DEPARTMENT OF MEDICAID

Medicaid eligibility

Federal medical assistance percentage for expansion eligibility group

- Requires the Department of Medicaid (ODM) to immediately terminate medical assistance for members of the Medicaid expansion eligibility group if the federal government sets the federal medical assistance percentage below 90%.

Medicaid coverage of aged, blind, and disabled (ABD) individuals

- Eliminates provisions of law that (1) permit the Medicaid program's eligibility requirements for the ABD population group to be more restrictive than the eligibility requirements for the Supplemental Security Income Program and (2) require those more restrictive eligibility requirements to be consistent with the 209(b) option provided for under federal law.

Nursing facilities

Case-mix score grouper methodology for nursing facilities

- When determining a case-mix score for a nursing facility, requires ODM to use the grouper methodology used on October 1, 2019 (instead of June 30, 1999), for the patient driven payment model nursing index for prospective payments of skilled nursing facilities under the Medicare program.
- Modifies the authority of ODM to adopt rules concerning case-mix scores.

Nursing facility quality incentive payment

- Eliminates a provision of law specifying that if a nursing facility undergoes a change of owner with an effective date of July 1, 2023, or later, the facility does not receive a Medicaid quality incentive payment for a specified period of time.
- Specifies that if a nursing facility undergoes a change of operator with an effective date of July 1, 2025 (changed from July 1, 2023), or later, the facility is unable to receive a Medicaid quality incentive payment for a specified period of time.

Waiver of ineligibility period for nursing facility services

- Permits, rather than requires, ODM under certain circumstances to grant a waiver to a resident of a nursing facility who is ineligible to receive nursing facility services due to the individual or individual's spouse disposing of assets for less than fair market value.

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 2026 and FY 2027 that exceed the Medicare rates for those services.

Home and community-based services (HCBS) direct care worker wages

- Requires ODM, jointly with the Department of Aging and the Department of Developmental Disabilities to collect data from providers regarding the wages paid to direct care workers providing direct care services under Medicaid HCBS waiver components, and submit a report to the Governor.

Direct care rate determinations

- Requires a nursing facility's direct care rate for FY 2026 and FY 2027, to equal a percentage of the difference between the rate in effect on January 1, 2025, and the rate determined utilizing the case-mix score calculated in accordance with the bill's requirements.

Special programs

Medicaid buy-in for workers with disabilities program premiums

- Eliminates the requirement that individuals whose income exceeds 150% FPL must pay an annual premium as a condition of qualifying for the Medicaid buy-in for workers with disabilities program.

Hospital Additional Payments Program

- Establishes the Hospital Additional Payments Program for inpatient and outpatient hospital services provided to enrollees in the Medicaid care management system at in-state hospitals.

Rural Southern Ohio Hospital Tax Pilot Program and assessment

- Permits the Medicaid Director to establish the Rural Southern Ohio Hospital Tax Pilot Program for directed payments to rural southern Ohio hospitals.
- Establishes requirements that a hospital must satisfy to participate in the pilot program.
- Permits counties in which the pilot program operates to establish a local hospital assessment to provide the nonfederal share of Medicaid payments made under the pilot program.

Medicaid state directed payment programs

- Establishes conditions that must be satisfied upon the creation of a Medicaid state directed payment program that is funded in a manner other than by ODM of the hospital franchise fee program.

- Requires such a state directed payment program to comply with applicable federal regulations.
- Generally limits state directed payment programs described above to those established for hospital providers and services or professional services provided by hospitals, and to one state directed payment program per identified provider class.
- Specifies that the ODM Director is not required to establish a state directed payment program described above if there is no available or sufficient federal or local funding to sustain the program.

340B grantees

- For purposes of the interaction between Medicaid managed care organizations (MCOs), third-party administrators, and 340B covered entities under the federal 340B Drug Pricing Program, removes certain hospitals from the list of entities included as 340B covered entities and instead refers to these entities as 340B grantees.
- Prohibits a contract between a Medicaid MCO, third-party administrator, and 340B grantee from including a payment rate for a prescribed drug provided by a 340B grantee that is less than the payment rate for health care providers that are not 340B grantees.
- Requires a Medicaid MCO or third-party administrator to provide a payment rate for all prescribed drugs obtained through the federal 340B Pricing Program by providers that are not 340B grantees that is equal to the payment rate for those drugs under the Medicaid state plan.
- Specifies that payments made under payment rates specified in a contract between Medicaid MCOs, third-party administrators, and 340B grantees are subject to audit by ODM.

General

Exemption from adjudication

- Exempts ODM from the requirement to conduct an adjudication in accordance with the Administrative Procedure Act, and subjects providers to existing reconsideration procedures instead, under the following circumstances:
  - When a Medicaid provider agreement requires the provider to hold a license, permit, or certificate and it is inactive by any means or has been surrendered, withdrawn, retired, or otherwise restricted.
  - When a provider's application for a provider agreement is denied or the provider agreement is terminated or not revalidated because a license, permit, or certificate is inactive by any means.

Right of recovery for cost of medical assistance

- Permits an individual who was a recipient of medical assistance and repaid money between April 6, 2007, and September 28, 2007, to ODM or a county department of job

and family services pursuant to a right of recovery, to request a hearing regarding those payments.

- Authorizes any of the following to request a hearing: (1) a medical assistance recipient, (2) the authorized representative, (3) the executor or administrator of the estate, (4) a court-appointed guardian, or (5) an attorney directly retained by a recipient, or the recipient's parent, or legal or court-appointed guardian.

MyCare Ohio expansion

- Requires the Director to continue to expand the Integrated Care Delivery System (ICDS, also known as "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.

MyCare successor program

- Authorizes ODM to include a Fully Integrated Dual Eligible Special Needs Plan established in accordance with federal law as a replacement for the ICDS in the Medicaid care management system.

Hospital Care Assurance Program; franchise permit fee

- Eliminates the sunset of the Hospital Care Assurance Program and franchise permit fee that were set to terminate the program and assessment on October 1, 2025.

Appeal of hospital assessment or audit

- Specifies that a final reconciliation of an annual hospital assessment constitutes an interim final order.
- Permits a hospital that requests reconsideration of a preliminary determination of an assessment imposed on the hospital to submit its written materials to ODM by (1) regular mail, (2) electronic mail, or (3) in-person delivery.
- Eliminates a requirement that ODM hold a public hearing if one or more hospitals requests a reconsideration of a preliminary determination of an assessment to be imposed upon the hospital.
- When a hospital appeals a final determination of the hospital's annual assessment, clarifies that the complete record of the proceedings includes all documentation considered by ODM in issuing the final determination.
- Requires a hospital to seek a declaratory judgment, rather than appeal the results of an audit conducted by ODM, when the audit determines the hospital paid amounts to ODM that the hospital should not have been required to pay or paid amounts it should have been required to pay.

- When seeking a declaratory judgment, requires a hospital to deposit any funds that are not in dispute into the Hospital Care Assurance Program fund while judicial proceedings are pending.

Medicaid eligibility

Overview

Medicaid is a health insurance program for low-income individuals. State governments administer state-specific Medicaid programs subject to federal oversight by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services (HHS). Funding for the program comes primarily from federal and state government sources. The Ohio Department of Medicaid (ODM) administers Ohio's Medicaid program.

Federal medical assistance percentage for expansion eligibility group

(R.C. 126.70)

For most Medicaid service costs, federal financial participation (FFP) is determined for each state by the state's federal medical assistance percentage (FMAP). A state's FMAP is the percentage of dollars spent on Medicaid costs that are reimbursed by the federal government. FMAP is generally established for each state using a formula and varies between the states. However, in some instances, federal law specifies a designated FMAP for certain services or services provided to certain Medicaid eligibility groups. One such group is the Medicaid expansion eligibility group (often referred to as Group VIII). Group VIII includes nondisabled adults under the age of 65 with no dependents and incomes at or below 138% FPL. Under current federal law, the FMAP for services provided to Medicaid enrollees in Group VIII is 90%.[87] The bill specifies that if the FMAP for medical assistance provided to Group VIII enrollees is set below 90%, ODM must immediately terminate medical assistance for members of the group.

Medicaid coverage of aged, blind, and disabled individuals

(R.C. 5163.05, repealed; conforming changes in R.C. 5163.03)

The bill eliminates ODM's authority to impose more restrictive Medicaid eligibility requirements for the aged, blind, and disabled (ABD) eligibility group than the eligibility requirements for individuals receiving benefits under the Supplemental Security Income (SSI) Program. The bill also eliminates a related provision that requires that any more restrictive eligibility requirements established for the ABD eligibility group must be consistent with the 209(b) option provided for under federal law. ODM has not exercised the option described above since 2016 and has instead based eligibility for individuals in the ABD eligibility group on SSI eligibility requirements.

[87] 42 U.S.C. 1396d(y).

Nursing facilities

Case-mix score grouper methodology for nursing facilities

(R.C. 5165.192; Section 333.280)

The bill requires ODM, when determining case-mix scores for a nursing facility, to use the grouper methodology used for the patient driven payment model index by HHS on October 1, 2019, for prospective payment of skilled nursing facilities under the Medicare program, rather than the grouper methodology used on June 30, 1999, as required under current law.

Additionally, the bill eliminates ODM's authority to adopt rules concerning any of the following:

- Adjusting case-mix values to reflect changes in relative wage differentials that are specific to Ohio;
- Expressing case-mix values in numeric terms that are different from the terms specified by HHS but that do not alter the relationship of case-mix values to one another;
- Modifying the grouper methodology by (1) establishing a different hierarchy for assigning residents to case-mix categories under the methodology, and (2) allowing the use of the index maximizer element of the methodology.

Nursing facility quality incentive payment

(R.C. 5165.26)

The bill eliminates a provision of current law, enacted in 2024 in S.B. 144 of the 135th General Assembly, regarding calculating quality incentive payments for nursing facilities that undergo a change of owner. The law provides that if a nursing facility undergoes a change of owner with an effective date of July 1, 2023, or later, the facility is ineligible to receive a Medicaid quality incentive payment for a period of time. The facility will not receive a quality incentive payment until the earlier of the first day of January or the first day of July, at least six months after the effective date of the change of owner, if within one year after the change of owner, there is an increase in the lease payments or other financial obligations of the operator to the owner above the payments or obligations specified by the agreement between the previous owner and the operator. The bill eliminates this provision.

Similarly, current law provides that if a nursing facility undergoes a change of operator with an effective date of July 1, 2023, or later, the facility is ineligible to receive a quality incentive payment until the earlier of the first day of January or the first day of July, at least six months after the effective date of the change of operator. The bill modifies this date from July 1, 2023, to July 1, 2025, to adjust for the upcoming biennium.

Waiver of ineligibility period for nursing facility services

(R.C. 5163.30)

Under continuing law unchanged by the bill, an institutionalized individual is ineligible to receive nursing facility services, nursing facility equivalent services, and home and community-based services under the Medicaid program for a period of time determined by ODM,

if the individual or individual's spouse disposes of assets for less than fair market value on or after the designated look-back period following the date on which the institutionalized individual becomes eligible for or applies for Medicaid benefits. The bill permits ODM to grant a waiver of all or a portion of the ineligibility period for the institutionalized individual if the administrator of a nursing facility in which the individual resides has notified the individual of a proposed transfer or discharge from the facility for a failure to pay for the care provided to the individual, and the transfer or discharge has been upheld by a final determination. Current law requires ODM to grant such a waiver.

Medicaid provider payment rates

Payment rates for community behavioral health services

(Section 333.170)

The bill permits ODM to establish Medicaid payment rates for community behavioral health services provided during FY 2026 and FY 2027 that exceed the Medicare rates for those services. This authorization does not apply to those services provided by hospitals, nursing facilities, or ICFs/IID.

Home and community-based services (HCBS) direct care worker wages

(Section 333.270)

The bill requires ODM, jointly with the Department of Aging and the Department of Developmental Disabilities, to collect data from providers regarding the wages paid to direct care workers providing direct care services under Medicaid HCBS waiver components administered by the departments. Not later than December 31 of each fiscal year of the biennium, ODM must compile a report and submit it to the Governor.

Direct care rate determinations

(Section 333.280)

The bill makes several changes to how a nursing facility's direct care rate is determined. That rate is calculated utilizing case-mix scores. From July 1, 2025, through December 31, 2025, the bill specifies that a nursing facility's direct care rate is to be determined utilizing the quarterly case-mix score for the nursing facility as of July 1, 2025. Beginning January 1, 2026, through the remainder of FY 2026, the bill requires that the increase or decrease to a nursing facility's direct care rate equal one-third of the difference between the direct care rate in effect on January 1, 2025, and the direct care rate determined utilizing case-mix scores calculated in accordance with the changes to grouper methodology required by the bill. For FY 2027, the increase or decrease to a nursing facility's direct care rate is equal to $^{2}/_{3}$ of the difference between the direct care rate in effect on January 1, 2025, and the direct care rate determined utilizing case-mix scores calculated in accordance with the changes to grouper methodology required by the bill.

Special programs

Medicaid buy-in for workers with disabilities program premiums

(R.C. 5162.133, 5163.091, 5163.093, 5163.094, and 5163.098)

The bill eliminates a requirement that individuals whose income exceeds 150% FPL must pay an annual premium as a condition of qualifying for the Medicaid buy-in for workers with disabilities (MBIWD) program. MBIWD is an optional eligibility group covered by the Medicaid program. It allows certain disabled individuals who are employed to be enrolled in the Medicaid program so long as their income does exceed 250% FPL.

Hospital Additional Payments Program

(Section 333.140)

The bill establishes the Hospital Additional Payments Program as a state directed payment program for inpatient and outpatient hospital services provided to enrollees in the Medicaid care management system who receive care at in-state hospitals. Under the program, participating hospitals and hospital industry representatives must work collaboratively with ODM to establish quality improvement initiatives that align with and advance the goals of ODM's quality strategy required under federal law. Participating hospitals will receive direct payments for services provided under the program.

Rural Southern Ohio Hospital Tax Pilot Program and assessment

(Sections 333.290 and 333.300)

Pilot program

The bill authorizes the Medicaid Director to establish the Rural Southern Ohio Hospital Tax Pilot Program to provide directed payments to rural southern Ohio hospitals and their related health systems. To be eligible to participate in the pilot program, a hospital must (1) be enrolled as a provider in the Medicaid program, and (2) be located in Fayette, Greene, Highland, Hocking, Muskingum, Perry, Pike, Ross, or Scioto County.

The pilot program must comply with all federal law requirements governing state directed payment programs, including all of the following:[88]

- The pilot program must be approved by CMS and the Medicaid Director must seek approval for the pilot program in accordance with existing law.
- Directed payments under the program may not exceed the average commercial rate under a preprint form as approved by CMS.
- The pilot program must be subject to an evaluation plan.

As a condition of participation in the pilot program, a hospital must enter into one or more contracts related to the program that ODM considers necessary. The bill specifies that any

[88] 42 C.F.R. 438.6(c).

required contracts must be executed not later than October 1 in a year immediately preceding the first fiscal year of a biennium. Additionally, a hospital must comply with (1) average commercial rate reporting requirements established by ODM and (2) ODM's quality measure set, including the metrics and targets set by ODM to advance the goals and objectives of ODM's quality strategy, as required under federal regulations. Hospitals must also cooperate with any evaluation or reporting requirements established by ODM.

The bill further specifies that no hospital provider may participate in the pilot program unless sufficient tax funds are assessed, collected, obligated, and appropriated. The Medicaid Director may terminate or decline to establish the pilot program if federal or local tax funding is not available or sufficient to sustain the program, and at no time is ODM required to provide funding for the program. If at any time ODM is informed that the assessment established to fund the nonfederal share of the pilot program is an impermissible health care related tax, it must promptly refund the amounts paid by each hospital into the Rural Southern Ohio Hospital Tax Pilot Program Fund under the program (see "**Assessment**" below).

Assessment

To provide the nonfederal share of payments made under the pilot program, the bill permits counties in which the program will operate to establish a local hospital assessment. If a local hospital assessment is established, it must comply with all federal requirements applicable to provider assessments.

The bill permits counties to set the annual rate of the local hospital assessment. An assessment must apply uniformly to all nonpublic hospitals with the jurisdiction of the county, and at the discretion of the counties, may also apply to public hospitals. The rate of an assessment, in the aggregate, must be sufficient to cover (1) the nonfederal share of Medicaid payments that benefit hospitals in the counties, and (2) the administrative expenses for administering the local hospital assessment, up to $150,000 annually. The bill further provides that the implementation of a local hospital assessment must further Ohio's evolving quality goals, including (1) improving mental health, (2) substance abuse prevention, and (3) advancing maternal health. Counties may impose penalties upon hospitals that fail to pay the assessment in a timely manner.

The bill permits contiguous counties participating in the pilot program to establish a multi-county funding district for the purposes of a local hospital assessment. The boundaries of a multi-county funding district are coextensive with the combined boundaries of the counties that comprise the funding district. The bill specifies that a multi-county funding district is a governmental entity.

To establish a multi-county funding district, the bill requires the board of county commissioners of each county within the boundaries of a proposed district to pass a resolution or ordinance establishing the district and appointing a county commissioner to serve on the district's governing board. Before a new county may join the district, the resolution or ordinance of each county in the district must be amended. The appointed county commissioner from each member county constitutes the governing board of the district. A county may replace its appointment to the governing board by resolution or ordinance. The bill authorizes a governing

board to delegate the operational and administrative burdens of the funding district to the counties within the district. Not later than 60 days after a funding district is established, a governing board must designate at least one county to serve as the operational and administrative lead for the district. The designation may be changed at any time.

Medicaid state directed payment programs

(R.C. 5162.25)

The bill establishes conditions that must be satisfied upon the creation of a state directed payment program that is funded in a manner other than by ODM or the hospital franchise permit fee program. All new and existing state directed payment programs subject to the bill's requirements must comply with all federal law requirements governing state directed payment programs, including all of the following:[89]

- The program must be approved by CMS and the ODM Director must seek approval for the program in accordance with existing law.
- Directed payments under the program may not exceed the average commercial rate for all providers participating under a preprint form approved by CMS, unless the payments are exempted by a value-based purchasing agreement approved by CMS.
- The program must be subject to an evaluation plan.

The bill further specifies that a state directed payment program must be for hospital providers and services or professional services provided by hospitals. At the discretion of the Director, one state directed preprint form approved by CMS may be approved for (1) inpatient and outpatient hospital services, (2) physician services, and (3) children's hospitals participating in the Acceleration for Kids Quality Initiative.

As a condition of participating in a state directed payment program, a hospital provider must enter into one or more contracts related to the program, as ODM considers necessary. The bill specifies that any required contract must be executed not later than October 1 in a year immediately preceding the first fiscal year of a biennium.

Additionally, a hospital must comply with (1) average commercial rate reporting requirements established by ODM and (2) ODM's quality measure set, including the metrics and targets set by ODM to advance the goals and objectives of the Department's quality strategy, as required under federal regulations. Hospitals must also cooperate with any evaluation or reporting requirements established by ODM.

The bill stipulates that a hospital provider may not participate in a state directed payment program unless sufficient funds are obligated and appropriated. The ODM Director may terminate or decline to establish a state directed payment program if federal or local funding is not available or sufficient to sustain the program. ODM is not required to provide funding for a state directed payment program.

[89] 42 C.F.R. 438.6(c).

340B grantees

(R.C. 5167.01 and 5167.123; conforming changes in R.C. 3902.70 and 4729.29)

The bill includes provisions relating to the pricing of prescribed drugs under the Medicaid care management system obtained under the federal 340B Drug Pricing Program. For purposes of the interactions between a Medicaid MCO, third-party administrator, and 340B covered entity, the bill removes most hospitals from the list of entities that are included as 340B covered entities. In making this change, the bill instead refers to 340B covered entities as 340B grantees and specifies that to be considered a 340B grantee, an entity must be designated as an active entity under the Health Resources and Services Administration covered entity daily report. The bill maintains the current law definition of a 340B covered entity outside of the Medicaid program, for purposes of a contract between a health plan issuer, third-party administrator, and 340B covered entity, and for purposes of a contract between a terminal distributor of dangerous drugs and a 340B covered entity.

The bill eliminates a prohibition against a contract between a Medicaid MCO, third-party administrator, and 340B grantee including a payment rate for a prescribed drug that is less than the national average drug acquisition costs rate for the drug as determined by CMS, or if no rate is available, a reimbursement rate that is less than the wholesale acquisition cost of the drug. Instead, the bill prohibits a contract between the entities described above from including a provision for a payment rate for a prescribed drug provided by a 340B grantee to an individual as a result of health care services provided by the grantee directly to the individual, that is less than the payment rate applied to health care providers that are not 340B grantees.

In addition, the bill requires a Medicaid MCO or third-party administrator to provide a payment rate for all prescribed drugs obtained under the 340B Drug Pricing Program by providers that are not 340B grantees that is equal to the payment rate for those prescribed drugs under the Medicaid state plan. The bill provides that any payment made under payments rates specified in contracts between Medicaid MCOs, third-party administrators, and 340B grantees are subject to audit by ODM.

General

Exemption from adjudication

(R.C. 5164.38)

The bill exempts ODM from the requirement to conduct an adjudication in accordance with the Administrative Procedure Act (APA) under certain circumstances primarily related to the inactive status of a provider's license, permit, or certificate. Generally, under existing law, ODM must issue an order pursuant to an adjudication under the APA when it does any of the following:

- Refuses to enter into a provider agreement with a Medicaid provider;
- Refuses to revalidate a Medicaid provider's provider agreement;
- Suspends or terminates a Medicaid provider's provider agreement;

One circumstance under which ODM is not required to conduct an adjudication under the APA is when the terms of a provider agreement require the Medicaid provider to hold a license, permit, or certificate or maintain a certification issued by another governmental entity (credential), and the credential has been denied, revoked, not renewed, suspended, or otherwise limited. The bill adds to these circumstances: when the credential is inactive by any means, or is surrendered, withdrawn, retired, or otherwise restricted.

Another circumstance under which ODM is not required to conduct an APA adjudication is when the Medicaid provider's application for a provider agreement is denied or the provider agreement is terminated or not revalidated because of the termination, refusal to renew, or denial of the credential, even if the provider may hold the credential in another state. The bill adds the inactivation of the credential by any means to these circumstances.

Under existing law, when ODM denies, refuses to validate, suspends, or terminates a provider agreement, the provider may request a reconsideration of the provider's exclusion from participating in the Medicaid program.[90]

Right of recovery for cost of medical assistance

(R.C. 5160.37)

Under current law, ODM and county departments of job and family services have an automatic right of recovery against the liability of a third party that pays for the cost of medical assistance provided to a medical assistance recipient enrolled in the Medicaid program. The law provides that when a medical assistance recipient secures a settlement, compromise, judgment, or award or any recovery related to a claim by a medical assistance recipient against a third party for the cost of medical assistance, there is a rebuttable presumption that ODM or the county department is entitled to the lesser of (1) one-half of the remaining amount after fees, costs, and expenses are deducted from the total judgment, award, settlement, or compromise, or (2) the actual amount of medical assistance paid.

The bill permits an individual who was a recipient of medical assistance who repaid money to ODM or a county department under the automatic right of recovery described above, between April 6, 2007, and September 28, 2007, to request a hearing to rebut the presumption about the amount the individual repaid. A request must be made within 180 days after the bill's effective date. The presumption described above is successfully rebutted if the requestor demonstrates by clear and convincing evidence that a different allocation is warranted.

Under the bill, any of the following may submit a request for a hearing:

- The medical assistance recipient;
- The recipient's authorized representative;
- The executor or administrator of a recipient's estate who is authorized to make or pursue a request;

[90] R.C. 5164.33, not in the bill.

- A court-appointed guardian;
- An attorney who has been directly retained by the recipient, or the recipient's parent, legal guardian, or court-appointed guardian.

MyCare Ohio expansion

(Section 333.250)

The bill requires the Director, in accordance with the provisions established in 2023 in H.B. 33 of the 135th General Assembly, to continue to expand the Integrated Care Delivery System (ICDS, known as "MyCare Ohio") to all Ohio counties during FY 2026 and FY 2027. 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.

MyCare Ohio successor program

(R.C. 5167.01 and 5167.03)

The bill permits ODM to include a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) in the Medicaid care management system as a replacement for the ICDS. Both the ICDS and a FIDE SNP permit individuals who are dually eligible for services under both the Medicaid and Medicare programs to receive services under a single managed care plan.

Hospital Care Assurance Program; franchise permit fee

(Section 610.10)

The Hospital Care Assurance Program (HCAP) is a program administered by ODM to distribute funds to hospitals that provide a disproportionate share of services to low-income individuals. As a condition of receiving payments under HCAP, hospitals must provide basic, medically necessary, hospital-level services to state residents with incomes below the federal poverty level. To raise funds necessary to make payments under HCAP, ODM imposes annual

assessment fees on all hospitals. In addition to the HCAP annual assessment, ODM also imposes a separate annual assessment on hospitals to help pay for the Medicaid program. To distinguish that assessment from HCAP, the assessment is sometimes called a hospital franchise permit fee.

H.B. 870 of the 119th General Assembly (1992) established a sunset provision for HCAP and the hospital franchise permit fee. The initial sunset was scheduled for October 1, 1995. However, the sunset date has since been extended by each subsequent General Assembly. Most recently, H.B. 33 of the 135th General Assembly (2023) extended the sunset to October 16, 2025. The bill repeals this sunset provision, thereby making the continued operation of HCAP and the hospital franchise permit fee permanent.

Appeal of hospital assessment or audit

(R.C. 5168.08, 5168.11, and 5168.22)

Hospital assessments

Hospital Care Assurance Program

The bill makes substantive changes to the Hospital Care Assurance Program (HCAP) annual assessment imposed on all hospitals as a funding mechanism for the program. Continuing law, unchanged by the bill, requires ODM to issue a preliminary determination of the amount the hospital is to be assessed during the program year. Upon receipt of a preliminary determination from ODM, a hospital may request reconsideration of the preliminary determination. The bill specifies that a final reconciliation constitutes a final interim order that may be subject to adjustments made by CMS. Under current law, if a hospital does not request reconsideration of the preliminary determination, the preliminary determination constitutes final reconciliation of the assessment.

If one or more hospitals seeks a redetermination of a preliminary determination, current law requires the hospital to submit a written request to ODM not later than 14 days after the preliminary determination is issued. The request must include written materials that set forth the basis for the redetermination.

The bill expands these notice provisions by permitting delivery of the written materials by (1) regular mail, (2) electronic mail, or (3) in-person delivery. It also eliminates a requirement that ODM hold a public hearing if one or more hospitals seek redetermination of a preliminary determination. The bill's provisions specifying that a final reconciliation constitutes a final interim order that may be subject to adjustments made by CMS also apply to final reconciliations that are the result of a redetermination (current law provides that the redetermination result constitutes final reconciliation of a hospital's assessment).

Under current law unchanged by the bill, ODM must issue each hospital a written notice of its assessment under the final reconciliation, and a hospital may appeal the final reconciliation to the Franklin County court of common pleas. The bill clarifies that the complete record of the appeal proceedings includes all documentation considered by ODM in issuing the final reconciliation.

Hospital franchise permit fee

In addition to the assessment imposed upon hospitals as part of HCAP, Ohio law also imposes the hospital franchise permit fee upon hospitals. The bill makes similar changes to the law governing the additional assessment to those made concerning the assessment imposed under HCAP, including (1) that written materials submitted to ODM by a hospital seeking redetermination of a preliminary determination of the assessment may be delivered to ODM by regular mail, electronic mail, or in-person delivery, and (2) that if a hospital appeals a final determination of its assessment, the complete record of the proceedings includes all documentation considered by ODM in issuing the final determination.

Hospital audit

Under continuing law unchanged by the bill, funds paid by a hospital pursuant to the HCAP assessment are deposited into the Hospital Care Assurance Program fund. ODM may audit the amounts of payments made by a hospital and (1) make payments to a hospital that paid amounts it should not have been required to pay or did not receive amounts it should have, and (2) take action to recover from a hospital any amounts the hospital should have been required to pay but did not or that it should have not received but did.

The bill eliminates the ability of a hospital to appeal the results of an audit and instead requires a hospital that disagrees with the results of an audit to seek a declaratory judgment in Franklin County court. While judicial proceedings are pending, the hospital must pay to the fund any amounts identified by an audit that are not in dispute.