DEPARTMENT OF MEDICAID

Medicaid waiver component definition

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

Duties of area agencies on aging

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

Hospital Care Assurance Program, franchise permit fee

- Continues, for two additional years, the Hospital Care Assurance Program and the franchise permit fee imposed on hospitals under Medicaid.

Voluntary community engagement program

- Requires the Medicaid Director to establish a voluntary community engagement program for medical assistance recipients.
- Requires the program to encourage work among able-bodied medical assistance recipients of working age, including providing information about the benefits of work on physical and mental health.
- Provides that the program is in effect through FY 2022 and FY 2023, or until Ohio is able to implement the waiver component establishing work requirements and community engagement as a condition of enrolling in the Medicaid expansion eligibility group (also known as "Group VIII").

Medicaid Cost Assurance Pilot Program

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

Care Innovation and Community Improvement Program

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

Ohio Invests in Improvements for Priority Populations

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

Medicaid rates for community behavioral health services

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

Adult day care service payment rates

- Earmarks $5 million in each fiscal year to increase the payment rates during FY 2022 and FY 2023 for adult day care service providers under the home and community-based waivers administered by the Department of Developmental Disabilities and the PASSPORT program.
- Requires the Departments of Developmental Disabilities and Medicaid to establish a methodology for calculating the rate increase from those funds.

Value-based purchasing supplemental rebate

- Requires the Department of Medicaid to submit a federal state plan amendment to permit the Department to enter into value-based purchasing supplemental rebate agreements with pharmaceutical manufacturers.

Nursing facilities

Critical access nursing facilities

- For calculating the occupancy and utilization rates to determine if a nursing facility is a critical access nursing facility, provides that "as of the last day of the calendar year" refers to the rates for the entire cost reporting period for which the nursing facility participated in the Medicaid program during the applicable calendar year.

Medicaid payment rate formula

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

Resident assessment data

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

Special Focus Facility Program

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

Quality payments

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

Quality incentive payments

- Modifies the nursing facility's base rate calculation to include the subtraction of $1.79, included as part of the calculation for the nursing facility's per Medicaid day quality payment.
- Provides that a nursing facility receives zero quality points if (1) its total number of points for FY 2022 for the quality metrics is less than the total equal to the bottom 33% of all nursing facilities or (2) its total points for FY 2023 for all of the quality metrics is less than its total number of points for FY 2022.
- Modifies the calculation used to determine the total amount to be spent on quality incentive payments in a fiscal year by (1) adding $1.79 to the calculation for 5.2% of each nursing facility's base rate and (2) including a $108.5 million add-on to the total in each fiscal year.
- Clarifies that if a nursing facility undergoes a change of operator during FY 2022 or FY 2023, the quality incentive payment paid to the entering operator for that fiscal year beginning on the date of the change is the same rate in effect for the outgoing operator.

Nursing Facility Payment Commission

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

Nursing facility rebasing

- Requires the Department to conduct its next nursing facility rebasing by June 30 2022, using nursing facility calendar year 2019 data.

Medicaid waiver component definition

(R.C. 5166.01)

The bill specifies that the current law definition of a "Medicaid waiver component" does not include services that are delivered under a prepaid inpatient health plan.[76] Medicaid waiver component means a component of the Medicaid program authorized by a waiver granted by the U.S. Department of Health and Human Services and does not include the care management system.

Duties of area agencies on aging

(Section 333.170)

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

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

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

Hospital Care Assurance Program, franchise permit fee

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

The bill continues the Hospital Care Assurance Program (HCAP) for two additional years. The program is scheduled to end October 16, 2021. The bill extends it to October 16, 2023. Under HCAP, hospitals are annually assessed an amount based on their total facility costs, and government hospitals make annual intergovernmental transfers. The Department distributes to hospitals money generated by the assessments and intergovernmental transfers along with federal matching funds. A hospital compensated under the program must provide (without

[76] Federal law defines a "prepaid inpatient health plan" as an entity that provides limited services to Medicaid enrollees through a limited-benefit risked-based plan. (42 C.F.R. 438.2.)

charge) basic, medically necessary, hospital-level services to Ohio residents who are not recipients of Medicare or Medicaid and whose income does not exceed the federal poverty line.

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

Voluntary community engagement program

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

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

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

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

Continuing law requires the Director to establish a Medicaid waiver component under which an individual eligible for Medicaid on the basis of being included in the expansion eligibility group (also known as "Group VIII") – adults under age 65 with no dependents and incomes at or below 138% of the federal poverty level – must meet one of a list of enumerated criteria to enroll in Medicaid. The criteria include (1) being at least age 55, (2) being employed, (3) being enrolled in a school or occupational training program, (4) participating in an alcohol and drug addiction treatment program, or (5) having intensive physical health care needs or serious mental illness.[77] Pursuant to this requirement, the Department submitted a waiver request to the U.S. Centers for Medicare and Medicaid Services (CMS) to implement a Work Requirement and Community Engagement Section 1115 Demonstration waiver program. CMS approved the waiver on March 15, 2019; however, the program was never implemented because the federal Coronavirus

[77] R.C. 5166.37, not in the bill.

Aid, Relief, and Economic Security (CARES) Act prohibits state Medicaid programs from imposing additional eligibility criteria on Medicaid enrollees during the COVID-19 public health emergency.

Medicaid Cost Assurance Pilot Program

(Section 333.217)

The bill requires the Department to establish the Medicaid Cost Assurance Pilot Program to operate during FYs 2022 and 2023. The Department must open the program to Medicaid enrollees in the expansion eligibility group (otherwise known as "Group VIII"), initially. It may expand the program based on the program outcome data and cost findings in its report (see "**Report and subcommittee**" below).

The pilot program must do all of the following:

- Identify eligible Medicaid enrollees who are members of the expansion eligibility group to participate in the program;
- Provide Medicaid services to pilot program participants at a rate of 95% of current Medicaid managed care organization capitation rates;
- Use technology to (1) utilize automation and artificial intelligence to provide Medicaid program savings by avoiding traditional cost structures, (2) diversify care management system programs to achieve better health outcomes at better value, (3) enable seamless communication between providers and care management entities, (4) improve the Medicaid program experience for providers and enrollees;
- Develop and implement strategies to provide opportunities for pilot program participants to rise above the poverty level criteria for Medicaid eligibility;
- Enable care management entities under the program to take the risks incidental to the practice of insurance, like an insurer licensed in Ohio; and
- Include 90-day study periods to determine whether to expand, sustain, or terminate the pilot program.

Care management entity

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

- Be an insurer licensed in Ohio;
- Be a start-up company domiciled in Ohio; and
- Have sufficient capital of at least $30 million.

Report and subcommittee

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

Additionally, the members of the House Health Committee must appoint a subcommittee to make determinations about the progress of the pilot program.

Rules

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

Care Innovation and Community Improvement Program

(Section 333.60)

The bill requires the Medicaid Director to continue the Care Innovation and Community Improvement Program for the FY 2022-FY 2023 biennium. The Director was originally required to establish it for the FY 2018-FY 2019 biennium.[78]

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

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

Each participating hospital agency is to receive supplemental Medicaid payments for physician and other professional services that are covered by Medicaid and provided to Medicaid recipients. The payments must equal the difference between the Medicaid rate and the average commercial payment rates for the services. The Director may terminate, or adjust the amount of, the payments if funding for the program is inadequate.

The Director must maintain a process to evaluate the work done under the program by nonprofit and public hospital agencies and their progress in meeting the program's goals. The Director may terminate a hospital agency's participation if the Director determines that it is not participating in required quality improvement initiatives or making progress in meeting the program's goals.

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

[78] Section 333.320 of H.B. 49 of the 132nd General Assembly and Section 333.220 of H.B. 166 of the 133rd General Assembly.

of supplemental Medicaid payments made through the program. All data contained in the report is required to be aggregated.

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

Ohio Invests in Improvements for Priority Populations

(Section 333.175)

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

Under the OIPP Program, participating hospitals receive payments directly (instead of through the contracted Medicaid managed care organization) for inpatient and outpatient hospital services provided under the program and remit to the Department of Medicaid the nonfederal share of payment for those services. The hospital must make the payment to the Department through intergovernmental transfer, with the funds deposited into the Hospital Directed Payment Fund.

In general, under federal law, states are prohibited from (1) directing Medicaid managed care organization expenditures or (2) making payments directly to providers for Medicaid managed care organization plan services ("directed payments") unless permitted under federal law or subject to federal authorization.[79] The bill requires the Medicaid Director to seek approval from the Centers for Medicare and Medicaid Services, in accordance with continuing Ohio law, to operate the OIPP Program.

Medicaid rates for community behavioral health services

(Section 333.160)

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

Adult day care service payment rates

(Sections 261.170 and 333.165)

The bill earmarks $5 million in each fiscal year to increase the payment rates during FY 2022 and FY 2023 for adult day care service providers under the home and community-based

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

waivers administered by the Department of Developmental Disabilities and the PASSPORT program. It provides that the payment increase applies to waiver-funded and state-funded providers under those waivers and programs. The Departments of Developmental Disabilities and Medicaid must establish a methodology for calculating the rate increase from those funds.

Value-based purchasing supplemental rebate

(Section 333.215)

Not later than 60 days after the bill's effective date, the bill requires the Department of Medicaid to submit to CMS a Medicaid state plan amendment to authorize the Department to enter into value-based purchasing supplemental rebate agreements with pharmaceutical manufacturers. The agreements must establish criteria for the Department to make supplemental rebate payments to drug manufacturers. The rebates can be calculated and paid in a single year or over multiple years.

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

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

Nursing facilities

Critical access nursing facilities

(R.C. 5165.01)

The bill clarifies terminology relating to the critical access incentive payment received by nursing facilities that qualify as critical access nursing facilities. Under current law, to qualify as a critical access nursing facility, the nursing facility must meet certain occupancy and Medicaid utilization rate metrics. For purposes of calculating the occupancy and utilization rates, the bill clarifies that "as of the last day of the calendar year" refers to the rates for the entire cost reporting period for which the nursing facility participated in the Medicaid Program during the calendar year and identified in its annual cost report filed with the Department.

Medicaid payment rate formula

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

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

The bill also removes provisions of law, under the ancillary and support costs and capital cost center components of the nursing facility payment rate, that require the Department, when

determining a nursing facility's occupancy rate, to include any beds that the facility removes from its Medicaid certified capacity, unless the facility also removes them from its licensed capacity.

Resident assessment data

(R.C. 5165.191)

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

Special Focus Facility Program

(R.C. 5165.771)

The bill modifies the Special Focus Facility (SFF) Program, which requires the Department to terminate a nursing facility's Medicaid participation if the facility is placed on the federal SFF list and fails to make improvements or graduate from the SFF Program within certain periods of time. The SFF list is part of the SFF Program that federal law requires the U.S. Department of Health and Human Services to create for nursing facilities identified as having substantially failed to meet federal requirements.[80]

SFF tables

The SFF has different tables. Table A identifies nursing facilities that are newly added to the list. Table B identifies nursing facilities that have not improved. Table C identifies nursing facilities that have shown improvement. Table D identifies nursing facilities that have recently graduated from the SFF Program.

The bill makes nonsubstantive changes to current law regarding the SFF tables, which requires the Department to terminate a nursing facility's Medicaid participation if:

1. The nursing facility was listed in Table A or Table B on September 29, 2013, and failed to be placed on Table C by September 29, 2014 (12 months after the provision's effective date);

2. The nursing facility was listed in Table A, Table B, or Table C on September 29, 2013, and failed to be placed on Table D by September 29, 2015 (24 months after the provision's effective date);

3. The nursing facility is placed on Table A after September 29, 2013, and fails to be placed in Table C not later than 12 months after the placement in Table A;

4. The nursing facility is placed in Table A after September 29, 2013, and fails to be placed in Table D not later than 24 months after the placement in Table A.

The bill removes the effective date references. Instead, under the bill, the Department must terminate a nursing facility's Medicaid participation if:

[80] 42 U.S.C. 1396r(f)(10).

1. The nursing facility is placed in Table A or Table B and fails to be placed in Table C not later than 12 months after being placed in Table A or Table B;

2. The nursing facility is placed in Table A, Table B, or Table C and fails to be placed in Table D not later than 24 months after being placed in Table A, Table B, or Table C;

3. The nursing facility is placed in Table A and fails to be placed in Table C not later than 12 months after being placed in Table A;

4. The nursing facility is placed in Table A and fails to be placed in Table D not later than 24 months after the nursing facility is placed in Table A.[81]

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

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

Quality payments

(R.C. 5165.25, repealed)

The bill repeals the quality payments nursing facilities receive under current law. Those payments are made to nursing facilities for meeting at least one of five quality indicators. The largest quality payment is to be paid to nursing facilities that meet all of the quality indicators for the measurement period (the calendar year preceding the year in which the fiscal year begins). The following are the quality indicators used to determine the payment:

- Not more than a target percentage of short-stay residents (those residing in a nursing facility for less than 100 days) at high risk for pressure ulcers had new or worsening pressure ulcers and not more than a target population of long-stay residents (those residing in a nursing facility for at least 100 days) at high risk for pressure ulcers had pressure ulcers for the measurement period;
- Not more than the target percentage of the nursing facility's short-stay residents newly received antipsychotic medication and not more than a target percentage of the nursing facility's long-stay residents received an antipsychotic medication for the measurement period;

[81] Under the bill, numbers (3) and (4) appear to be included in (1) and (2).

- Not more than the target percentage of the nursing facility's long-stay residents had an unplanned weight loss for the measurement period;
- The nursing facility's employee retention rate is at least a target rate that the Department is to specify;
- The nursing facility obtained a target score determined by the Department on the Department of Aging's most recently published resident or family satisfaction survey.

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

Quality incentive payments

(R.C. 5165.26 and 5165.15)

The bill modifies the calculations for quality incentive payments that are added to nursing facility's Medicaid payment rates based on the score the facility receives for meeting certain quality metrics regarding its residents who have resided in the nursing facility for at least 100 days (long-stay residents).

First, the bill extends the payments for FY 2022 and FY 2023. Under current law, the payments end after FY 2021. Second, the bill modifies the base rate used as part of the calculation for a nursing facility's quality incentive payment to include a subtraction of $1.79, so the base rate is calculated by determining the sum of the following:

1. The nursing facility's per Medicaid day payment rate for each of the four cost centers (ancillary and support costs, capital costs, direct care costs, and tax costs) and, if the nursing facility qualifies as a critical access nursing facility, its critical access incentive payment;

2. To that sum, add $16.44;

3. From that sum, subtract $1.79.

Current law does not include step (3) as part of the base rate calculation.

Third, the bill clarifies that a nursing facility receives zero quality points if either of the following is the case:

- The nursing facility's total number of points for FY 2022 for all of the quality metrics is less than the total equal to the bottom 33% of all nursing facilities;
- The nursing facility's total points for FY 2023 for all of the quality metrics is less than its total number of points for FY 2022.

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

1. For each nursing facility, determine the amount that is 5.2% of the nursing facility's base rate on the first day of the fiscal year plus $1.79;

2. Multiply that amount by the number of the nursing facility's Medicaid days for the calendar year preceding the fiscal year for which the rate is determined;

3. Determine the sum of (1) and (2) above for all nursing facilities for which the product was determined for the state fiscal year;

4. To that sum, add $108.5 million.

Current law does not add $1.79 as part of the calculation in (1) above or include the $108.5 million add-on to the total to be spent on the payments in each fiscal year (number 4 above).

Finally, the bill clarifies that if a nursing facility undergoes a change of operator during FY 2022 or FY 2023, the quality incentive payment paid to the entering operator for services provided beginning on the date of the change of operator and ending on the last day of that fiscal year is the same rate in effect for the outgoing operator. For the following fiscal year, the rate for the entering operator is determined under the regular calculation. These provisions are similar to the provisions relating to the repealed quality payments made to nursing facilities.

Nursing Facility Payment Commission

(R.C. 5165.261)

The bill requires the Department to establish the Nursing Facility Payment Commission comprised of various nursing facility stakeholders. The Commission consists of the following members:

- Two members appointed by the Governor;
- Two members appointed by the Speaker of the House;
- Two members appointed by the Senate President; and
- One public member, well-versed and with experience in the long-term care and nursing home industry, appointed by the Governor.

Appointments must be made by December 31, 2021. In the event of a vacancy, a replacement member must be appointed in the same manner as initial appointments. Members serve without compensation.

The Commission must analyze the efficacy of the following:

1. The current quality incentive payment formula;

2. The nursing facility base rate calculation; and

3. The nursing facility cost centers, which are used to calculate a nursing facility's per Medicaid day payment rate and are redetermined as part of rebasing.

By August 31, 2022, the Commission must submit a report to the General Assembly with its recommendations and determinations on whether the quality measures under the quality incentive payment formula are sufficient or whether the measures need to be changed.

Nursing facility rebasing

(R.C. 5165.36)

The bill requires the Department to conduct its next nursing facility rebasing by June 30, 2022 (FY 2021), using data provided by nursing facilities for calendar year 2019. Current law requires the Department to conduct a rebasing at least once every five state fiscal years. The Department conducted its last rebasing in FY 2017. A rebasing is a redetermination of the four cost components used to calculate a nursing facility's per Medicaid day payment rate.[82]

[82] 42 U.S.C. 1396r(f)(10).