Ohio Legislative Service Commission

Bill Analysis

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Sub. H.B. 89*

131st General Assembly
(As Reported by H. Health & Aging)

Reps. DeVitis, Ginter, Grossman, Rezabek, Boose, McColley, Brenner, Romanchuk, Sprague, Hagan, Duffey, Gonzales, Butler, Cera, Patterson, Sykes

BILL SUMMARY

- Provides for the Ohio Department of Education (ODE) to receive at least 2.5% of the federal matching funds the state receives for the Medicaid School Program (MSP).
- Requires the Ohio Department of Medicaid (ODM) and ODE to jointly prepare procedural guidelines for, and other informational materials about, the MSP that give school providers clear instructions for participating in the MSP.
- Requires each MSP school provider to submit to ODE an annual report containing certain information about the provider's students.
- Requires ODE to use an MSP school provider's report to determine the provider's individualized education program rate and Medicaid eligible rate.
- Eliminates a requirement that an MSP service be provided in a school.
- Specifies conditions under which an MSP claim is to be rejected.
- Requires each MSP school provider to submit to ODM annually all claims data ODM needs for the provider's MSP claims.
- Permits ODM to make to MSP school providers interim payments of the federal funds ODM receives for MSP claims.
- Requires each MSP school provider to submit to ODM annually a cost report documenting the provider's actual costs incurred in providing MSP services to Medicaid recipients.

* This analysis was prepared before the report of the House Health and Aging Committee appeared in the House Journal. Note that the list of co-sponsors and the legislative history may be incomplete.

- Requires ODM to reconcile interim payments made to an MSP school provider for a fiscal year with the provider's cost report for that fiscal year.
- Requires that the MSP cover delegated nursing services provided by an unlicensed adult employed by or under contract with an MSP school provider.
- Requires the MSP to cover personal care services under certain circumstances.

CONTENT AND OPERATION

Medicaid School Program

The bill revises the law governing the Medicaid School Program (MSP), which permits participating qualified school providers to submit claims to the Ohio Department of Medicaid (ODM) for federal matching funds for providing services covered by the MSP to Medicaid recipients eligible for the services. Continuing law permits the board of education of a city, local, or exempted village school district, the governing authority of a community school, the State School for the Deaf, and the State School for the Blind to participate in the MSP as a qualified school provider by obtaining a Medicaid provider agreement and meeting all other conditions for participation in the MSP established in rules. Except as otherwise provided by state statutes and rules governing the MSP, a qualified school provider is subject to all conditions of participation in Medicaid that generally apply to Medicaid providers, including conditions regarding audits and recovery of overpayments.

Administration of the MSP

The Ohio Department of Education (ODE) is required to administer aspects of the MSP pursuant to an interagency agreement with ODM. The bill requires that the interagency agreement include a provision that provides for ODE to receive at least 2.5% of the federal matching funds the state receives for the MSP.[1]

Instructions for participation

ODM and ODE are required by the bill to jointly prepare procedural guidelines for, and other informational materials about, the MSP that give qualified school providers clear instructions for participating in the MSP. ODM and ODE must annually update the guidelines.[2]

[1] R.C. 5162.361.

[2] R.C. 5162.366.

Annual provider reports about students

The bill requires each qualified school provider to submit to ODE a report about students not later than the last day of each fiscal year. The report must include, for the most recent previous October, (1) the total number of the provider's students for whom an individualized education program was developed, (2) the total number of those students who were Medicaid recipients, (3) the total number of all of the provider's students who were Medicaid recipients, and (4) the total number of the provider's students. Not later than the last day of each calendar year, ODE is required to (1) review each qualified school provider's report and make any corrections needed to ensure its accuracy, (2) using the information reported on a provider's report (including any corrections ODE makes to it), determine the provider's individualized education program rate and Medicaid eligible rate, and (3) notify each provider of the provider's individualized education program rate and Medicaid eligible rate.[3]

Provider claims

Under current law, a qualified school provider must have provided a service in a school to be able to submit an MSP claim to ODM for federal matching funds. The bill eliminates this requirement.[4]

The bill requires that a qualified school provider's claim for a service be rejected if either of the following apply:

(1) Unless the service is an initial assessment or evaluation performed in the development of a Medicaid recipient's individualized education program (IEP), the service is not included in the recipient's IEP.

(2) Another reason for rejection specified in rules governing the MSP applies to the claim.[5]

Claims data submissions

Each qualified school provider is required by the bill to submit to ODM, not later than the last day of each calendar year, all claims data ODM needs for the claims the provider submitted for the fiscal year that ended during that calendar year.[6]

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[3] R.C. 5162.365(A) and (B)(1) to (3).

[4] R.C. 5162.362.

[5] R.C. 5162.363 (primary) and 5162.01(B)(9).

[6] R.C. 5162.365(C).

Paying claims

Continuing law requires ODM to seek federal funds for each claim a qualified school provider properly submits to ODM. The bill permits ODM to make interim payments of the funds it receives from the federal government for such claims.[7]

Not later than 18 months after the end of each fiscal year, each provider must submit to ODM a cost report documenting the provider's actual costs incurred in providing, during that fiscal year, services covered by the MSP to Medicaid recipients who are eligible for the services. ODE is required to (1) issue a request for proposals for an entity, pursuant to a contract with ODE, to create a computer software program that provides a template for providers to use when submitting the cost reports and (2) make the template available to each provider not later than the last day of each calendar year. A certified public accountant must conduct an agreed-upon procedures review of the cost report before the provider may submit the report to ODM.[8]

ODM is required to reconcile interim payments made to a qualified school provider for a fiscal year with the provider's cost report for that fiscal year. ODM must complete the reconciliation in time for the following to occur within two years after the last day of the fiscal year:

(1) If the provider is owed money under the reconciliation, ODM paying the provider the amount owed to the provider.

(2) If the provider owes money under the reconciliation, the provider paying ODM the amount owed to ODM.[9]

Services covered by the MSP

The services that the MSP covers are currently specified in rules rather than statute. The bill expressly requires the MSP to cover certain nursing services and personal care services. The Medicaid Director continues to be authorized to adopt rules specifying other services the MSP is to cover.[10]

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[7] R.C. 5162.364.

[8] R.C. 5162.365(B)(4) and (D) and 5162.366.

[9] R.C. 5162.365(E).

[10] R.C. 5162.368, 5162.369, and 5162.3610(B).

Nursing services

An ODM rule provides for the MSP to cover nursing services provided by registered nurses and licensed practical nurses.[11] The bill codifies that rule and requires that the MSP also cover nursing services provided by a school health aide or any other individual who is not licensed, certified, or otherwise authorized by a board or other agency of the state to provide a health care service, but only if (1) the individual is at least 18 years of age, (2) a registered nurse or licensed practical nurse has delegated the nursing services to the individual in accordance with the Board of Nursing's rules, and (3) the individual and the registered nurse or licensed practical nurse who delegated the nursing services to the individual are employed by or under contract with the qualified school provider that submits the claim to ODM for federal funds for providing the nursing services.[12] An ODM rule currently excludes services provided by a nonlicensed person from coverage under the MSP.[13]

Personal care services

ODM's rules do not provide for the MSP to cover personal care services. The bill requires the MSP to cover personal care services when both of the following requirements are met:

(1) The services (a) are provided to a Medicaid recipient who is eligible for the MSP, needs the services because the recipient either cannot perform one or more activities of daily living or instrumental activities of daily living or has a limitation in performing one or more such activities due to a functional, cognitive, or behavioral impairment and (b) help the recipient benefit from special education and related services.

(2) The services are provided by an individual who (a) is at least 18 years of age, (b) is trained to provide the services to the Medicaid recipient who receives the services, and (c) provides the services under the direct supervision of a health care professional who is licensed, certified, or otherwise authorized by a board or other agency of the state to provide a health care service and is employed by or under contract with the qualified school provider that submits the claim to ODM for the services.[14]

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[11] Ohio Administrative Code (O.A.C.) 5160-35-05(B)(5).

[12] R.C. 5162.368.

[13] O.A.C. 5160-35-05(C)(15).

[14] R.C. 5162.369.

The bill provides that "personal care services" has the same meaning as in a federal Medicaid regulation.[15] The federal regulation defines the term as services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental disease that are (1) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the state) otherwise authorized for the individual in accordance with a service plan approved by the state, (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (3) furnished in a home, and at the state's option, in another location.[16]

HISTORY

ACTION	DATE
Introduced	02-25-15
Reported, H. Health & Aging	---

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[15] R.C. 5162.01(B)(14).

[16] 42 Code of Federal Regulations 440.167.