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.

Group VIII eligibility redeterminations

- To the extent permissible under federal law, requires ODM to conduct eligibility redeterminations for members of Group VIII every six months.

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 to issue one or more requests for information relating to Medicaid eligibility data and operations, to identify and assess systems and solutions that may be able to improve or augment the management, efficiency, frequency, and accuracy of Medicaid eligibility determinations and processing.
- Requires ODM to consider augmenting existing vendor arrangements relating to processing and managing Medicaid eligibility cases.
- Authorizes ODM to procure one or more vendors to implement any solutions identified as cost effective and feasible.
- Specifies that any vendor compensation is performance based.

Continuous Medicaid enrollment for children

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

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.

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.
- Adds a multiplier to nursing facility direct care cost per case-mix units, due to the difference in scale between the old resource utilization group (RUG) model and the new patient driven payment model.
- Modifies the authority of ODM to adopt rules concerning case-mix scores.

Gradual implementation of the patient driven payment model

- Provides for a gradual implementation of the patient driven payment model, by specifying that for the first half of FY 2026, a nursing facility's direct care costs are determined by multiplying the cost per case-mix unit determined for the facility's peer group by the facility's case-mix score during FY 2025 or the semiannual period beginning July 1, 2025.
- Requires ODM to report quarterly to the General Assembly on the progress of transitioning to the patient driven payment model.
- States that these changes are intended to be budget neutral during FYs 2026 and 2027.

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.

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 direct care worker wages paid for services provided under Medicaid HCBS waiver components, and submit a report to the Governor and specified members of the General Assembly.

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.

Assisting end-stage renal disease patients

- Requires ODM to take certain actions regarding Medicare benefits for individuals with end-stage renal disease.
- Requires ODM, not later than September 1, 2026, to prepare and submit a report to the General Assembly detailing its findings, including whether it is feasible to assist patients with end-stage renal disease in applying for Medicare.

Care management system

Medicaid MCO data cross checks

- Requires ODM to conduct a request for information to establish the feasibility of requiring Medicaid MCOs to conduct internal data cross checks.

Managed care financial dashboard

- Requires ODM to include on its managed care financial dashboard both (1) actuarial metrics for annual and quarterly cost reports for specified Medicaid eligibility populations and (2) quarterly and annual composite per member per month category of service reports.

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 Ohio Hospital Tax Pilot Program and assessment

- Permits the Medicaid Director to establish the Rural Ohio Hospital Tax Pilot Program for directed payments to certain rural 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.
- Prohibits ODM from establishing more than 50 state directed payment programs during a fiscal biennium.
- Prohibits the Medicaid Director from establishing a state directed payment program described above if there is no available or sufficient federal or local funding to sustain the program or the federal government requires the state to utilize general revenue funds as a condition of establishing a state directed payment program.
- Prohibits ODM from utilizing more than 2% of funds received to support a state directed payment program for the administration of state directed payment programs, and not more than 2% of those funds for the administration of ODM and the Medicaid program.

340B grantees

- For purposes of the interaction between Medicaid 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

Diversity, equity, and inclusion

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

Monitoring of federal Medicaid changes

- Requires ODM to monitor and track legislative enactments from the 119th Congress, including any federal policy changes related to the Medicaid program.
- If ODM identifies federal legislative or policy changes, requires ODM to conduct a feasibility study regarding implementation of those changes.
- Requires ODM to prepare and submit a report to JMOC related to its findings and recommendations that result from any feasibility study conducted.

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.

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.

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.

Reports, notifications, and audits

Medicaid reports regarding fraud, waste, and abuse

- Modifies ODM's existing reporting requirements regarding fraud, waste, and abuse in the Medicaid program to require that ODM provide additional information in these reports.
- Requires that these reports be submitted to JMOC and the chairs and ranking members of the House and Senate committees overseeing Medicaid.
- Removes a requirement that ODM's report be made available to the public on request.

Presumptive eligibility error rate quarterly report

- Requires ODM to submit a quarterly report to the General Assembly detailing the presumptive eligibility error rate for the previous quarter.

Legislative notice of Medicaid amendments and waivers

- Requires ODM to provide notice to JMOC and the House and Senate committees with jurisdiction over Medicaid before seeking an amendment to the Medicaid state plan or a Medicaid waiver that would (1) expand Medicaid coverage to any additional class of individuals or (2) increase any net costs to the state.
- Requires ODM to provide those committees with updates regarding the status of any amendment or waiver and to seek their input to design any amendment or waiver.

Audit of Next Generation

- Requires the Auditor of State to conduct a performance and fiscal audit of ODM's Next Generation system and submit copies of the audit report 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%.[137] 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.

Group VIII eligibility redeterminations

(R.C. 5163.11)

The bill requires ODM, to the extent permissible under federal law, to conduct eligibility redeterminations for members of Group VIII every six months. Current federal regulations governing the Medicaid program restrict eligibility redeterminations for Medicaid enrollees to once every 12 months.[138] However, the version of H.R. 1 (the 2025 federal budget reconciliation bill) passed by the U.S. House of Representatives on May 22, 2025, proposes to implement six-month eligibility redeterminations for members of Group VIII.

[137] 42 U.S.C. 1396d(y).

[138] 42 C.F.R. 435.916.

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

Change in circumstances eligibility verification

(R.C. 5163.50)

The bill requires ODM to issue one or more requests for information related to Medicaid eligibility data and operations, to identify and assess systems and solutions that may be available to improve or augment the management, efficiency, frequency, and accuracy of Medicaid eligibility determinations and processing. The requests for information must include data systems related to the following: (1) Medicaid enrollee or applicant identity verification, (2) Medicaid enrollee death verification, (3) employment and wages, (4) lottery winnings, (5) residency verification including residency relating to concurrent enrollment in Medicaid programs in other states, (6) household composition, (7) Medicaid enrollee incarceration status, (8) third-party liability verification, (9) asset verification, and (10) any other records or systems ODM considers appropriate in order to strengthen program integrity, reduce costs, and to reduce fraud, waste, and abuse in the Medicaid program.

As part of the considerations described above, the bill requires ODM to consider augmenting existing vendor arrangements relating to processing and managing Medicaid eligibility cases. The bill further authorizes ODM to procure one or more vendors to implement any solutions identified as cost effective and feasible, but specifies that any vendor compensation is to be performance based.

Continuous Medicaid enrollment for children

(R.C. 5166.45, repealed)

The bill repeals 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.

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.

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. 5195.19 and 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.

As part of this change, the bill includes an adjustment to nursing facility direct care cost per case-mix units, due to the difference in scale between the old resource utilization group (RUG) model and the new patient driven payment model. Under the bill, ODM must multiply each cost per case-mix unit by the nursing facility's peer group average case-mix score for the semiannual period beginning January 1, 2026. That product is the cost per case-mix unit used to determine the nursing facility's direct care costs beginning January 1, 2026, and continuing until ODM's next rebasing takes effect.

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.

Gradual implementation to patient driven payment model

(Section 333.280)

Due to the transition to the patient driven payment model for nursing facility case-mix scores for direct care costs, the bill provides for a gradual implementation of these new rates.

H.B. 33 modified nursing facility direct care costs for FY 2024 and FY 2025. Under that act, a nursing facility could select for its case mix score either (1) the semiannual case-mix score determined under the standard calculation or (2) the facility's quarterly case-mix score from March 31, 2023, for the period from January 1, 2024, through June 30, 2025 (the second half of FY 2025).

Accordingly, the bill adjusts for that modification from the rates calculated last biennium. Under the bill, from July 1, 2025, through December 31, 2025 (the first half of FY 2026), a nursing facility's direct care rate is to be determined by multiplying the facility's cost per case-mix unit determined under the direct care rate formula for the nursing facility's peer group by the case-mix score under the standard formula, or, if the facility's case-mix score for FY 2025 was the alternate score under (2) above, then the facility's semiannual case-mix score for the semiannual period beginning July 1, 2025. Additionally:

- From January 1, 2026, through the remainder of FY 2026, the increase or decrease to a nursing facility's direct care rate must equal ⅓ 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 ⅔ 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.

The bill notes that this transition to the patient driven payment model is intended to be budget neutral during FYs 2026 and 2027 and to not increase nursing facility payment rates during the fiscal biennium.

PDPM transition report

Beginning October 1, 2025, quarterly during the fiscal biennium, ODM must report to the General Assembly on the progress of transitioning to the patient driven payment model. The report must cover the progress made during the previous quarter and must be submitted to the chairperson and ranking member of the standing committees overseeing Medicaid in the House and Senate.

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.

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, the President and Minority Leader of the Senate, the Speaker and Minority Leader of the House, and the chairpersons of the standing committees handling Medicaid matters in the House and Senate.

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.

Assisting end-stage renal disease patients

(R.C. 5160.25)

The bill requires ODM to do all of the following regarding individuals with end-stage renal disease:

- Evaluate Medicare application requirements and review state policies and procedures related to patients who are age 65 or younger and have end-stage renal disease;

- Review and identify whether there exist Medicare eligibility gaps for individuals with end-stage renal disease and take steps to address any identified gaps to improve patient access to Medicare benefits;
- Develop a process to assist patients with end-stage renal disease in applying for Medicare benefits.

The bill further requires ODM, not later than September 1, 2026, to prepare and submit a report to the General Assembly detailing the review described above, including the feasibility of developing a process to help patients with end-stage renal disease apply for Medicare benefits. If ODM determines it is not feasible to do so, the report must include the results of those findings and the steps taken to reach that conclusion.

Care management system

Medicaid MCO data cross checks

(Section 751.120)

The bill requires ODM to conduct a request for information to study the feasibility of requiring Medicaid MCOs to conduct internal data cross checks.

Managed care financial dashboard

(R.C. 5167.09)

The bill requires ODM to include actuarial metrics for annual and quarterly cost reports on its managed care financial dashboard. These metrics must be delineated by the following categories:

- Adults for whom financial eligibility for the Medicaid program is determined utilizing the modified adjusted gross income standard, and who are not members of Group VIII;
- Children for whom financial eligibility for the Medicaid program is determined utilizing the modified adjusted gross income standard;
- Individuals in the ABD eligibility group who are age 21 or older;
- Individuals in the ABD eligibility group who are age 20 or younger;
- Individuals who are members of Group VIII;
- Individuals who are members of the adoption and foster kids eligibility groups;
- All other individuals eligible for Medicaid benefits.

The dashboard must also include quarterly and annual composite per member per month category of service reports for each Medicaid MCO, delineated by: (1) inpatient services, (2) outpatient facility services, (3) professional services, (4) radiology, pathology, and laboratory services, (5) pharmacy services, (6) behavioral health services, and (7) all other services.

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 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 Ohio Hospital Tax Pilot Program to provide directed payments to certain rural 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 either a rural hospital or a critical access hospital. For purposes of the pilot program, a "rural hospital" includes any hospital located in Fayette, Greene, Highland, Hocking, Muskingum, Perry, Pike, Ross, Scioto, or Washington County.

The pilot program must comply with all federal law requirements governing state directed payment programs, including all of the following:[139]

- 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.

[139] 42 C.F.R. 438.6(c).

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 by 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 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 local hospital assessment is established, it must meet 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, that each contain two or fewer rural hospitals, 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 county's participation in 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:[140]

- The program must be approved by CMS and the Medicaid 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 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. Moreover, the bill prohibits ODM from establishing more than 50 state directed payment programs during a fiscal biennium.

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, beginning for any preprint effective for a rating period beginning on or after January 1, 2027, 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.

---

[140] 42 C.F.R. 438.6(c).

The bill requires ODM to enter into an agreement with the authorized representative of each entity participating in a state directed payment program. No agreement between ODM and an entity is valid and enforceable unless the OBM Director first certifies that there is a balance in the appropriation used to support state directed payment programs that is not already obligated under existing programs, in an amount at least equal to the cost of the program.

The bill stipulates that a hospital provider may not participate in a state directed payment program unless sufficient funds are obligated and appropriated. ODM is prohibited from providing general revenue funds or other state funds for a state directed payment program. The ODM Director must terminate or decline to establish a state directed payment program if (1) local funding is not available or sufficient to sustain the program, or (2) the federal government restricts or otherwise limits the availability of federal funds to support state directed payment programs, or requires the state to utilize general revenue funds as a condition of establishing or maintaining a state directed payment program.

The bill further stipulates that ODM may not use more than 2% of funds received to support a state directed payment program for the administration of such programs and also may not use more than 2% of those funds for the administration of ODM or the Medicaid program.

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

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.

Monitoring of federal Medicaid changes

(Section 751.111)

The bill requires ODM to monitor and track legislative enactments from the 119th Congress, including any federal policy changes related to the Medicaid program. As part of the monitoring, ODM must identify state flexibilities, authorities, and requirements related to Medicaid program integrity eligibility, accountability, and efficiency. Specifically, the bill requires ODM to monitor the following:

- Changes related to presumptive eligibility determinations made by hospitals;
- The establishment of work requirements as a condition of continued participation in the Medicaid program;
- The establishment of new responsibilities on Medicaid enrollees as a condition of continued participation in the Medicaid program, including cost-sharing requirements and program premiums.

If ODM identifies legislative or policy changes, the bill requires ODM to conduct a feasibility study regarding the implementation of those changes. As part of the study, ODM must evaluate the administrative costs related to implementing changes, the level of effort and staffing resources needed to implement and operate the changes, the necessary timeframe for implementing the changes, and the estimated savings and costs for implementing the changes. ODM must prepare and submit a report to JMOC related to the feasibility study.

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;
- Services provided under Medicaid waiver components administered by the Department of Developmental Disabilities;
- Services provided under the OhioRISE Medicaid waiver component;
- Any other services the Directors determine should have a separate appropriation item.

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 (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. 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.

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.

Reports, notifications, and audits

Medicaid reports regarding fraud, waste, and abuse

(R.C. 5162.132 (primary) and 5101.98)

Continuing law requires ODM to prepare and submit a report regarding its efforts to minimize fraud, waste, and abuse in the Medicaid program. The bill adds that the report must be prepared and submitted by December 31 of each year, and include all of the following information for the most recently concluded state fiscal year:

- Improper Medicaid payments and expenditures, including the individual and total dollar amounts for claims that were determined to be the result of fraud, waste, and abuse;
- Federal and state recovered funds, including the dollar amount per claim and the total dollar amounts concerning fraud, waste, and abuse in the Medicaid program;
- Aggregate data concerning improper payments and ineligible Medicaid recipients who received Medicaid services as a percentage of the claims investigated or reviewed;
- The number of payments made in error, the dollar amount of those payments within the Medicaid program, and the number of confirmed cases of intentional program violation and fraud (these requirements apply to JFS under current law).

In addition to making this report available on ODM's website and providing it to JMOC as required under current law, the bill requires ODM to also provide copies of the report to the chairpersons and ranking members of the House and Senate committees with jurisdiction over Medicaid. The bill removes the requirement that the report be submitted to the Governor, the General Assembly generally, and to the public upon request.

Presumptive eligibility error rate quarterly report

(R.C. 5163.104)

The bill requires ODM to submit a quarterly report to the General Assembly regarding the presumptive eligibility error rate for presumptive eligibility determinations made during the previous quarter. Current law unchanged by the bill defines the "presumptive eligibility error rate" as the rate at which a qualified entity or qualified provider deems an individual presumptively eligible for Medicaid, when the individual is not eligible to participate in the Medicaid program.

Legislative notice of Medicaid amendments and waivers

(R.C. 5162.08 and 5166.03)

The bill prohibits ODM from seeking to implement an amendment to the Medicaid state plan or an 1115 or 1915 Medicaid waiver that would (1) expand Medicaid coverage to any additional individuals or class of individuals or (2) increase any net costs to the state, unless ODM first provides notice to JMOC and the standing committees of the House and Senate with jurisdiction over Medicaid. The bill further requires ODM to provide updates to those committees regarding the status of any amendment or waiver submitted. Additionally, ODM must seek input from the committees to design amendments and waivers.

Continuing law requires the ODM Director to provide written notice to the Speaker of the House and Senate President at least ten days prior to submitting a request for an 1115 Medicaid waiver. The bill requires that this notice also include confirmation that ODM has informed the committees as described above, if doing so is required for the proposed waiver.

Audit of Next Generation

(Section 751.70)

The bill requires the Auditor of State to conduct a performance and fiscal audit of ODM's Next Generation system and submit copies of the audit report to the JMOC Executive Director by December 31, 2027. In conducting the audit, the Auditor may 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.