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Before the Senate Finance Committee
Testimony on House Bill 96 As Passed by the House

May 29, 2025

Good morning, Chair Cirino, Vice-Chair Chavez, Ranking Member Hicks-Hudson, and members of the Finance Committee. I am Pete Van Runkle with the Ohio Health Care Association. OHCA is a membership organization for providers across the spectrum of aging and disability services. Today I'm representing our assisted living, home care, and hospice members who serve aged and disabled Medicaid beneficiaries in programs operated by ODA and ODM. These programs include PASSPORT, Assisted Living Waiver, Ohio Home Care Waiver, MyCare Ohio Waiver (which packages those three programs in a managed care environment), and state plan home health, private duty nursing, and hospice services.

Sustaining Gains in Home Care and Assisted Living Services (SC 1021 or SC1050, SC1022 or SC 1057)

We appreciate the opportunity to discuss the impact of HB 96 on aging services. Last session's budget, HB 33, was remarkable for making bold strides to correct many years of underinvestment in services for our seniors and people with disabilities. Providers saw significant Medicaid rate increases specifically intended to give them the resources to pay higher wages for direct care workers, who are the foundation of home and community-based services (HCBS). The goal of increasing wages was to attract more caregivers into the HCBS workforce and give them an incentive to stay. In turn, a stronger workforce allows providers to serve more Ohioans in need.

We are exceedingly grateful to the General Assembly and the DeWine Administration for the last budget's accomplishments. The rate increases were substantial and broadly covered HCBS (except hospice), particularly hands-on services and supports.

This year, HB 96, allocates GRF dollars to avoid cutting those desperately needed rate increases, which had been funded partly by one-time federal dollars under the American Rescue Plan Act (ARPA). We are grateful for the decision to maintain the rates at the same level, but would note that when the state used ARPA funding to support ongoing rates, it committed to sustaining them after the ARPA dollars expired. HB 96 follows through on this commitment, but that is all.

Continuing rates at a flat level is not the same as maintaining the additional workforce that the past rate increases brought to aging and disability services. Workers expect periodic pay raises.

We don't want to find ourselves back in a world where rates and wages stagnate for an extended period of time, requiring a large investment later to catch up. It is better to provide incremental rate increases on a regular basis to keep pace with the cost of providing services, allowing providers to raise wages and maintain a stable workforce.

The rate increases from the last budget and resulting higher wages mostly took effect January 1, 2024. If rates are kept flat in the current budget, direct care workers in HCBS would not see another raise until at least January 1, 2028. They would have to wait four years for a raise, when in other jobs, they could expect some kind of increase annually. We are concerned that without regular pay raises, the direct care workforce will begin to dissipate again, moving to better-paying jobs where wages are not stagnant. As they go, so goes providers' capacity to serve the increasing number of Ohioans who need their services.

As stated in the Department of Aging's State Plan on Aging:

> The largest population of adults ages 60 and older is expected in 2030, with 3,050,200 older adults in the state, an 8.4% increase from 2020. By 2040, Ohioans, ages 60 and older, will make up 25% of Ohio's total population. The proportion of Ohio's total population, ages 85 and older, is projected to increase at an even greater rate, growing 51% from 2020 to 2040.

That growth in the aging population started several years ago and is continuing today.

The HB 33 rate increases had a demonstrably positive impact on serving more Ohio seniors and people with disabilities. Taking just the PASSPORT and assisted living programs, for which we have high-quality, longitudinal data on ODA's Medicaid waiver program data web page, the impact is clear. Provider rate increases began January 1, 2024. During calendar year 2024, the number of seniors in PASSPORT increased by 1,200, or 6.7%. Comparatively, the number had fallen during the previous 12-month period, before the rate increases. The Assisted Living Waiver grew during 2024 by 559 participants, or 17%, compared to only 3% during 2023, before the rate increases.

Looking farther back in time, these HCBS programs experienced more growth in people served during the last year than during the previous 4 years combined. For the entire period from July 2019 to December 2023, the number of PASSPORT members grew by only 200, while for the same period, assisted living participants decreased by 1,144. This period saw only very minimal rate increases, preventing providers from serving the growing need.

For assisted living in particular, another goal was to increase access to affordable assisted living by supporting providers who wish to build communities dedicated to serving the Medicaid population or shift their model to include more Medicaid residents. Adequate rates to make developing affordable assisted living properties economically feasible are critical to increasing access. Following the rate increases in January 2024, Ohio saw nearly 10% growth in the number of affordable assisted living providers, but more are needed to meet demand. Developers need

sustainable revenue from the waiver program to support long-term financial commitments for constructing affordable assisted living communities and bringing more business to Ohio.

To meet the growing need for services and maintain workforce stability, but also recognizing this budget's fiscal constraints, we are proposing two amendments to HB 96. These amendments would provide modest, 2% rate increases to HCBS providers that would not take effect until January 1, 2027, minimizing the budget impact. Amendment SC1050 would apply to assisted living, while SC1057 would apply to Medicaid waiver and state plan home care services. Both amendments are attached to my testimony. They carry small appropriation increases of $2.4 million and $6.7 million in state share, respectively.

While small, these rate increases would allow providers a chance to offer raises to their employees and compete in the job market. The wage increase for 2027 would be only $0.36 per hour on average, but it would help low-wage caregivers who are struggling to make ends meet.

In addition, the amendments would provide a long-term solution for HCBS rates. This solution is an annual rate review process based on cost data collected from providers. ODA and ODM would adopt rules prescribing a methodology for gathering and analyzing cost data from Ohio providers to determine year-over-year cost growth. These data would help inform decisions about provider rates for the upcoming fiscal year. The amendment rate review process would not apply to rates until January 1, 2028. The intervening two years would be used to set up the process and collect the first round of data.

It is important to note that the rate review process would not mandate automatic increases or otherwise "tie the hands" of the administration or the legislature. The administration would remain free to make its own recommendations on rates and the General Assembly would retain the power to decide the level of appropriations. Nothing in the amendments would disturb these authorities.

Additionally, SC 1050 would establish retainer payments for Medicaid assisted living communities that would allow a resident to be away from the community for up to 30 days per year for medical reasons, vacations, or visits with family without losing their apartment.

As an alternative solution for your consideration, we are offering two additional amendments that are similar to the ones I just discussed but are budget-neutral. They are SC 1021 (assisted living) and SC1022 (home care) and are also attached to my testimony. They are budget-neutral because they only include the rate review language and not the 2% rate increase for FY 2027. While this solution would be helpful in the long run, it would keep rates and wages flat through the coming biennium.

Supporting EVV language in House-passed budget

We support a provision the House added to HB 96 that would prohibit state agencies or managed care plans from refusing to pay Medicaid claims for services covered by electronic visit

verification (EVV) when the claims don't match EVV data. ODM has been denying claims for home health services on this basis since March 1, 2025. Denials will be phased into other home care services over the coming months.

While on the surface, it might make sense to deny claims that don't match EVV data, but in reality, Ohio's EVV system (contracted out to Sandata) is very challenging for providers to use, especially small agencies and independent (solo) providers. The claims must match in every particular, not just show that the service was provided.

Instead of denying claims up front, the House-passed language would authorize the state to use EVV data in post-payment audits. The problem with denying claims up front is that like other state data systems, EVV remains fraught with errors and technological challenges that can result in matching failures despite the provider's best efforts. The provider is out the money while the struggle to navigate the system. Many caregivers in Ohio's home and community-based services arena are independent providers who are self-employed and do not work for an agency. These providers cannot afford to have their claims denied. It is their paycheck, all they have to live on. Even agencies can be put in a severe financial bind if the state refuses to pay their claims. If independent providers or agencies are forced out of business because they can't get paid, Ohio's frail elderly and disabled citizens have reduced access to care.

The better way to use EVV data is for post-payment audits, which is the normal way Medicaid program integrity works. The agency notifies the provider of paid claims that do not match and gives the provider the opportunity to furnish documentation supporting the claims before taking the money back.

We have heard assertions that up-front claim denials are mandated by the 21st Century Cures Act or by CMS. These contentions are inaccurate. The Cures Act reduces federal matching funds for Medicaid personal care or home health care services "unless a State requires the use of an electronic visit verification system for such services furnished in such quarter under the plan or such waiver." That's all. The requirement for retaining full funding is use of an EVV system, not how it is used. The statute lists various components of a required EVV system, which do not include up-front claims denials. Ohio met the requirement by implementing an EVV system, although the system itself still does not function well enough to support claim denials.

Likewise, CMS has never issued any guidance or other direction requiring up-front claim denials. Conversely, CMS recognizes that states have the option of using EVV data either for pre-payment review (approval/denial of claims) or post-payment review (audits/takebacks). Nowhere does CMS guidance even a hint that up-front denial is required.

While neither the Cures Act nor CMS requires states to use EVV to deny claims pre-payment, we have been asked whether there is a timeframe after which Ohio should implement denials. The answer turns on whether the Sandata system is demonstrably improved so it is ready to use in that manner. We would support an amendment to the House-passed language stating that denials would start when 95% of the providers in a given category (e.g., home health, DD waiver

services) are able to submit claims that match EVV data. By applying the standard on a provider level instead of a claims level, it ensures that small and independent providers can use the Sandata system successfully and continue providing access to services for our frail elderly and people with disabilities.

Achieving equitable hospice pass-through payments (SC1020 or SC1048)

The amount of the hospice pass-through payment is a long-standing problem with Medicaid payments to hospices for hospice patients who live in skilled nursing facilities (SNFs) or intermediate care facilities for people with intellectual and developmental disabilities (ICFs). Under an ODM rule, payment for these patients is only 95% of the daily rate for the facility where they live. The hospice, however, must pay the SNF or ICF 100% of the daily rate, which causes the hospice to take a loss on each day of care in the facility. As facility rates increase over time, the loss grows, particularly when the facility receives an enhanced rate for such things as ventilator care or a private room.

Federal law allows a state Medicaid program to pay more than 95%. The Social Security Act (42 USC 1396a(13)(B)) specifies that the payment must be at least 95% of the facility's rate. Ohio Medicaid simply chose to set the rate as low as they could, despite the impact on hospices.

SC1048 would eliminate the gap in Medicaid payments for hospice patients who reside in SNFs or ICFs by changing the percentage to 100% of the facility's daily rate. As a result, the amendment would eliminate the loss hospices experience on each day of care in a facility, leaving them at a break-even point.

SC1020 is a lower-cost alternative that would make a start toward a solution by moving the percentage to 96% of the facility's daily rate. While not eliminating the loss hospices experience, the amendment at least would reduce it.

Supporting personal needs allowance increase

I'd like to conclude with the personal needs allowance (PNA) for Medicaid residents in Ohio's assisted living communities, SNFs, and ICFs. We strongly support the proposals in the executive and House budgets to increase the PNA. While we prefer the executive's $100-per-month level, we support the $75 allowance in the House-passed budget because it is more than the current $50 PNA. The PNA is all residents can keep out of their monthly income to spend on personal items (e.g., gifts or cards for grandchildren, clothing, special food or toiletry items, beauty or barber shop services). The allowance has not increased in many years. It is high time our seniors and people with disabilities have a little more freedom. We also urge this committee to make sure assisted living residents can receive the increased PNA without reducing assisted living room-and-board payments to providers.

Thank you for your attention to these important issues. I would be happy to answer any questions you may have. Please reach out via email (pvanrunkle@ohca.org) or phone (614-361-5169).

SC1020

Am. Sub. H. B. No. 96
As Passed by the House

_____ moved to amend as follows:

After line 111718, insert:

"Sec. 5164.16. (A) The medicaid program may cover one or more state plan home and community-based services that the department of medicaid selects for coverage. A medicaid recipient of any age may receive a state plan home and community-based service if the recipient has countable income not exceeding two hundred twenty-five per cent of the federal poverty line, has a medical need for the service, and meets all other eligibility requirements for the service specified in rules adopted under section 5164.02 of the Revised Code. The rules may not require a medicaid recipient to undergo a level of care determination to be eligible for a state plan home and community-based service.

(B) Effective not later than January 1, 2026, the director shall adopt rules specifying that a medicaid hospice provider shall be reimbursed for room and board for a hospice patient who is a resident of a nursing facility or an ICF/IID at an additional per diem amount equal to ninety-six per cent of the rate established for the facility for days when the patient receives routine home care or continuous home care."

In the table on line 134304, in row D, delete "$20,211,530,933 $21,720,893,421" and insert "$20,212,702,075 $21,723,235,704"

In the table on line 134304, in row E, delete "5,617,145,790 5,985,478,373" and insert "$5,617,555,690 $5,986,298,172"

In the table on line 134304, in row F, delete "14,594,385,143 15,735,415,048" and insert "$14,595,146,385 $15,736,937,532"

In the table on line 134304, in rows H and AD, add $1,171,142 to fiscal year 2026 and $2,342,283 to fiscal year 2027

Update the title, amend, enact, or repeal clauses accordingly

The motion was _____ agreed to.

SYNOPSIS

Hospice payments

R.C. 5164.16

Requires the ODM Director, not later than January 1, 2026, to adopt rules specifying that a Medicaid hospice provider will be reimbursed at an additional per diem amount of 96% of the facility's rate for room and board for a hospice patient who is a resident of a nursing facility or an ICF/IID for days when the patient receives routine home care or continuous home care.

Department of Medicaid

Section 333.10

Increases GRF ALI 651525, Medicaid Health Care Services, by $1,171,142 ($409,900 state share) in FY 2026 and $2,342,283

($819,799 state share) in FY 2027.

SC1021

Am. Sub. H. B. No. 96
As Passed by the House

_____ moved to amend as follows:

After line 20138, insert:

"Sec. 173.54. (A) The department of medicaid shall create the medicaid-funded component of the assisted living program. In creating the medicaid-funded component, the department of medicaid shall collaborate with the department of aging. As used in this section, "assisted living program" includes the medicaid-funded component of the waiver operated as part of the ICDS successor program defined in section 5167.01 of the Revised Code that offers the same services as the assisted living program created under this section.

(B) ~~Unless~~ All of the following apply to the medicaid-funded component of the assisted living program ~~is terminated under division (C) of this section, all of the following apply~~:

(1) The department of aging shall administer the medicaid-funded component through a contract entered into with the department of medicaid under section 5162.35 of the Revised Code.

(2) The contract shall include an estimate of the medicaid-funded component's costs.

(3) The medicaid-funded component shall be operated as a separate medicaid waiver component.

(4) The medicaid-funded component may not serve more individuals than is set by the United States secretary of health and human services in the assisted living waiver.

(5) To the extent authorized by rules authorized by section 5162.021 of the Revised Code, the director of aging may adopt rules under Chapter 119. of the Revised Code regarding the medicaid-funded component.

(C) In consultation with industry stakeholders, the director shall adopt rules under division (B)(5) of this section to establish a mechanism to review and update provider rates for the assisted living program that includes consideration of data on annual changes in the cost of providing assisted living services. The rules shall do all of the following:

(1) Specify a survey tool for collecting data on cost changes during the calendar year preceding the calendar year in which the survey is conducted. To the greatest extent practicable, the survey tool shall minimize the administrative burden on providers and the department by using a small number of defined cost categories that meet both of the following requirements:

(a) The categories are cost categories providers commonly track.

(b) The categories align with any federal requirements for reporting provider costs that apply to assisted living program services.

(2) Prescribe a methodology for the department to select a

representative sample of providers participating in the assisted living program to complete the survey and the time and manner for selected providers to complete the survey and submit it to the department.

(3) Provide a method for the department to analyze the data collected from the survey to determine the percentage change in costs during the calendar year covered by the survey.

(4) Require that, beginning January 1, 2028, the department shall consider the uniform cost increase percentage the department determines in accordance with division (C)(3) of this section for the calendar year covered by the survey in determining updates to rates for all assisted living program services during the calendar year when the rate updates take effect."

Update the title, amend, enact, or repeal clauses accordingly

The motion was _____ agreed to.

SYNOPSIS

Assisted living program - rate update mechanism

R.C. 173.54

Requires the ODM Director to adopt rules establishing a mechanism to review and update provider rates for services provided under the assisted living program.

SC1022

Am. Sub. H. B. No. 96
As Passed by the House

_____ moved to amend as follows:

After line 20112, insert:

"Sec. 173.52. (A) The department of medicaid shall create the medicaid-funded component of the PASSPORT program. In creating the medicaid-funded component, the department of medicaid shall collaborate with the department of aging. As used in this section, "PASSPORT program" includes the medicaid-funded component of the waiver operated as part of the ICDS successor program as defined in section 5167.01 of the Revised Code that offers the same services as the PASSPORT program created under this section.

(B) All of the following apply to the medicaid-funded component of the PASSPORT program:

(1) The department of aging shall administer the medicaid-funded component through a contract entered into with the department of medicaid under section 5162.35 of the Revised Code.

(2) The medicaid-funded component shall be operated as a separate medicaid waiver component.

(3) For an individual to be eligible for the medicaid-

funded component, the individual must be a medicaid recipient and meet the additional eligibility requirements applicable to the individual established in rules adopted under division (B)(4) of this section.

(4) To the extent authorized by rules authorized by section 5162.021 of the Revised Code, the director of aging shall adopt rules in accordance with Chapter 119. of the Revised Code to implement the medicaid-funded component.

(C) In consultation with industry stakeholders, the director shall adopt rules under division (B)(4) of this section to establish a mechanism to review and update provider rates for the PASSPORT program that includes consideration of data on annual changes in the cost of providing PASSPORT program services. The rules shall do all of the following:

(1) Specify a survey tool for collecting data on cost changes during the calendar year preceding the calendar year in which the survey is conducted. To the greatest extent practicable, the survey tool shall minimize the administrative burden on providers and the department by using a small number of defined cost categories that meet both of the following requirements:

(a) The categories are cost categories providers commonly track.

(b) The categories align with any federal requirements for reporting provider costs that apply to PASSPORT program services.

(2) Prescribe a methodology for the department to select a representative sample of providers participating in the PASSPORT program to complete the survey and the time and manner for

selected providers to complete the survey and submit it to the department.

(3) Provide a method for the department to analyze the data collected from the survey to determine the percentage change in costs during the calendar year covered by the survey.

(4) Require that, beginning January 1, 2028, the department consider the uniform cost increase percentage the department determines in accordance with division (C)(3) of this section for the calendar year covered by the survey in determining updates to rates for all PASSPORT program services during the calendar year when the rate updates take effect, including personal care and homemaker services."

After line 111718, insert:

"Sec. 5164.16. (A) The medicaid program may cover one or more state plan home and community-based services that the department of medicaid selects for coverage. A medicaid recipient of any age may receive a state plan home and community-based service if the recipient has countable income not exceeding two hundred twenty-five per cent of the federal poverty line, has a medical need for the service, and meets all other eligibility requirements for the service specified in rules adopted under section 5164.02 of the Revised Code. The rules may not require a medicaid recipient to undergo a level of care determination to be eligible for a state plan home and community-based service.

(B) In consultation with stakeholders, the medicaid director shall adopt rules under this division in accordance with section 5164.02 of the Revised Code to establish a mechanism to review and update provider rates for state plan

home health and private duty nursing services that includes consideration of data on annual changes in the cost of providing those services. The rules shall do all of the following:

(1) Specify a survey tool for collecting data on cost changes during the calendar year preceding the calendar year in which the survey is conducted. To the greatest extent practicable, the survey tool shall minimize administrative burden on providers and the department by using a small number of defined cost categories that providers commonly track.

(2) Prescribe a methodology for the department to select a representative sample of providers providing state plan home health and private duty nursing services to complete the survey and the time and manner for selected providers to complete the survey and submit it to the department.

(3) Provide a method for the department to analyze the data collected from the survey to determine the percentage change in costs during the calendar year covered by the survey.

(4) Require that, beginning January 1, 2028, the department shall consider the uniform cost increase percentage the department determines in accordance with division (B)(3) of this section for the calendar year covered by the survey in determining updates to rates for all state plan home health and private duty nursing services during the calendar year when the rate update takes effect, including services provided by nurses aides and therapists. The rate increases apply to payments made through both the fee-for-service component of the medicaid program and through the care management system."

After line 112341, insert:

"Sec. 5166.11. (A) ~~As used in this section, "Ohio home~~

~~care program" means the program the department of medicaid administers that provides state plan services and medicaid waiver component services pursuant to rules adopted for the medicaid program and a medicaid waiver that went into effect July 1, 1998.~~

~~(B)~~ The department of medicaid may create and administer ~~two~~ one or more medicaid waiver components under which home and community-based services are provided to eligible individuals who need the level of care provided by a nursing facility or hospital. These components may be known as the Ohio home care waiver and include the medicaid-funded component of the waiver operated as part of the ICDS successor program as defined in section 5167.01 of the Revised Code that offers the same services as the Ohio home care waiver created under this section. In administering the medicaid waiver components, the department may specify the following:

(1) The maximum number of individuals who may be enrolled in each of the medicaid waiver components;

(2) The maximum amount the medicaid program may expend each year for each individual enrolled in the medicaid waiver components;

(3) The maximum amount the medicaid program may expend each year for all individuals enrolled in the medicaid waiver components;

(4) Any other requirements the department selects for the medicaid waiver components.

~~(C)~~

~~(D) After the first of any of the medicaid waiver~~

~~components that the department administers under this section begins to enroll eligible individuals, the department may cease to enroll additional individuals in a medicaid waiver component of the Ohio home care program~~(B) In consultation with industry stakeholders, the medicaid director shall adopt rules under this division in accordance with section 5166.02 of the Revised Code to establish a mechanism to review and update provider rates for services provided under the Ohio home care waiver to reflect annual changes in the cost of providing those services. The rules shall do all of the following:

(1) Specify a survey tool for collecting data on cost changes during the calendar year preceding the calendar year in which the survey is conducted. To the greatest extent practicable, the survey tool shall minimize administrative burden on providers and the department by using a small number of defined cost categories that meet both of the following requirements:

(a) The categories are cost categories providers commonly track.

(b) The categories align with any federal requirements for reporting provider costs that apply to Ohio home care waiver services.

(2) Prescribe a methodology for the department to select a representative sample of providers participating in the Ohio home care waiver to complete the survey and the time and manner for selected providers to complete the survey and submit it to the department.

(3) Provide a method for the department to analyze the data collected from the survey to determine the percentage

change in costs during the calendar year covered by the survey.

(4) Require that, beginning January 1, 2028, the department consider the uniform cost increase percentage the department determines in accordance with division (B)(3) of this section for the calendar year covered by the survey in determining updates to rates for all Ohio home care waiver services during the calendar year when the rate update takes effect, including waiver nursing, personal care, and homemaker services. "

Update the title, amend, enact, or repeal clauses accordingly

The motion was _____ agreed to.

SYNOPSIS

Medicaid provider rates - update methodologies

R.C. 173.52, 5164.16, and 5166.11

Requires both the ODM Director and ODA Director to adopt rules establishing a mechanism to review and update provider rates for services provided under the following (1) the PASSPORT program, (2) the Ohio Home Care waiver, and (3) state plan home health and private duty nursing services.

SC1048

Am. Sub. H. B. No. 96
As Passed by the House

_____ moved to amend as follows:

After line 111718, insert:

"Sec. 5164.16. (A) The medicaid program may cover one or more state plan home and community-based services that the department of medicaid selects for coverage. A medicaid recipient of any age may receive a state plan home and community-based service if the recipient has countable income not exceeding two hundred twenty-five per cent of the federal poverty line, has a medical need for the service, and meets all other eligibility requirements for the service specified in rules adopted under section 5164.02 of the Revised Code. The rules may not require a medicaid recipient to undergo a level of care determination to be eligible for a state plan home and community-based service.

(B) Effective not later than January 1, 2026, the director shall adopt rules specifying that a medicaid hospice provider shall be reimbursed for room and board for a hospice patient who is a resident of a nursing facility or an ICF/IID at an additional per diem amount equal to one hundred per cent of the rate established for the facility for days when the patient receives routine home care or continuous home care."

In the table on line 134304, in row D, delete "$20,211,530,933 $21,720,893,421" and insert "$20,217,386,642 $21,732,604,840"

In the table on line 134304, in row E, delete "5,617,145,790 5,985,478,373" and insert "$5,619,195,288 $5,989,577,370"

In the table on line 134304, in row F, delete "14,594,385,143 15,735,415,048" and insert "$14,598,191,354 $15,743,027,470"

In the table on line 134304, in rows H and AD, add $5,855,709 to fiscal year 2026 and $11,711,419 to fiscal year 2027

Update the title, amend, enact, or repeal clauses accordingly

The motion was _____ agreed to.

SYNOPSIS

Hospice payments

R.C. 5164.16

Requires the ODM Director, not later than January 1, 2026, to adopt rules specifying that a Medicaid hospice provider will be reimbursed at an additional per diem amount of 100% of the facility's rate for room and board for a hospice patient who is a resident of a nursing facility or an ICF/IID for days when the patient receives routine home care or continuous home care.

Department of Medicaid

Section 333.10

Increases GRF ALI 651525, Medicaid Health Care Services, by $5,855,709 ($2,049,498 state share) in FY 2026 and

$11,711,419 ($4,098,997 state share) in FY 2027.

SC1050

Am. Sub. H. B. No. 96
As Passed by the House

_____ moved to amend as follows:

After line 20138, insert:

"Sec. 173.54. (A) The department of medicaid shall create the medicaid-funded component of the assisted living program. In creating the medicaid-funded component, the department of medicaid shall collaborate with the department of aging. As used in this section, "assisted living program" includes the medicaid-funded component of the waiver operated as part of the ICDS successor program defined in section 5167.01 of the Revised Code that offers the same services as the assisted living program created under this section.

(B) ~~Unless~~ All of the following apply to the medicaid-funded component of the assisted living program ~~is terminated under division (C) of this section, all of the following apply~~:

(1) The department of aging shall administer the medicaid-funded component through a contract entered into with the department of medicaid under section 5162.35 of the Revised Code.

(2) The contract shall include an estimate of the medicaid-funded component's costs.

(3) The medicaid-funded component shall be operated as a separate medicaid waiver component.

(4) The medicaid-funded component may not serve more individuals than is set by the United States secretary of health and human services in the assisted living waiver.

(5) To the extent authorized by rules authorized by section 5162.021 of the Revised Code, the director of aging may adopt rules under Chapter 119. of the Revised Code regarding the medicaid-funded component.

(C) In consultation with industry stakeholders, the director shall adopt rules under division (B)(5) of this section to establish a mechanism to review and update provider rates for the assisted living program that includes consideration of data on annual changes in the cost of providing assisted living services. The rules shall do all of the following:

(1) Specify a survey tool for collecting data on cost changes during the calendar year preceding the calendar year in which the survey is conducted. To the greatest extent practicable, the survey tool shall minimize the administrative burden on providers and the department by using a small number of defined cost categories that meet both of the following requirements:

(a) The categories are cost categories providers commonly track.

(b) The categories align with any federal requirements for reporting provider costs that apply to assisted living program services.

(2) Prescribe a methodology for the department to select a

representative sample of providers participating in the assisted living program to complete the survey and the time and manner for selected providers to complete the survey and submit it to the department.

(3) Provide a method for the department to analyze the data collected from the survey to determine the percentage change in costs during the calendar year covered by the survey.

(4) Require that, beginning January 1, 2028, the department shall consider the uniform cost increase percentage the department determines in accordance with division (C)(3) of this section for the calendar year covered by the survey in determining updates to rates for all assisted living program services during the calendar year when the rate updates take effect.

Sec. 173.549. (A) Beginning January 1, 2027, the department of medicaid shall make retainer payments to an assisted living program provider under this chapter to reserve an assisted living unit during a temporary absence under conditions prescribed by the department, including hospitalization for an acute condition, vacation, visits with relatives and friends, and participation in therapeutic programs outside the facility.

(B) The maximum period for which retainer payments may be made to reserve a unit under this section shall not exceed thirty days in a calendar year.

(C) The per medicaid day payment rate for a retainer payment under this section shall equal one hundred per cent of the daily rate for the unit under the assisted living program."

In the table on line 134304, in row D, delete "$21,720,893,421" and

insert "$21,727,834,598"

In the table on line 134304, in row E, delete "$5,985,478,373" and insert "$5,987,907,785"

In the table on line 134304, in row F, delete "$15,735,415,048" and insert "$15,739,926,813"

In the table on line 134304, in rows H and AD, add $6,941,177 to fiscal year 2027

After line 134639, insert:

"**Section 333.262.** LEGISLATIVE INTENT REGARDING ASSISTED LIVING PROVIDER RATES

It is the intent of the General Assembly that the Departments of Medicaid and Aging do all of the following:

(A) Utilize the necessary portions of the foregoing appropriation items 651425, Medicaid Program Support - State, 651525, Medicaid Health Care Services, and 651624, Medicaid Program Support - Federal, to increase direct care provider rates for the Medicaid assisted living program.

(B) Increase the rates described in division (A) of this section, beginning January 1, 2027, by 2% over the rates that are in effect on the day immediately preceding the day on which the rate increase takes effect.

(C) Apply the rate increases described in this section to payments made through both the fee-for-service component of the Medicaid program and through the care management system."

Update the title, amend, enact, or repeal clauses accordingly

The motion was _____ agreed to.

SYNOPSIS

Assisted living program - rate update mechanism

R.C. 173.54 and 173.549; Section 333.262

Requires the ODM Director to adopt rules establishing a mechanism to review and update provider rates for services provided under the assisted living program.

Declares that it is the intent of the General Assembly that the departments increase provider rates for services provided under program by 2% beginning January 1, 2027.

Beginning January 1, 2027, requires ODM to make retainer payments of 100% of the unit's daily rate to assisted living program providers to reserve an assisted living unit during a resident's absence from the assisted living facility.

Department of Medicaid

Section 333.10

Increases GRF ALI 651525, Medicaid Health Care Services, by $6,941,177 ($2,429,412 state share) in FY 2027.

SC1057

Am. Sub. H. B. No. 96
As Passed by the House

_____ moved to amend as follows:

After line 20112, insert:

"Sec. 173.52. (A) The department of medicaid shall create the medicaid-funded component of the PASSPORT program. In creating the medicaid-funded component, the department of medicaid shall collaborate with the department of aging. As used in this section, "PASSPORT program" includes the medicaid-funded component of the waiver operated as part of the ICDS successor program as defined in section 5167.01 of the Revised Code that offers the same services as the PASSPORT program created under this section.

(B) All of the following apply to the medicaid-funded component of the PASSPORT program:

(1) The department of aging shall administer the medicaid-funded component through a contract entered into with the department of medicaid under section 5162.35 of the Revised Code.

(2) The medicaid-funded component shall be operated as a separate medicaid waiver component.

(3) For an individual to be eligible for the medicaid-

funded component, the individual must be a medicaid recipient and meet the additional eligibility requirements applicable to the individual established in rules adopted under division (B)(4) of this section.

(4) To the extent authorized by rules authorized by section 5162.021 of the Revised Code, the director of aging shall adopt rules in accordance with Chapter 119. of the Revised Code to implement the medicaid-funded component.

(C) In consultation with industry stakeholders, the director shall adopt rules under division (B)(4) of this section to establish a mechanism to review and update provider rates for the PASSPORT program that includes consideration of data on annual changes in the cost of providing PASSPORT program services. The rules shall do all of the following:

(1) Specify a survey tool for collecting data on cost changes during the calendar year preceding the calendar year in which the survey is conducted. To the greatest extent practicable, the survey tool shall minimize the administrative burden on providers and the department by using a small number of defined cost categories that meet both of the following requirements:

(a) The categories are cost categories providers commonly track.

(b) The categories align with any federal requirements for reporting provider costs that apply to PASSPORT program services.

(2) Prescribe a methodology for the department to select a representative sample of providers participating in the PASSPORT program to complete the survey and the time and manner for

selected providers to complete the survey and submit it to the department.

(3) Provide a method for the department to analyze the data collected from the survey to determine the percentage change in costs during the calendar year covered by the survey.

(4) Require that, beginning January 1, 2028, the department consider the uniform cost increase percentage the department determines in accordance with division (C)(3) of this section for the calendar year covered by the survey in determining updates to rates for all PASSPORT program services during the calendar year when the rate updates take effect, including personal care and homemaker services."

After line 111718, insert:

"Sec. 5164.16. (A) The medicaid program may cover one or more state plan home and community-based services that the department of medicaid selects for coverage. A medicaid recipient of any age may receive a state plan home and community-based service if the recipient has countable income not exceeding two hundred twenty-five per cent of the federal poverty line, has a medical need for the service, and meets all other eligibility requirements for the service specified in rules adopted under section 5164.02 of the Revised Code. The rules may not require a medicaid recipient to undergo a level of care determination to be eligible for a state plan home and community-based service.

(B) In consultation with stakeholders, the medicaid director shall adopt rules under this division in accordance with section 5164.02 of the Revised Code to establish a mechanism to review and update provider rates for state plan

home health and private duty nursing services that includes consideration of data on annual changes in the cost of providing those services. The rules shall do all of the following:

(1) Specify a survey tool for collecting data on cost changes during the calendar year preceding the calendar year in which the survey is conducted. To the greatest extent practicable, the survey tool shall minimize administrative burden on providers and the department by using a small number of defined cost categories that providers commonly track.

(2) Prescribe a methodology for the department to select a representative sample of providers providing state plan home health and private duty nursing services to complete the survey and the time and manner for selected providers to complete the survey and submit it to the department.

(3) Provide a method for the department to analyze the data collected from the survey to determine the percentage change in costs during the calendar year covered by the survey.

(4) Require that, beginning January 1, 2028, the department consider the uniform cost increase percentage the department determines in accordance with division (B)(3) of this section for the calendar year covered by the survey in determining updates to rates for all state plan home health and private duty nursing services during the calendar year when the rate update takes effect, including services provided by nurses aides and therapists. The rate increases apply to payments made through both the fee-for-service component of the medicaid program and through the care management system."

After line 112341, insert:

"Sec. 5166.11. (A) ~~As used in this section, "Ohio home~~

~~care program" means the program the department of medicaid administers that provides state plan services and medicaid waiver component services pursuant to rules adopted for the medicaid program and a medicaid waiver that went into effect July 1, 1998.~~

~~(B)~~ The department of medicaid may create and administer ~~two~~ one or more medicaid waiver components under which home and community-based services are provided to eligible individuals who need the level of care provided by a nursing facility or hospital. These components may be known as the Ohio home care waiver and include the medicaid-funded component of the waiver operated as part of the ICDS successor program as defined in section 5167.01 of the Revised Code that offers the same services as the Ohio home care waiver created under this section. In administering the medicaid waiver components, the department may specify the following:

(1) The maximum number of individuals who may be enrolled in each of the medicaid waiver components;

(2) The maximum amount the medicaid program may expend each year for each individual enrolled in the medicaid waiver components;

(3) The maximum amount the medicaid program may expend each year for all individuals enrolled in the medicaid waiver components;

(4) Any other requirements the department selects for the medicaid waiver components.

~~(C)~~

~~(D) After the first of any of the medicaid waiver~~

~~components that the department administers under this section begins to enroll eligible individuals, the department may cease to enroll additional individuals in a medicaid waiver component of the Ohio home care program~~(B) In consultation with industry stakeholders, the medicaid director shall adopt rules under this division in accordance with section 5166.02 of the Revised Code to establish a mechanism to review and update provider rates for services provided under the Ohio home care waiver to reflect annual changes in the cost of providing those services. The rules shall do all of the following:

(1) Specify a survey tool for collecting data on cost changes during the calendar year preceding the calendar year in which the survey is conducted. To the greatest extent practicable, the survey tool shall minimize administrative burden on providers and the department by using a small number of defined cost categories that meet both of the following requirements:

(a) The categories are cost categories providers commonly track.

(b) The categories align with any federal requirements for reporting provider costs that apply to Ohio home care waiver services.

(2) Prescribe a methodology for the department to select a representative sample of providers participating in the Ohio home care waiver to complete the survey and the time and manner for selected providers to complete the survey and submit it to the department.

(3) Provide a method for the department to analyze the data collected from the survey to determine the percentage

change in costs during the calendar year covered by the survey.

(4) Require that, beginning January 1, 2028, the department consider the uniform cost increase percentage the department determines in accordance with division (B)(3) of this section for the calendar year covered by the survey in determining updates to rates for all Ohio home care waiver services during the calendar year when the rate update takes effect, including waiver nursing, personal care, and homemaker services. "

In the table on line 134304, in row D, delete "$21,720,893,421" and insert "$21,739,548,418"

In the table on line 134304, in row E, delete "$5,985,478,373" and insert "$5,992,194,172"

In the table on line 134304, in row F, delete "$15,735,415,048" and insert "$15,747,354,246"

In the table on line 134304, in rows H and AD, add $18,654,997 to fiscal year 2027

After line 134639, insert:

"**Section 333.262.** LEGISLATIVE INTENT REGARDING HOME CARE PROVIDER RATES

It is the intent of the General Assembly that the Departments of Medicaid and Aging do all of the following:

(A) Utilize the necessary portions of the foregoing appropriation items 651425, Medicaid Program Support - State, 651525, Medicaid Health Care Services, and 651624, Medicaid Program Support - Federal, to increase direct care provider rates for Medicaid home and community-based services offered

under the following programs:

(1) The PASSPORT program, including personal care and homemaker services;

(2) The Ohio Home Care waiver, including waiver nursing, personal care, and homemaker services;

(3) State plan home health and private duty nursing services, including services performed by a nurse, an aide, or a therapist.

(B) Increase the rates described in division (A) of this section, beginning January 1, 2027, by 2% over the rates that are in effect on the day immediately preceding the day on which the rate increase takes effect.

(C) Apply the rate increases described in this section to payments made through both the fee-for-service component of the Medicaid program and through the care management system."

Update the title, amend, enact, or repeal clauses accordingly

The motion was _____ agreed to.

SYNOPSIS

Medicaid provider rates - update methodologies

R.C. 173.52, 5164.16, and 5166.11; Section 333.262

Requires both the ODM Director and ODA Director to adopt rules establishing a mechanism to review and update provider rates for services provided under the following (1) the PASSPORT program, (2) the Ohio Home Care waiver, and (3) state plan home

health and private duty nursing services.

Declares that it is the intent of the General Assembly that the departments increase provider rates for services provided under programs described above by 2% beginning January 1, 2027.

Department of Medicaid

Section 333.10

Increases GRF ALI 651525, Medicaid Health Care Services, by $18,654,997 ($6,715,799 state share) in FY 2027.