculation by the case-mix score selected by the nursing facility. A facility may select either of the following for its case-mix score:

1. The semi-annual case-mix score determined under the regular calculation; or

2. The facility's quarterly case-mix score from March 31, 2023, which will apply during the period from January 1, 2024, through June 30, 2025.

If a facility does not select its case-mix score mechanism by October 1, 2023, the case-mix score determined under the regular calculation applies.

Low occupancy deduction

(R.C. 5165.23 and 5165.15)

The act grants to a nursing facility that has an occupancy rate lower than 65% a low occupancy deduction as part of its per Medicaid day payment rate. Each state fiscal year, ODM must determine the low occupancy deduction for each low occupancy nursing facility, equal to 5% of the facility's total per Medicaid day payment rate for that fiscal year.

For purposes of this deduction, ODM must calculate the facility's occupancy rate based on the occupancy rate of the licensed beds listed on its cost report for the calendar year before the fiscal year for which the rate is determined, or if the facility is not licensed, the occupancy rate for its certified beds. If the facility surrenders licensed or certified beds before July 1 of the calendar year in which the fiscal year begins, ODM must calculate the facility's occupancy rate by

dividing the number of inpatient days reported on the facility's cost report for the calendar year preceding the fiscal year for which the rate is determined by the product of (1) the number of days in the calendar year and (2) the facility's number of licensed or certified beds on July 1. The following facilities are ineligible for the low occupancy deduction:

- A facility where the beds are owned by the county and the facility is operated by a person other than the county;
- A facility that opened during the calendar year before the fiscal year for which the rate is determined; and
- A facility that underwent a renovation during the calendar year before the fiscal year for which the rate is determined, if the renovation (1) involved a capital expenditure of at least $150,000 and (2) included one or more beds that are part of the facility's licensed capacity and that were taken out of service for at least 30 days.

Private room incentive payment

(R.C. 5165.158 and 5165.01)

Beginning six months from CMS approval or the effective date of applicable ODM rules, but not sooner than April 1, 2024, the act adds a private room incentive payment rate to the per Medicaid day payment rate formula. The private room incentive payment is $30 for a Category One private room and $20 for a Category Two private room, beginning in FY 2024. ODM may increase the rate in subsequent fiscal years. Nursing facilities with private rooms are eligible for the incentive payment. A private room is a bedroom that:

1. Has four permanent, floor-to-ceiling walls and a full door;
2. Contains one licensed or certified bed occupied by only one individual;
3. Has access to a hallway without traversing another bedroom;
4. Has access to a toilet and sink shared by not more than one other resident without traversing another bedroom; and
5. Meets all applicable licensure or other standards pertaining to furniture fixtures, and temperature control.

ODM must approve rooms in nursing facilities for the private room incentive payment beginning on January 1, 2024, for Category One private rooms and on March 1, 2024, for Category Two private rooms. Under the act, a Category One private room is a private room that has unshared access to a toilet and sink and a Category Two private room is a private room that has shared access to a toilet and sink. A nursing facility provider must apply for approval of its private rooms in the form and manner prescribed by ODM. ODM may specify evidence that an applicant must supply and may conduct an inspection to demonstrate that a room meets the definition of a private room. ODM may consider only applications that meet the following criteria, and may specify evidence an applicant must supply and may conduct an inspection of the room to demonstrate it meets those criteria:

1. Rooms that are in existence on July 1, 2023, in facilities where all licensed beds are in service on the application date;

2. Rooms created by surrendering licensed or certified beds from the facility's licensed or certified bed capacity;

3. Rooms created by adding space to the facility or renovating nonbedroom space, without increasing the facility's licensed bed capacity; or

4. Rooms in a nursing facility licensed after July 1, 2023, in which all licensed beds are in service or in which private rooms were created by surrendering licensed beds.

ODM must approve an application for rooms that meet the definition of a private room described above, but may deny an application if it determines any of the following:

- The rooms included in the application do not meet the definition of a private room or the criteria listed above;
- The applicant created private rooms by reducing the number of available beds without reducing the facility's licensed capacity;
- Approval of the room would cause projected expenditures for private room incentive payments to exceed $40 million in FY 2024 or $160 million in subsequent fiscal years, using a utilization percentage of 50%. In such a case, ODM must prioritize Category One private rooms.
- On the application date, the facility is listed on Table A or Table D of the SFF list or has a one-star overall rating in CMS's Care Compare database.

An applicant can request a reconsideration of a denial.

Beginning July 1, 2025, to retain eligibility for private rooms, a nursing facility must have a policy in place to prioritize placement in a private room based on a resident's needs and participate in the resident or family satisfaction survey performed pursuant to continuing law.

ODM must hold all private room applications in pending status until CMS approves private room incentive payments and ODM determines that a facility is qualified for the payment.

Quality incentive payments

(R.C. 5165.26 and 5165.15; Section 333.290)

Under Ohio law, a nursing facility's per Medicaid day payment rate includes a quality incentive payment, which is determined through a statutorily specified calculation. The act modifies the quality incentive payment rate calculation as follows.

First, it extends the duration of the quality incentive payments in perpetuity (former law ended them after FY 2023).

Second, it includes provisions in the event CMS develops new nursing facility metrics. A nursing facility's quality points are based on the number of points that CMS assigned to the facility using its five-star quality rating system, known as the Nursing Home Care Compare, for

specified quality metrics. The act specifies that in the event CMS develops new quality metrics, the calculation is to be based on the successor metrics on the same topics.

Third, the act adds an occupancy adjustment to the calculation. If a nursing facility's occupancy rate exceeds 75%, the facility receives an additional 7.5 points in FY 2024 and three points in subsequent fiscal years.

ODM must calculate a nursing facility's occupancy rate using the facility's occupancy rate for licensed beds on its cost report for the calendar year preceding the fiscal year for which the rate is determined, or if the facility is not licensed, its occupancy rate for certified beds. If the facility surrenders licensed or certified beds before July 1 of the calendar year in which the fiscal year begins, ODM must calculate the facility's occupancy rate by dividing the number of inpatient days reported on the facility's cost report for the calendar year preceding the fiscal year for which the rate is determined by the product of (1) the number of days in the calendar year and (2) the facility's number of licensed or certified beds on July 1 of the calendar year in which the fiscal year begins.

Fourth, the act adds three new quality metrics to the calculation beginning in FY 2025. Beginning on July 1, 2024, ODM must add the number of points the facility receives in ODM's Nursing Home Care Compare, or successor metrics, for the following metrics:

1. The percentage of the facility's long-stay residents whose need for help with daily activities has increased;

2. The percentage of the facility's long-stay residents experiencing one or more falls with major injury;

3. The percentage of the facility's long-stay residents who were administered antipsychotic medication; and

4. The adjusted total nurse staffing hours per resident per day, using quintiles instead of deciles for the points assigned to the higher of the two deciles that constitute the quintile.

In its notice to nursing facilities with their FY 2024 rates, ODM must notify each facility of how many quality points the facility would have received, based on calendar year 2022 data, for the new quality metrics.

Fifth, the act eliminates and modifies exemptions to the quality incentive payments under former law. It eliminates a requirement that a facility's occupancy percentage was less than 80% in the applicable fiscal year, *unless* certain conditions were met. The act adds a new requirement that a facility's quality score be recalculated for the second half of each fiscal year based on the most recent four quarter average data. If a facility's points for all of the quality metrics is less than the bottom 25th percentile of all nursing facilities, ODM must reduce the facility's quality points to zero, as under former law, until the next point recalculation.

Sixth, the act adds a component to be included in the calculation for the total amount to be spent on quality incentive payments based on the facility's cost centers. As part of the calculation, ODM must include 60% of the sum of the per diem amount by which the nursing facility's rate for direct care costs changed as a result of the rebasing conducted for FY 2024.

Seventh, the act caps the amount that is to be added to the amount to be spent on quality incentive payments in a fiscal year at $125 million in each fiscal year.

Eighth, the act grants quality incentive payments to new nursing facilities and, under certain circumstances, nursing facilities that undergo a change of operator. Under the act, beginning July 1, 2023, a new nursing facility receives a quality incentive payment for the fiscal year of its initial provider agreement and the immediately following fiscal year equal to the median quality incentive payment amount determined for nursing facilities for the fiscal year. After those years, the facility receives a payment based on the normal calculation.

A nursing facility that undergoes a change of operator effective July 1, 2023, or after will not receive a quality payment until the earlier of the January 1 or July 1 that is six months after the effective date of the change. Thereafter, the payment rate will be determined by the normal calculation.

Rebasing

(R.C. 5165.36; Section 333.300)

At least once every five years, ODM must recalculate each nursing facility's cost centers to account for increasing costs over time and use those figures when determining a nursing facility's per Medicaid day payment rate. Beginning in FY 2024, the act restricts the rebasing to only the direct care and tax cost centers. The act also eliminates the requirement that nursing facility providers spend additional money received as a result of the FY 2022 rebasing on direct care costs, ancillary and support costs, and tax cost centers only. The act further provides that for FY 2024 and FY 2025, ODM must include in each nursing facility's per Medicaid day payment base rate only 40% of the sum of the increase in the facility's rate for direct care costs and its rate for ancillary and support costs that result from the FY 2024 rebasing.

Medicaid provider payment rates

Payment rates for community behavioral health services

(Section 333.140)

The act permits ODM to establish Medicaid payment rates for community behavioral health services provided during FY 2024 and FY 2025 that exceed the Medicare rates for those services. This authorization does not apply to those services provided by hospitals on an inpatient basis, nursing facilities, or ICFs/IID.

Competitive wages for direct care workforce

(Section 333.230)

The act includes funding from ODM, in collaboration with the Department of Developmental Disabilities and the Department of Aging (ODA), to be used for provider rate increases, in response to the adverse impact experienced by direct care providers as a result of the COVID-19 pandemic and inflationary pressures. The act requires the provider rate increases be used to increase wages and workforce supports to ensure workforce stability and greater access to care for Medicaid recipients.

Assisted Living program payment rates (PARTIALLY VETOED)

(Section 333.240)

The act requires ODM, in consultation with ODA, to adopt rules to both:

1. Establish an assisted living services base payment rate for residential care facilities (commonly known as "assisted living" facilities) participating in the Medicaid-funded component of the Assisted Living program;

2. Establish an assisted living memory care service payment rate for such facilities that is at least $25 more per day than the base payment rate described above. The memory care service payment rate must be based on additional costs that a provider may incur from serving individuals with dementia. It is only available for patients who were determined by a practitioner to need a memory care unit and who reside in units with a direct care staff to resident ratio that is at least 20% higher for individuals with dementia than for individuals without.

The Governor vetoed provisions that would have required the rules to be effective November 1, 2023, and would have required the assisted living base payment rate to be at least $130 per day and required the memory care service payment rate to be at least $25 per day more than the assisted living services base payment rate.

The Governor vetoed provisions that would have required the departments to adopt rules establishing an assisted living critical access payment rate for residential care facilities participating in the Medicaid-funded Assisted Living program that averaged at least 50% of their residents receiving Medicaid-funded services during the last fiscal year. For these facilities, the critical access payment would have had to be at least $15 more per day than the base payment rate and the memory care service payment at least $10 higher than the critical access payment rate.

The Governor also vetoed a requirement that the departments, in consultation with industry stakeholders, adopt rules by July 1, 2024, establishing a methodology for determining assisted living service rates, including memory care services and critical access services.

Direct care provider payment rates (PARTIALLY VETOED)

(Section 333.29)

The act earmarks Medicaid funds to be used to increase provider base payment rates for the following services provided under Medicaid components of the home and community-based services waivers administered by ODM or ODA:

1. Personal care services;

2. Adult day services;

3. Community behavioral health services; and

4. Other waiver services under the HCBS waivers administered by the departments.

The Governor vetoed a provision that would have increased the base payment rates to $17 per hour beginning January 1, 2024, and $18 per hour during FY 2025.

Federally qualified health center payment rates (VETOED)

(Section 333.17)

The Governor vetoed an earmark of $20.7 million in each fiscal year to increase payment rates to federally qualified health centers (FQHCs) and FQHC look-alikes.

Vision and eye care services provider payment rate (VETOED)

(Section 333.25)

The Governor vetoed provisions that would have earmarked funds to increase Medicaid provider payment rates for vision services and medically billed eye care provided to Medicaid recipients during FY 2024. The increase would have been added to FY 2023 payment rates and maintained during FY 2025.

Dental provider payment rates (VETOED)

(Section 333.27)

The Governor vetoed provisions that would have earmarked $122 million in FY 2024 and $244 million in FY 2025 to increase the payment rate to dental providers treating Medicaid enrollees.

Medicaid MCO credentialing

(Repealed R.C. 5167.102; R.C. 5167.12)

The act repeals law that requires ODM to permit Medicaid managed care organizations (MCOs) to create a credentialing process for providers, because ODM is now credentialing Medicaid providers instead of Medicaid MCOs. As a conforming change, the act modifies language that prohibits a Medicaid MCO from imposing a prior authorization requirement on certain antidepressant or antipsychotic drugs that are prescribed by a physician credentialed by the Medicaid MCO to instead refer to a physician who has registered with ODM.

Payment of claims by third parties

(R.C. 5160.40)

The act decreases from 90 days to 60 days the time in which a third party must respond to a claim for payment of a medical item or service submitted to the third party by ODM.

Medicaid payment rate for neonatal and newborn services

(R.C. 5164.78)

The act requires that the Medicaid payment rate for the neonatal and newborn services specified in continuing law must be *at least* 75% of the Medicare payment rate for the services, rather than equaling 75% of the Medicare payment rate as required by former law.

Medicaid providers

Interest on payments to providers

(R.C. 5164.35 and 5164.60)

The act limits the time frame when interest is assessed against a Medicaid provider (1) that willingly or by deception received overpayments or unearned payments or (2) that receives an overpayment without intent, to the time period determined by ODM, but not exceeding the time period from the payment date until the repayment date, instead of from the payment date until the repayment date.

Provider penalties

(R.C. 5164.35)

The act clarifies that when a Medicaid provider agreement is terminated due to the provider engaging in prohibited activities, the provider may not provide Medicaid services *on behalf of* any other Medicaid provider, instead of to any other Medicaid provider.

Suspension of provider agreements and payments

(R.C. 5164.36)

The act revises in the following ways the law governing the suspension of Medicaid provider agreements when there are credible allegations of fraud or disqualifying indictments against Medicaid providers or their officers, agents, or owners. First, it prohibits ODM from suspending a provider agreement or Medicaid payments if the provider or owner can demonstrate good cause. The act directs ODM to specify by rule what constitutes good cause as well as the information, documents, or other evidence that must be submitted as part of a good cause demonstration.

Second, the act maintains the law prohibiting ODM from suspending a provider agreement or Medicaid payments if the provider or owner can demonstrate, by written evidence, that the provider or owner did not sanction the action of an agent or employee resulting in a credible allegation of fraud or disqualifying indictment. Under the act, ODM must grant the provider or owner – before suspension – an opportunity to submit the written evidence. The act also eliminates law allowing a Medicaid provider or owner, when requesting ODM to reconsider its suspension, to submit documents pertaining to whether the provider or owner can demonstrate that it did not sanction the agent's or employee's action resulting in a credible allegation of fraud or disqualifying indictment.

Third, the act adds two new circumstances to continuing law's two circumstances until which the suspension of a provider agreement may continue – the provider (1) pays in full fines and debts it owes ODM and (2) no longer has certain civil actions pending against it. The suspension must continue until the latest of the four circumstances occurs.

Fourth, when, under continuing law, a provider or owner requests ODM to reconsider a suspension, the act eliminates the requirement that ODM complete not later than 45 days after receiving documents in support of a reconsideration both of the following actions: (1) reviewing the documents and (2) notifying the provider or owner of the results of the review.

Criminal records checks

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

The act revises the law governing the availability of criminal records check reports for Medicaid providers, independent providers, and waiver agencies and their employees. Continuing law specifies that the reports are not public records and prohibits making them available to any person, with certain limited exceptions.

In the case of a waiver agency, the act authorizes a report of an employee's criminal records check to be made available to a court, hearing officer, or other necessary individual involved in a case or administrative hearing dealing with a denial, suspension, or termination of a Medicaid provider agreement.

With respect to a Medicaid provider or independent provider, the act authorizes a report of an employee's or provider's criminal records check to be made available to a court, hearing officer, or other necessary individual involved in a case or administrative hearing dealing with a provider agreement suspension. Continuing law authorizes such a report to be made available to the court, hearing officer, or other necessary individual in a case involving a denial or termination of a provider agreement.

The act further authorizes a criminal records check report to be introduced as evidence at an administrative hearing concerning a provider agreement denial, suspension, or termination. If admitted, the report becomes part of the hearing record. The act also requires such a report to be admitted only under seal and specifies that the report maintains its status as not a public record.

HHA and PCA training

(R.C. 5164.913)

The act prohibits ODM from requiring personal care aides (PCAs) providing services under MyCare Ohio (known in the Revised Code as the Integrated Care Delivery System) to receive more than 30 hours of pre-service training and six hours of annual in-service training. ODM determines what training is acceptable. It may not require home health aides (HHAs) providing services under MyCare to receive more pre-service training and annual training than required by federal law. The act also permits a licensed practical nurse to supervise an HHA or PCA, instead of only a registered nurse.

Under federal regulations, HHAs providing services through Medicare or Medicaid must receive 75 hours of pre-service training and 12 hours of annual in-service training. Additionally, federal regulations require that an HHA providing Medicare or Medicaid services be supervised by a registered nurse or other appropriate professional (such as a physical therapist, speech-language pathologist, or occupational therapist).[118]

[118] 42 C.F.R. 484.80.

ICF/IID bed conversion to OhioRISE program

(R.C. 5124.75)

The act prohibits an operator of an intermediate care facility for individuals with intellectual disabilities (ICF/IID) from reserving or converting any portion of the ICF/IID's beds from beds that provide ICF/IID services to beds that provide services to individuals receiving services through the OhioRISE program, if reserving or converting a bed would require the ICF/IID operator to discharge or terminate services to a resident occupying that bed.

Special programs

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 2024-FY 2025 biennium. The Director was originally required to establish it for the FY 2018-FY 2019 biennium.[119] 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 payments if funding for the program is inadequate.

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.

The act requires each participating hospital agency to jointly participate in quality improvement initiatives that align with and advance the goals of ODM's quality strategy.

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.

All intergovernmental transfers made under the program are deposited into the existing Care Innovation and Community Improvement Program Fund be used to make the supplemental payments under the program.

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[119] Section 333.320 of H.B. 49 of the 132nd General Assembly, Section 333.220 of H.B. 166 of the 133rd General Assembly, and Section 333.60 of H.B. 110 of the 134th General Assembly.

Ohio Invests in Improvements for Priority Populations

(Section 333.170)

The act continues 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 receiving care at state university-owned hospitals with fewer 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 ODM the nonfederal share of payment for those services. The hospital must pay ODM 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.[120] Therefore, the act requires the Director to seek CMS approval to operate the program.

Physician directed payment program

(Section 333.260)

The act also permits the Medicaid Director to seek CMS approval to establish one or more physician directed payment programs for directed payments for nonpublic hospitals and the related health systems. The programs must advance the maternal and child health goals of ODM's quality strategy.

Under the program, participating hospitals receive payment directly for physician services provided to enrollees and remit to ODM the nonfederal share of those services through intergovernmental transfer. The directed payments may equal up to the average commercial level for participating health systems for physician and other covered professional services provided to Medicaid MCO enrollees. Eligible public entities may transfer funds to be used for the directed payments through intergovernmental transfer into the Health Care/Medicaid Support and Recoveries Fund.

Under the programs, ODM may only make directed payments to the extent local funds are available for the nonfederal share of the cost for the services. If receipts credited to the program exceed the available amounts in the fund, the Director can adjust the directed payment amounts or terminate the program.

[120] CMS directed payments letter (PDF), January 8, 2021, available by conducting a keyword search of that date on CMS's website: medicaid.gov.

Ground emergency medical transportation supplemental payment

(R.C. 5164.96)

The act requires the Director to submit a Medicaid state plan amendment to CMS seeking authorization to establish a program that provides supplemental Medicaid payments to eligible emergency medical services (EMS) organizations operated by a government entity. If the state plan amendment is approved, the Director must establish the program and adopt rules to implement it.

An EMS organization is eligible to receive supplemental Medicaid payments under the program if it meets all of the following requirements: (1) it is a public organization operated by a governmental entity, (2) it holds a valid Medicaid provider agreement, and (3) it provides emergency medical transportation services to Medicaid recipients.

Hamilton County hospital directed payment program

(Section 333.265)

The act requires the Medicaid Director to create a hospital directed payment program for a hospital that meets the following criteria:

- It is located in Hamilton County;
- It is a nonprofit hospital;
- It has a Level 1 trauma center;
- It is affiliated with an Ohio public medical school; and
- It is not a children's hospital.

The program must advance at least one of the health goals established in ODM's quality strategy, which must be submitted to and approved by CMS. Under the program, participating hospitals will receive payments directly for inpatient and outpatient services provided to Medicaid enrollees and remit to ODM the nonfederal share of those services through intergovernmental transfer. Payments cannot exceed the average commercial level paid for inpatient and outpatient services provided to Medicaid recipients under the care management system. The act requires transfers for the program to be deposited into the Health Care/Medicaid Support and Recoveries Fund and permits the Director to adjust payment amounts or terminate the program if receipts credited to the program exceed available funds in the account.

Hospital Care Assurance Program; franchise permit fee

(Sections 610.80 and 610.81, amending Sections 125.10 and 125.11 of H.B. 59 of the 130th G.A.)

The act continues the Hospital Care Assurance Program (HCAP) for two additional years. The program had been scheduled to end October 16, 2023. The act extends it to October 16, 2025. Under HCAP, hospitals are annually assessed an amount based on their total facility costs, and government hospitals make annual intergovernmental transfers. 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, 2025. 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.

ODM doula program (PARTIALLY VETOED)

(R.C. 5164.071 and Section 105.40)

The act requires ODM to operate a program to cover doula services. The services must be provided by a doula who has a valid Medicaid provider agreement and is certified by the Ohio Board of Nursing (see "**Doula certification**" in the Board of Nursing chapter).

The program is to begin on October 3, 2024, and may conclude on October 3, 2028. It appears the Governor attempted to remove the time limit on the doula provisions by vetoing language referencing the five-year time limit. However, the Governor did not mark Section 105.40 of the act, which repeals this section of the Revised Code in five years, as being vetoed. As a result, the effect of this provision after five years is unclear. LSC could prepare an amendment to resolve this ambiguity in future legislation.

Medicaid payments (VETOED)

The Governor vetoed a provision establishing that Medicaid payments for doula services would have been determined on the basis of each pregnancy, regardless of whether multiple births occur as a result of that pregnancy.

Annual reports (VETOED)

The Governor vetoed a provision that would have established several reporting requirements related to the Medicaid Program, including the following:

- Outcome measurements and incentives for the program would have needed to be consistent with the state's Medicare-Medicaid Plan Quality Withhold methodology and benchmarks.
- The Director would have had to complete an annual report regarding program outcomes, including those related to maternal health and morbidity and estimated fiscal impacts.
- The final annual report would have been required to include recommendations related to whether the program should be continued.
- The Medicaid Director would have been required to provide a copy of the annual report to the Joint Medicaid Oversight Committee.

Rulemaking

The Director must adopt rules to implement the doula program. The act exempts the rules from the law that limits regulatory restrictions adopted by certain agencies.

General

Medicaid coverage of services at outpatient health facilities

(Repealed R.C. 5164.05)

The act repeals law that required Medicaid to cover comprehensive primary health services provided by "outpatient health facilities." Under the repealed law, an outpatient health facility was a facility that (1) provided comprehensive primary health services by or under the direction of a physician at least five days per week on a 40-hour per week basis to outpatients, (2) was operated by the board of health of a city or general health district or another public agency or by a nonprofit private agency or organization under the direction and control of a governing board that has no health-related responsibilities other than the direction and control of outpatient health facilities, and (3) received at least 75% of its operating funds from public sources.

Medicaid program reforms

(R.C. 5162.70)

Under continuing law, the Director must limit the growth in the Medicaid program for a fiscal biennium to not more than the lesser of (1) the average increase in inflation for the most recent three-year period for which there is data on the first day of the biennium, or (2) the medical inflation rate for the fiscal biennium projected by the Joint Medicaid Oversight Committee (JMOC). The act prohibits the Director from excluding any Medicaid eligibility group, provider wages, or Medicaid service when calculating the growth of the per member per month cost of the Medicaid program. The Director may, however, exclude one-time expenses or expenses that are not directly related to enrollees. Not later than October 1 of each year, the act requires the Medicaid Director to submit a report to JMOC detailing the reforms that ODM implemented in the preceding two fiscal years. In even-numbered years, the report must include ODM's historical and projected Medicaid program expenditure and utilization trend rates, by Medicaid program and service category, for each year of the upcoming biennium and an explanation of how the trend rates were calculated.

Medicaid program cost savings report

(R.C. 5162.137)

The act requires ODM to annually (1) conduct a cost-savings study of the Medicaid program and (2) prepare a report based on the study, recommending measures to reduce Medicaid program costs, and submit the report to the Governor.

HCBS direct care worker wages

(Sections 751.20 and 751.21)

The act requires ODM, ODA, and the Department of Developmental Disabilities to work jointly to submit a report regarding wages paid to direct care workers providing home and community-based services (HCBS) to enrollees in Medicaid waiver components administered by them. The report, submitted to the General Assembly not later than July 1 each year, must be

divided by service type and detail the wages paid by each agency to direct care workers in the previous fiscal year.

Medicaid work requirements

(R.C. 5166.37)

The act requires the ODM Director, not earlier than February 1, 2025, and not later than March 1, 2025, to apply to CMS to implement a new waiver establishing Medicaid work requirements.

H.B. 49 of the 132nd General Assembly required the ODM Director to establish a Medicaid waiver component under which individuals eligible for Medicaid on the basis of being included in the Medicaid expansion eligibility group were required to meet work requirements. ODM applied for this waiver in April 2018, and the request was approved by CMS in March 2019. However, before it could be implemented, the work requirement waiver was placed on hold as a result of the COVID-19 pandemic, and CMS subsequently withdrew approval of the waiver in August 2021.

Meaningful employment for Medicaid recipients

(R.C. 5167.35)

Meaningful employment program

To address Medicaid population health and social determinants of health and to encourage optimal health and self-sufficiency of Medicaid enrollees, the act requires ODM, in collaboration with ODJFS, to develop a program to assist Medicaid enrollees with securing meaningful employment.

As part of this program, each Medicaid MCO must develop a specialized component of its MCO plan to provide referral and support services to Medicaid enrollees to assist in obtaining and maintaining meaningful employment. Medicaid MCOs must give priority for participation in the program to identified enrollees who are of working age and are able-bodied, or who would benefit from assistance to overcome unemployment or underemployment.

In carrying out the program, the act requires Medicaid MCOs to do all of the following:

- Identify any barriers that these enrollees have to achieving greater financial independence, including:
  - Education;
  - Employment;
  - Physical and behavioral health care;
  - Transportation;
  - Childcare;
  - Housing; and
  - Legal history, including prior conviction of a criminal offense.

- Develop state and local relationships that link and refer identified enrollees to assessments, resources, and supports that assist with obtaining and maintaining meaningful employment; and
- Utilize a standard health risk assessment form established by the Medicaid Director to identify enrollees who are eligible to receive assistance under the program.

To assist in establishing the program, the act permits the Medicaid Director to establish additional requirements for Medicaid MCOs in administering the program, adopt rules as necessary to implement the program, and create supplemental assessments to assist Medicaid MCOs identify additional barriers to enrollees achieving financial independence other than those discussed above.

Workgroup

Not later than April 3, 2024, the Medicaid Director and the ODJFS Director must convene a workgroup consisting of the following members selected by the directors:

- Representatives of the Director of Opportunities for Ohioans with Disabilities, the Director of Developmental Disabilities, and the Director of Mental Health and Addiction Services;
- Representatives of the ODJFS Directors' Association and workforce development agencies;
- Representatives of technical, career, and higher education;
- Representatives of each Medicaid MCO; and
- Representatives of other organizations with expertise and resources involved in career and job development, as determined by the directors.

The workgroup must (1) identify state and local resources that provide job skills and career development, including available resources that will support identified enrollees seek employment and develop needed skills, (2) develop models for local agreements or protocols for collaboration between Medicaid MCOs and other community agencies, and (3) identify conflicts among program requirements that should be addressed by state agencies and the General Assembly to facilitate enrollees to securing and maintaining employment.

Periodic report

During the first year of the program and then annually, the Medicaid Director and the ODJFS Director must submit periodic reports regarding the program's implementation and operation. The report must be submitted to the Governor, the Senate Medicaid Committee, and any other standing legislative committees having jurisdiction over Medicaid.

MyCare Ohio expansion

(Section 333.320)

The act requires the Medicaid Director, by July 1, 2024, to seek approval from CMS to expand the MyCare Ohio program to all Ohio counties. If the Director terminates MyCare Ohio,

the successor program must serve all Ohio counties as well. The Director must select the entities for the expanded program.

ODM must establish requirements for care management and coordination of wavier services in the expanded program, subject to the following:

- The selected entities must employ the applicable area agency on aging to be coordinators of home and community-based services under a Medicaid waiver component available for eligible individuals over age 59;
- The entities may delegate to the area agency on aging full care coordination function for home and community-based services and other health care services received by those eligible individuals;
- Individuals enrolled in an entity's plan may choose the entity or its designee as the care coordinator, as an alternative to the area agency on aging;
- ODM may specify an alternative approach to care management and coordination of waiver services if the area agency on aging's performance does not meet the program requirements or if ODM determines that the needs of a defined group of individuals require an alternative approach.

Medicaid coverage of remote ultrasounds and fetal nonstress tests

(R.C. 5164.092)

The act requires the Medicaid program to cover remote ultrasound procedures and remote fetal nonstress tests when the patient is in a different location from the patient's Medicaid provider. ODM must adopt rules to implement the coverage requirement. The coverage applies only if the Medicaid provider uses digital technology that:

- Is used only to collect medical and other data from a patient and electronically transmit that data securely to a health care provider in a different location for the provider's examination of the data; and
- Has been approved by the U.S. Food and Drug Administration for remote data acquisition, if required.

Medicaid reimbursement for remote fetal nonstress tests is applicable only if the current procedural terminology (CPT) code that was used includes a place of service modifier for at home monitoring using remote monitoring solutions that are cleared by the FDA for monitoring fetal heart rate, maternal heart rate, and uterine activity.

Coverage for donor breast milk and human milk fortifiers

(R.C. 5164.072)

The act requires Medicaid coverage for pasteurized donor human milk and human milk fortifiers in both hospital and home settings in specified circumstances. The milk or fortifier must be determined medically necessary by a licensed health professional for an infant whose gestationally corrected age is less than 12 months. The milk or fortifier is medically necessary when any of the following apply:

- The infant has a body weight below healthy weight levels;
- The infant was less than 1,800 grams at birth;
- The infant was born at or before 34 weeks gestation; and
- The infant has any congenital or acquired condition that a licensed health professional indicates would be supported by human milk or fortifier.

Additionally, the act requires Medicaid coverage for donor human milk and fortifier only when the infant is unable to receive maternal breast milk because either the infant is unable to participate in breast feeding or the mother cannot produce enough calorically sufficient milk. The mother and infant must participate in lactation support before donor human milk or fortifier may be covered by Medicaid.

The act permits ODM to adopt any rules necessary to implement these provisions.

Lockable and tamper-evident containers (PARTIALLY VETOED)

(Sections 333.270 and 333.10)

The act requires ODM to reimburse pharmacists for expenses related to dispensing drugs in lockable containers or tamper-evident containers. The Governor vetoed a provision that would have defined “lockable container” and “tamper-evident container” for purposes of this reimbursement. The Governor also vetoed the following related provisions:

- A provision that would have limited the pharmacist reimbursement to FY 2024 and FY 2025, and only for drugs used in medication-assisted treatment;
- A provision that would have required ODM, during FY 2025 and FY 2025, to reimburse prescribers for expenses related to personally furnishing drugs used in medication-assisted treatment in lockable containers or tamper-evident containers.

Nursing Home Franchise Permit Fee Fund uses

(R.C. 5168.54)

The act expands the permitted uses of the Nursing Home Franchise Permit Fee Fund to also include expansion of the State Ombudsman Long-Term Care Program (sic.) and resident and family surveys at ODA, the addition of ODH surveyors, and to fund quality and consumer information resources.

Obsolete waiver repeal

(Repealed R.C. 5166.14, with conforming changes in various other R.C. sections)

The act repeals the requirement that ODM create a Long-Term Services and Support Medicaid waiver component and removes all references to the waiver component, as it was never implemented.