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 (Group VIII) if the federal government sets the federal medical assistance percentage (FMAP) below 90%.
- Requires ODM, not later than 15 days following a change in the FMAP as described above, to certify the state and federal shares of the total actual expenditures for Group VIII for the most recently completed month before the change.
- Establishes procedures for keeping those state share amounts within the General Revenue Fund during each fiscal year in the biennium, before transferring those amounts to the Budget Stabilization Fund or Expanded Sales Tax Holiday Fund under continuing law.
- If medical assistance is terminated as described above during FY 2026 or FY 2027, requires ODM to establish a phased transition plan to assist former members of Group VIII by redirecting them to private insurance subsidies or charity care programs.
- Authorizes ODM to establish a temporary hospital assessment or a temporary federally qualified health center or federally qualified health center look-alike assessment to offset the cost of uncompensated care provided to former Group VIII enrollees.

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

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

Change in circumstances eligibility verification

- Requires ODM or its designee to begin utilizing third-party data sources and systems to conduct eligibility change in circumstances checks for all Medicaid recipients on at least a quarterly basis.
- Requires ODM to disenroll individuals found to be no longer eligible for Medicaid.
- Requires ODM to submit periodic reports to the Executive Director of the Joint Medicaid Oversight Committee (JMOC) detailing verification efforts and any findings of fraud, waste, and abuse in the Medicaid program.
- Permits ODM to employ a similar process for determining whether members of Group VIII are complying with any established work and community engagement requirements.

- Specifies that any third-party vendor expenses incurred from the required verification are contingent on validated cost savings realized by ODM.

Medicaid waiver for reentry services

- Requires ODM to establish a Medicaid waiver component to provide services to Medicaid-eligible inmates for 90-days prior to release.

Continuous Medicaid enrollment for children

- Eliminates law that requires ODM to seek approval to provide continuous Medicaid enrollment for Medicaid-eligible children from birth through age three.

Unearned income disregard for individuals with disabilities

- When determining eligibility for the Medicaid Buy-In for Workers with Disabilities program or the program referred to as Ohio WorkAbility, requires that $20,000 of an individual's unearned income be disregarded.

Hospital presumptive eligibility

- Requires ODM, by January 1, 2026, to submit a waiver request to eliminate mandatory Medicaid hospital presumptive eligibility and to limit presumptive eligibility determinations to only pregnant women and children.
- Requires that under the waiver request, ODM also seek to establish requirements for qualified hospitals making presumptive eligibility determinations, including penalties for failure to meet those requirements.
- Prohibits ODM from designating itself as a qualified health entity for presumptive eligibility determinations or any other purpose not expressly authorized by state or federal law.
- Within 90 days after receiving waiver approval, requires the Auditor of State to conduct an audit to ensure compliance with the bill's requirements.

Medicaid eligibility fraud restitution

- Permits a court to order restitution of 200% of the amount paid for Medicaid services provided for a person found guilty of Medicaid eligibility fraud.

Medicaid workforce development study

- Requires ODM to conduct a comprehensive study on the feasibility, legality, and potential cost savings of establishing a Medicaid waiver component that imposes work requirements for Medicaid recipients and includes additional supplemental workforce development requirements.
- Requires the Medicaid Director, not later than September 1, 2026, to prepare and submit a report detailing ODM's findings and any policy recommendations.

Private insurance outreach program

- Requires ODM to create and administer an outreach program to provide information, awareness, and assistance to Medicaid recipients to help them transition to private insurance.

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 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.
- Extends from July 1, 2023, to July 1, 2025, the law prohibiting a nursing facility from receiving a Medicaid quality incentive payment for a specified period of time if the facility undergoes a change of operator on or after that date.

Nursing facility private room incentive payments

- Repeals current law that permits ODM to deny an application for a private room if approval would cause expenditures for private rooms to exceed $160 million in a fiscal year.
- Instead, permits ODM to deny an application if approval would cause the total number of private rooms to exceed 15,000 rooms and prohibits ODM from paying a private room incentive payment for more than 15,000 rooms.
- Requires ODM to submit a quarterly report on the number of private rooms in Ohio to JMOC and requires the OBM Director to include that information in its biennial Medicaid caseload and expenditure report to the Governor.

Personal needs allowance

- Increases the Medicaid personal needs allowance for nursing facility and ICF/IID residents on Medicaid from $50 to $75 for individuals and from $100 to $150 for married couples.

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 providers

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.

Doula services

- Limits Medicaid coverage of doula services to the six counties with the most infant deaths.

Freestanding birthing centers

- Requires a hospital with a maternity unit that accepts Medicaid to enter into a transfer agreement with any freestanding birthing center located within a 30-mile radius that requests one.
- Requires the freestanding birthing center to file a copy of the transfer agreement with the ODH Director.

Medicaid services

Social gender transition

- Prohibits the distribution of Medicaid funds to provide mental health services that promote or affirm social gender transition.

Rapid whole genome sequencing

- Requires the Medicaid Director to provide Medicaid reimbursement for rapid whole genome sequencing to infants under one year old with complex or acute unexplained illnesses.

Nursing facility dialysis services

- For FY 2026 and FY 2027, requires ODM to provide a rate add-on of $110 per treatment for dialysis services provided in a nursing facility to a Medicaid recipient.

Care management system

Medicaid MCO data cross checks

- Requires each Medicaid MCO to conduct internal cross checks of its data systems for specified information related to Medicaid enrollees assigned to the MCO.

Automatic enrollment in Medicaid MCO plan

- Permits individuals participating in the Medicaid care management system to enroll in the Medicaid MCO plan of their choosing.
- If an individual does not select a Medicaid MCO plan, requires ODM to randomly assign the individual to a plan without giving preference to a specific MCO plan or group of plans.
- Requires ODM to notify the General Assembly, the JMOC Executive Director of, and the Auditor of State within 30 days if it determines it cannot satisfy these 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.
- Specifies that a state directed payment program subject to the bill's requirements may not be established without first being approved by JMOC.
- 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 Medicaid 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.

General

Diversity, equity, and inclusion

- Prohibits Medicaid funds from being used for diversity, equity, and inclusion initiatives.

Prior authorization

- Requires ODM to reestablish and resume prior authorization requirements for prescription and other drugs, tests and diagnostic procedures, and medical procedures under the Medicaid program.

Medicaid separate health care services line items

- Requires the OBM Director, in consultation with the Medicaid Director, to request and propose multiple Medicaid health care services general revenue fund appropriation line items in subsequent state budgets.

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 the Director to (1) include entities that offer Medicare coordination only dual special needs plans but do not participate in the ICDS and (2) allow program participants the choice to enroll in a Medicare coordination only dual special needs plan offered by an entity that does not participate in the program, or to remain with their current plan.
- 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.
- Requires the successor program to (1) include entities that offer Medicare coordination only dual special needs plans but do not participate in the successor program and (2) allow program participants the choice to enroll in such a plan offered by an entity that does not participate in the program, or to remain with their current plan.

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.

Residential facility directory

- Requires ODM to publish a directory of all residential facilities licensed by DBH on ODM's website.

Medicaid visit verification system

- Establishes duties on, and grants authority to, ODM, the Department of Developmental Disabilities, Medicaid MCOs, and other entities authorized to pay Medicaid claims in the event the Medicaid Director establishes an electronic visit verification system in rule.

Reports, notifications, and audits

Quarterly Medicaid statement of expenditures form

- Requires the Director to immediately provide notice if CMS takes certain actions related to the Quarterly Medicaid Statement of Expenditures Form submitted by ODM.

Medicaid audit of MCOs

- Requires ODM to conduct an annual financial audit of each Medicaid MCO and prepare and submit a report to the General Assembly and the Joint Medicaid Oversight Committee.

Audit of Next Generation

- Requires the Auditor of State to conduct both a performance audit and a fiscal audit of ODM's Next Generation system and submit copies of the audit reports to the JMOC Executive Director by December 31, 2027.

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. 5163.04; Sections 333.360 and 513.10)

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 certain 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%.[114] 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.

In addition to terminating medical assistance for members of Group VIII, the bill additionally requires ODM, not later than 15 days after such a change to the FMAP, to certify to (1) the OBM Director, (2) the Joint Medicaid Oversight Committee (JMOC), (3) the Speaker of the House, and (4) the Senate President the total state and federal shares of expenditures in the Medicaid program for Group VIII in the most recently completed month before the change to the FMAP.

The bill specifies that the state share amount that is certified by ODM as described above is to be multiplied by the number of months remaining in the fiscal year. This amount is to remain in the general revenue fund until the end of the fiscal year, at which time the amount is to be transferred in accordance with continuing law to the Budget Stabilization Fund or Expanded Sales Tax Holiday Fund. If the change to the FMAP occurs in the first year of a fiscal biennium, the state share amount is multiplied by 12 to calculate the amount for the second fiscal year of the biennium. The bill exempts these transfers from the bill's general provision requiring that the balance of the general revenue fund on June 30, 2025, and June 30, 2026, remain in the general revenue fund.

The bill further provides that if the FMAP for Group VIII is set below 90% during FY 2026 or FY 2027, ODM must establish a phased transition plan to assist former Group VIII enrollees by redirecting them to private insurance subsidies or charity care programs that provide medical assistance. As part of the transition plan, the bill permits the Director to establish (1) a temporary hospital assessment, (2) a temporary federally qualified health center assessment, or (3) a temporary federally qualified health center look-alike assessment to help offset the costs of uncompensated care that may result from providing care to former members of Group VIII. If the Director establishes any of the assessments described above, the Director may request approval from the Controlling Board to transfer and increase appropriations to implement the assessments.

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 group must be consistent with the federal 209(b) option for Medicaid eligibility. ODM has not exercised the option described above since 2016 and

[114] 42 U.S.C. 1396d(y).

has instead based eligibility for individuals in the ABD eligibility group on SSI eligibility requirements.

Change in circumstances eligibility verification

(R.C. 5163.50)

Within 30 days after this section takes effect, the bill requires ODM or its designee to begin utilizing third-party data sources and systems to conduct eligibility change in circumstances checks for all Medicaid recipients on at least a quarterly basis. To the extent permitted by state and federal law, ODM or its designee must verify each Medicaid recipient's enrollment records against third-party data systems, including: (1) information and databases available to ODM under federal law, (2) identity records, (3) death records, (4) employment and wage records, (5) lottery winning records, (6) residency checks, (7) household composition and asset records, (8) incarceration records, (9) records indicating concurrent enrollment in Medicaid programs in other states, (10) third-party liability records, and (11) any other records ODM considers appropriate in order to strengthen program integrity, reduce costs, and to reduce fraud, waste, and abuse in the Medicaid program. To the extent permitted by federal law, ODM must disenroll Medicaid recipients who are determined to be ineligible for Medicaid based on verified changed circumstances.

The bill requires ODM to prepare and submit a report to the JMOC Executive Director by December 31, 2025, detailing its findings from the verification described above, including any findings of fraud, waste, and abuse in the Medicaid program. ODM must submit updated reports to the Executive Director every six months following submission of the initial report.

The bill provides that to the extent practical, ODM must employ the verification processes described above to verify whether members of Group VIII comply with Ohio's work and community engagement waiver component authorized under continuing law. Additionally, the bill authorizes Medicaid providers to employ the same verification processes to verify an individual's eligibility for Medicaid.

The bill further provides that any third-party vendor expenses incurred from conducting the verification procedures described above are entirely contingent on validated cost savings realized by ODM.

Medicaid waiver for reentry services

(R.C. 5166.50)

Within one year, the bill requires ODM to apply for a Medicaid waiver component that provides reentry services to Medicaid-eligible imprisoned individuals for 90 days prior to the individual's expected release date. The reentry services include mental and behavioral health services and substance use disorder treatment and related services. The bill also requires the provision of a 30-day supply of prescription medicine to an eligible inmate who is being released, including medication administered by injection. ODM is required to implement the waiver component within one year of CMS approval.

If ODM is unable to apply for the waiver within one year of the bill's effective date, the Department may request an extension of up to 30 days from the Speaker of the House and the

Senate President. Similarly, if ODM is unable to implement the waiver in the required timeframe, it may request an extension for the amount of time needed.

If CMS does not approve the waiver, ODM is required to reapply within four years of the provision's effective date.

Although federal law prohibits Medicaid payment for most health care services to incarcerated individuals,[115] recently, CMS released guidance encouraging states to apply for a Section 1115 demonstration waiver to test strategies to support community reentry for incarcerated individuals.[116]

Continuous Medicaid enrollment for children

(R.C. 5166.45, repealed)

The bill eliminates law that requires ODM to seek CMS approval to provide continuous Medicaid enrollment for Medicaid-eligible children from birth through age three. Currently, ODM is required to establish a Medicaid waiver component that allows a Medicaid-eligible child to 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.

Unearned income disregard for individuals with disabilities

(R.C. 5163.093)

For purposes of determining eligibility for the Medicaid Buy-In for Workers with Disabilities (MBIWD) program and the program referred to as Ohio WorkAbility, the bill requires that $20,000 of an individual's unearned income be disregarded. The Ohio WorkAbility program is an optional eligibility group that is separate from the MBIWD eligibility group. Under state and federal law, the MBIWD eligibility group includes certain disabled individuals under the age of 65. The Ohio WorkAbility program also covers certain disabled individuals who are employed, but does not include an age restriction. H.B. 33 of the 135th General Assembly extended Medicaid coverage to individuals in the Ohio WorkAbility group and clarified that it was the General Assembly's intent to cover individuals in the Ohio WorkAbility program who are age 65 or older in a manner that is consistent with Medicaid coverage for individuals in the MBIWD program.[117]

[115] 42 U.S.C. 1396d(a)(A), not in the bill.

[116] As of April 8, 2025, according to the KFF Medicaid Waiver Tracker, CMS has approved waivers for 19 states: AZ, CA, CO, HI, IL, KY, MD, MA, MI, MT, NH, NM, NC, OR, PA, UT, VT, WA, and WV.

[117] R.C. 5163.063, not in the bill.

Medicaid presumptive eligibility

(R.C. 5163.102)

Background

The bill makes a number of changes involving Medicaid presumptive eligibility. Presumptive eligibility refers to a mechanism whereby individuals may receive immediate Medicaid benefits for a temporary period based on limited information, while applying for Medicaid. Federal Medicaid laws and regulations establish basic presumptive eligibility requirements, and states develop and implement presumptive eligibility programs within those requirements. Federal regulations require states to allow hospitals to make presumptive eligibility determinations for specified eligibility groups, and permit states to allow other qualified entities to make presumptive eligibility determinations. Ohio currently offers presumptive eligibility to children, pregnant women, and parents or caretaker relatives residing with a child.

Presumptive eligibility

The bill requires ODM, by January 1, 2026, to seek approval from CMS to eliminate mandatory hospital presumptive eligibility under Ohio's Medicaid program and limit presumptive eligibility determinations to only children and pregnant women. The bill specifies that if CMS denies or withdraws approval of the request, ODM must resubmit the request within 24 months following the denial or withdrawal. If CMS grants approval, the Auditor of State must conduct an audit within 90 days of the approval to ensure ODM's compliance with these requirements.

Hospital presumptive eligibility requirements

As part of its request to CMS, ODM must seek approval to establish a program that requires each hospital qualified to make presumptive eligibility determinations do the following:

- Notify ODM of each presumptive eligibility determination made by the hospital within five days of the determination date;
- Assist applicants who have been determined presumptively eligible to submit a complete Medicaid application;
- Notify the applicant in writing on all forms used for presumptive eligibility determinations that the applicant must file a complete Medicaid application before the last day of the following month, or the applicant will lose coverage;
- Notify the applicant that if the applicant's Medicaid application is filed before the last day of the month after the applicant is presumed eligible, the presumptive eligibility coverage will continue until a final determination is made on the application.

Hospital presumptive eligibility standards

The bill additionally imposes standards that a hospital must satisfy when making presumptive eligibility determinations to ensure the accuracy of those determinations. A hospital must ensure that ODM receives a completed Medicaid presumptive eligibility card within five business days of the date a hospital determines an applicant to be presumptively eligible. A hospital must further ensure that ODM receives a completed Medicaid application for an

applicant before the applicant's presumptive eligibility period expires. Finally, the hospital must ensure that each presumptive eligibility determination is approved for standard Medicaid eligibility after review of an applicant's completed application.

The first time that a hospital fails to meet any of the standards described above, ODM must send the hospital written notice within five days indicating that the standard was not satisfied. This notice must include (1) a description of the standard that was not satisfied and how it was not satisfied, and (2) notification that a subsequent failure to satisfy required standards within one year will result in mandatory training for all hospital staff responsible for presumptive eligibility determinations.

If a hospital fails to meet any presumptive eligibility standards within one year of a first violation, ODM must send additional notice to the hospital within five days from the date of violation. In addition to a description of the standard that was not satisfied, the notice must also provide the date, time, and location of the mandatory training that hospital staff must complete related to presumptive eligibility. This notice must also describe the appeal procedures that are available for a hospital to dispute the finding. Finally, the notice must include a warning that any additional failure to meet presumptive eligibility standards within one year will result in the hospital being disqualified from making further presumptive eligibility determinations.

If a hospital fails to meet one of the standards described above for a third time, and within one year of the second violation, ODM must send notice to the hospital within five days of the violation. This notice must (1) describe the standard that was not met, (2) describe the appeal processes that are available to the hospital, and (3) confirm to the hospital that effective upon the receipt of the notice, the hospital is disqualified from making presumptive eligibility determinations.

ODM as a qualified entity

Finally, the bill prohibits ODM from designating itself as a qualified health entity for purposes of making presumptive eligibility determinations or for any other purpose not expressly authorized by state or federal law.

Medicaid eligibility fraud restitution

(R.C. 2913.401)

Medicaid eligibility fraud is a crime, the severity of which varies from a first degree misdemeanor to a third degree felony depending on the value of the services received. Current law requires the court, in addition to imposing a criminal sentence, to order restitution in the full amount services paid for which the individual was not eligible, plus interest. The bill instead *permits* a court to order restitution of *200%* of that amount.

Medicaid workforce development study

(Section 751.20)

The bill requires ODM to conduct a comprehensive study on the feasibility, legality, and potential cost savings to the Medicaid program of establishing a Medicaid waiver component that imposes work requirements for Medicaid recipients and includes additional supplemental

workforce development requirements. As part of the study, ODM must evaluate the impact of requiring Medicaid recipients who maintain eligibility through satisfying work requirements for 12 consecutive months to enroll in a workforce development program that is either (1) a state-sponsored program that can be completed within 12 months or (2) is a program offered through a private or public training facility, community college, or university and can be completed within 12 months.

Through the study, ODM must assess all of the following:

- The legal feasibility of implementing work and supplemental workforce development requirements as described above;
- Ohio's workforce development training capacity;
- The potential cost savings associated with implementing work and supplemental workforce development requirements;
- The projected impact on Medicaid enrollment if the requirements described above were to be implemented.

By September 1, 2026, ODM must prepare a report detailing its findings from the study, as well as any policy recommendations. The report must be submitted to the Governor, Speaker of the House, Senate President, and the chairperson of the finance committees in the House and Senate.

Private insurance outreach program

(Section 751.80)

Under the bill, during FY 2027, ODM must create and administer an outreach program to provide information, awareness, and assistance to Medicaid recipients to help them transition from Medicaid to private insurance.

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 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.

Nursing facility private room incentive payments

(R.C. 5165.158)

The bill eliminates the nursing facility private room incentive payment dollar amount cap and instead establishes a cap on the number of private rooms eligible to receive the payment. H.B. 33 of the 135th General Assembly established a private room incentive payment that eligible nursing facilities can receive as an add-on to the nursing facility per Medicaid day payment rate for Medicaid residents living in private rooms. Under current law, ODM may deny an application for a private room incentive payment if ODM determines that approval of the room would cause projected expenditures for the private room incentive payments for a fiscal year to exceed $160 million (calculated based on a Medicaid utilization of 50% of private rooms). The bill eliminates the $160 million cap and instead permits ODM to deny an application if approval of the private room would cause the total number of private rooms to exceed 15,000 rooms in Ohio. It also prohibits ODM from paying a private room incentive payment rate for more than 15,000 rooms.

The bill also removes outdated provisions relating to ODM's initial approval of private room applications – such as requiring ODM to begin approving applications on January 1, 2024, and hold all applications in pending status until CMS approval of the private room incentive payments.

Private room report

(R.C. 5162.138 and 126.021)

The bill requires ODM to report quarterly on the number of private rooms in nursing homes in Ohio. The report must be submitted to JMOC and the JMOC Executive Director, and include all of the following information for the preceding quarter:

- The total number of licensed private room beds in Ohio nursing homes;
- The number of those beds that are utilized by Medicaid residents;
- The number of those beds that are utilized by private pay or non-Medicaid residents;
- The number of those beds that are occupied;
- The average length of time a Medicaid resident lived in a private room during that period.

Additionally, the OBM Director must submit this information as part of its Medicaid caseload and expenditures forecast report submitted to the Governor by January 1 of each odd-numbered year.

Personal needs allowance

(R.C. 5163.33)

The bill increases the Medicaid personal needs allowance for individuals and married couples. A personal needs allowance is a sum of money a nursing home resident on Medicaid can keep from their income to cover personal expenses not covered by Medicaid. Federal law requires states to set personal needs allowances of at least $30. The bill increases Ohio's nursing home personal needs allowance for nursing facility and ICF/IID residents from at least $50 to at least $75 for an individual and from $100 to $150 for married couples.

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 providers

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.
- From January 1, 2026, through the remainder of FY 2026, the increase or decrease to a nursing facility's direct care rate must 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.

Doula services

(R.C. 5164.071)

The bill limits Medicaid coverage of doula services to the six Ohio counties with the most infant deaths, as determined by ODH. Beginning October 3, 2024, and concluding October 3, 2028, current law requires ODM to operate a program to cover doula services. The bill limits that coverage to those six counties. Under continuing law unchanged by the bill, the services must be provided by a doula who has a valid Medicaid provider agreement and is certified by the Ohio Board of Nursing.

Freestanding birthing centers

(R.C. 3722.15)

The bill requires a hospital that is a Medicaid provider and that operates a maternity unit to agree to a transfer agreement with any freestanding birthing center within a 30-mile radius

that requests one. The transfer agreement must specify an effective procedure for the safe and immediate transfer of a patient from the birthing center to the hospital. Transfers occur when medical care is needed beyond the care that can be provided at the center, including when emergency situations or medical complications arise.

When a hospital enters into a transfer agreement with a freestanding birthing center, the center is responsible for filing a copy of the transfer agreement with the Director.

Medicaid services

Social gender transition

(Section 333.13)

The bill prohibits the distribution of Medicaid funds to provide mental health services that promote or affirm social gender transition, to the extent this prohibition is permitted by federal law. Social gender transition is the process in which a person goes from identifying with and living as a gender that corresponds with the person's biological sex, to identifying with and living as a gender different from the individual's biological sex.

Rapid whole genome sequencing

(R.C. 5164.093)

Rapid whole genome sequencing is an investigation of the entire human genome to identify disease-causing genetic changes, including whole genome sequencing of both a patient and a patient's biological parent or parents. The bill requires Medicaid, with approval from CMS, to cover rapid whole genome sequencing for Medicaid patients under one year old who have an unexplained complex or acute illness and who are receiving hospital services in an intensive care unit or other high acuity care unit within a hospital. The Director may also provide coverage for other next-generation sequencing and genetic testing.

Any of the following medical necessity criteria may be required for Medicaid reimbursement of rapid whole genome sequencing:

- Symptoms that suggest a broad differential diagnosis that would require an evaluation by multiple genetic tests if whole rapid genome sequencing is not performed;
- Timely identification of a molecular diagnosis is necessary to guide clinical decision-making, and testing results may guide condition treatment or management;
- Relevant family genetic history;
- Complex or acute illness with an unknown cause including at least one of the following conditions:
  - Congenital anomalies involving at least two organ systems or complex multiple congenital anomalies in one organ system;
  - Specific organ malformation highly suggestive of a genetic etiology;
  - Abnormal laboratory tests or chemistry profiles suggesting the presence of a genetic disease, complex metabolic disorder, or inborn error of metabolism;

- Refractory or severe hypoglycemia or hyperglycemia;
- Abnormal response to therapy related to an underlying medical condition affecting vital organs or bodily systems;
- Severe muscle weakness, rigidity, or spasticity;
- A high-risk stratification for a brief, resolved, unexplained, and recurrent event that is any of (1) an event without respiratory infection, (2) a witnessed seizure-like event, or (3) a cardiopulmonary resuscitation event;
- Refractory seizures;
- Abnormal cardiac diagnostic testing results suggestive of possible channelopathies, arrhythmias, cardiomyopathies, myocarditis, or structural heart disease;
- Abnormal diagnostic imaging studies or physiologic function studies suggestive of an underlying genetic condition;
- Any other condition added by the Director based on new medical evidence.

A laboratory performing rapid whole genome sequencing for an infant through Medicaid must return preliminary positive results within seven days of receiving a sample and must return final results within 15 days.

Genetic data generated as a result of performing rapid whole genome sequencing is protected health information subject to the requirements established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The primary use of the data is to assist health care professionals in diagnosing and treating a patient. The patient, the patient's legal guardian, or the patient's health care provider may request access to testing results for use in other clinical settings. A health care provider may charge a fee equal to the direct cost of producing the results for use in another clinical setting.

The genetic data may be used for scientific research if the patient's guardian consents. A patient or a patient's legal guardian may rescind consent at any time, and upon receiving written revocation of consent the entity using the data for research must cease use and expunge the patient's information from any data repository where it is held.

The Director may adopt rules or take other administrative action as necessary to implement Medicaid coverage of rapid whole genome sequencing for infants.

Nursing facility dialysis services

(Section 333.263)

For FY 2026 and FY 2027, the bill requires that ODM provide a rate add-on of $110 per treatment for dialysis services provided in a nursing facility to a Medicaid resident.

Care management system

Medicaid MCO data cross checks

(R.C. 5167.104)

Continuing law unchanged by the bill authorizes ODM to enter into contracts with Medicaid MCOs to authorize or arrange for the provision of health care services to Medicaid recipients participating in the care management system. The bill specifies that each contract entered into between ODM and a Medicaid MCO must require the MCO to conduct internal cross checks of its data systems for information concerning Medicaid enrollees under the MCO's plan. Specifically, the bill requires an MCO to check for an enrollee's (1) name, (2) date of birth, (3) Social Security number, and (4) home address.

Automatic enrollment in Medicaid MCO plan

(R.C. 5167.03)

The bill permits an individual participating in the Medicaid program through the care management system to select a Medicaid MCO plan in which to enroll, during a time period specified by ODM. If an individual does not select a MCO plan in which to enroll during that time period, the bill specifies that ODM must randomly assign the individual to a plan without giving deference to any specific MCO plan or group of plans.

The bill further specifies that if ODM is unable to satisfy the requirements described above, it must notify the General Assembly, the JMOC Executive Director of the Joint Medicaid Oversight Committee, and the Auditor of State within 30 days after making this determination. As part of the notice, ODM must provide an explanation as to why it is unable to satisfy the requirements.

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:[118]

- 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 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.

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

[118] 42 C.F.R. 438.6(c).

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:[119]

- The program must be approved by CMS and the Medicaid Director must seek approval for the program in accordance with existing law.

[119] 42 C.F.R. 438.6(c).

- 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.

Before a state directed payment program may be established, the bill requires that the program first be approved by JMOC.

The bill limits such state directed payment programs to 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.

General

Diversity, equity, and inclusion

(Section 333.12)

The bill prohibits Medicaid funds from being used for diversity, equity, and inclusion initiatives, to the extent permitted by federal law. This prohibition does not apply to funds appropriated to provide services that support access to the community for Medicaid recipients with intellectual and developmental disabilities.

Prior authorization

(Section 751.60)

The bill requires ODM to reestablish and resume the prior authorization requirements for prescription and other drugs, tests and diagnostic procedures, and medical procedures under the Medicaid program, beginning on the provision's effective date. On July 12, 2024, ODM sent a press bulletin to Medicaid providers announcing that due to technical issues with fee-for-service

prior authorization submissions in the electronic provider network, it would be lifting prior authorization requirements for claims with service dates beginning on July 30, 2024, until further notice. The bill requires a resumption of those Medicaid prior authorization requirements.

Medicaid separate health care services line items

(R.C. 126.024)

Beginning with the biennial state budget after H.B. 96, the bill requires the OBM Director, in consultation with the Medicaid Director, to request and propose multiple Medicaid health care services general revenue fund appropriation items. At a minimum, the bill requires that the Directors propose separate health care services appropriation items for all of the following:

- Services provided under the care management system;
- Nursing facility services;
- Hospital services;
- Behavioral health services;
- Services provided under Medicaid waiver components administered by ODA;
- Prescription Drug Services;
- Physician services;
- Services provided under the Ohio Home Care Waiver Program;
- Any other services the Directors determine should have a separate appropriation item.

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.[120]

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;
- 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

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

(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 bill requires the Director to select the entities for the expanded program, and to include entities that offer Medicare coordination only dual special needs plans but do not participate in MyCare. Specifically, the Director must approve entity contracts for coordination only dual special needs plans that are offered by entities not selected to participate in MyCare or the successor program and permit those entities to enroll MyCare or successor program participants. Additionally, the Director must allow MyCare participants the choice to enroll in a Medicare coordination only dual special needs plan offered by an entity that does not participate in MyCare or the successor program, or to remain on their current plan. Coordination only dual special needs plans are Medicare Advantage plans for individuals who are eligible for both Medicare and Medicaid, but they are not fully integrated plans.

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) as a replacement, successor program for MyCare Ohio. Both MyCare 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. Same as above for the MyCare expansion, the bill requires the Director, in the successor program, to (1) include entities that offer Medicare coordination only dual special needs plans but do not participate in the successor program and (2) allow program participants the choice to enroll in a Medicare coordination only dual special needs plan offered by an entity that does not participate in the program, or to remain with their current 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.

Residential facility directory

(R.C. 5160.53)

The bill requires ODM to collaborate with the Department of Behavioral Health to publish a directory of all residential facilities licensed by DBH. The directory must be published on ODM's website and include each facility's name, full address, services offered, and categorization as a Class 1, Class 2, or Class 3 facility. The categories vary based on the population served, number of individuals residing in the facilities, and services provided.

Medicaid visit verification system

(R.C. 5164.451)

The bill establishes duties on, and grants authority to, ODM, the Department of Developmental Disabilities, Medicaid MCOs, and other entities authorized to pay Medicaid claims in the event the Medicaid Director establishes an electronic visit verification (EVV) system in rule, including all of the following:

- Prohibits the EVV system from exceeding minimum requirements specified in federal law;

- Requires ODM and the Department to provide education and technical assistance to Medicaid providers to aid them in complying with the EVV system;
- Requires a Medicaid provider to be notified if a claim submitted is not supported by evidence in the EVV system;
- Requires ODM, the Department, a Medicaid MCO, or other entity authorized to pay a Medicaid claim to offer the Medicaid provider the opportunity to review and correct such a claim and data in the EVV system;
- Prohibits ODM, the Department, a Medicaid MCO, or other entity from denying a claim that is not supported by information in the EVV system;
- Allows ODM, the Department, a Medicaid MCO, or other entity authorized to conduct a post-payment audit or review to consider information in the EVV system as part of its audit or review protocol;
- Prohibits ODM, the Department, a Medicaid MCO, or other entity to conduct a post-payment audit or review based solely on information in the EVV system.

Reports, notifications, and audits

Quarterly Medicaid statement of expenditures form

(R.C. 5162.14)

The bill requires the ODM Director to immediately notify (1) the Speaker of the House, (2) the Senate President, (3) the JMOC Executive Director, and (4) the chairpersons of the relevant standing committees in the House and Senate if CMS takes certain actions related to the Quarterly Medicaid Statement of Expenditures Form submitted by ODM. A Quarterly Medicaid Statement of Expenditures Form is known as a CMS-64 Form and is used by states to report actual Medicaid program benefit costs and administrative expenses to CMS. Under the bill, the Director must provide notice if CMS does any of the following related to a CMS-64 Form submitted by ODM:

- Determines that the form has a variance of expenditures of 8% or greater;
- Asks any questions related to the form;
- Refuses to certify the information provided on the form;
- Refuses to release any funds to the state.

When providing the notice required under the bill, the Director must include any letter or information provided to ODM by CMS related to its questioning or decision not to certify a CMS-64 Form. Additionally, the Director must include any correspondence from ODM to CMS as part of the notice provided.

Medicaid audit of MCOs

(R.C. 5167.25)

The bill requires ODM to conduct an annual financial audit of each Medicaid MCO, which, at a minimum, includes an examination of the administrative costs and total expenditures of each MCO. As part of the audit, each MCO must submit to ODM a detailed breakdown of the MCO's costs for all capitated payment contracts. ODM must utilize the information provided by MCOs to determine whether they are complying with medical loss ratio requirements. The bill requires ODM to prepare and submit an annual report to the General Assembly and JMOC detailing its findings of the audits conducted.

Audit of Next Generation

(Section 751.70)

The bill requires the Auditor of State to conduct both a performance audit and a fiscal audit of ODM's Next Generation system that went into effect on February 1, 2023, and submit copies of the audit reports to the JMOC Executive Director by December 31, 2027. In conducting the audits, the Auditor must examine:

- The Provider Network Management;
- The Ohio Medicaid Enterprise System;
- The Ohio Resilience Through Integrated Systems and Excellent (OhioRISE) program;
- The Electronic Data Interchange;
- The Medicaid single state pharmacy benefit manager;
- Centralized provider credentialing;
- Prior authorization requirements;
- Issues with late payments to Medicaid providers;
- Any other aspects of the system the Auditor considers relevant.

Ohio's Next Generation program is an ODM initiative to modify Ohio's Medicaid program with a stated goal of improving member and provider experiences, including addressing complex needs. On February 1, 2023, ODM implemented the Next Generation managed care system, which included cross-agency coordination and new electronic data submission and interchange platforms. The bill requires audits of that system.