**Aging/Medicaid HCBS Amendment**

In line 27 of the title, after “173.391,” insert “173.52,”

In line 28 of the title, after “173.525,” insert “173.54,”

In line 189, of the title, after “5163.30,” insert “5164.16,”; after “5165.26,” insert “5166.11”

In line 264 of the title, after “169.081,” insert “173.549,”

In line 331, after “173.391,” insert “173.52,”; after “173.525,” insert “173.54,”

In line 451, after “5163.30,” insert “5164.16,”; after “5165.26,” insert “5166.11,”

In line 505, after “169.081,” Insert “173.549,”

Between lines 15906 and 15907, 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 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 stakeholders, the director of aging shall adopt rules under division (B)(4) of this section that establish a mechanism to update provider rates for the PASSPORT program to reflect 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 that precedes the calendar year in which the rate update takes effect. 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 criteria:

(a) They are categories of costs providers commonly track;

(b) They 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 manner and time for the selected providers to complete and submit the survey to the department.

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

(4) Specify that beginning January 1, 2028, the uniform cost increase percentage the department determines under division (C)(3) of this section for the calendar year covered by the survey will apply to rates for PASSPORT program services during the calendar year when the rate update takes effect, including at minimum personal care and homemaker services.”

Between lines 15932 and 15933, 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 and in section 173.549 of the Revised Code, “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 stakeholders, the director of aging shall adopt rules under division (B)(5) of this section that establish a mechanism to update provider rates for the assisted living program to reflect 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 that precedes the calendar year in which the rate update takes effect. 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 criteria:

(a) They are categories of costs providers commonly track;

(b) They 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 manner and time for the selected providers to complete and submit the survey to the department.

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

(4) Specify that beginning January 1, 2028, the uniform cost increase percentage the department determines under division (C)(3) of this section for the calendar year covered by the survey will apply to all rates for assisted living program services during the calendar year when the rate update takes effect.

**Sec. 173.549.** (A) The department of medicaid shall make retainer payments to an assisted living program provider under this chapter to reserve an assisted living unit for a resident during a temporary absence under conditions prescribed by the department, to include 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 be one hundred per cent of the daily rate for the unit under the assisted living program.”

Between lines 87906 and 87907, 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 director of medicaid shall adopt rules under section 5164.02 of the Revised Code that establish a mechanism to update provider rates for state plan home health and private duty nursing services 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 that precedes the calendar year in which the rate update takes effect. 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 participating in the state plan home health or private duty nursing program to complete the survey and the manner and time for the selected providers to complete and submit the survey to the department.

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

(4) Specify that beginning January 1, 2028, the uniform cost increase percentage the department determines under division (B)(3) of this section for the calendar year covered by the survey will apply to rates for state plan home health and private duty nursing services during the calendar year when the rate update takes effect, including at minimum services provided by nurses, aides, and therapists. The rate increases shall apply to payments through both the fee-for-service medicaid program and a managed care arrangement.

(C) Effective no later than January 1, 2026, the director of medicaid 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 intermediate care facility for individuals with intellectual disabilities at an additional per diem amount equal to one hundred per cent of the rate established for the long-term care facility for days when the patient receives routine home care or continuous home care. As used in this section, "nursing facility" has the same meaning as in section 5165.01 of the Revised Code and "intermediate care facility for individuals with intellectual disabilities" has the same meaning as in section 5124.01 of the Revised Code.”

Between lines 88353 and 88354, 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 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.

(B) In consultation with stakeholders, the director of medicaid shall adopt rules under section 5166.02 of the Revised Code that establish a mechanism to update provider rates for the Ohio home care waiver to reflect annual changes in the cost of providing Ohio home care waiver 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 that precedes the calendar year in which the rate update takes effect. 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 criteria:

(a) They are categories of costs providers commonly track;

(b) They 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 manner and time for the selected providers to complete and submit the survey to the department.

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

(4) Specify that beginning January 1, 2028, the uniform cost increase percentage the department determines under division (B)(3) of this section for the calendar year covered by the survey will apply to rates for Ohio home care waiver services during the calendar year when the rate update takes effect, including at minimum waiver nursing, personal care, and homemaker services.

~~(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.~~”

In line 102431, after “173.391,” insert “173.52,”; after “173.525,” insert “173.54,”

In line 102555, after “5163.30,” insert “5164.16,”; after “5165.26,” insert “5166.11,”

In section 333.10:

In line C, increase column 5 by $300,000

In line D, increase column 4 by $53,100,000 and increase column 5 by $39,500,000

In line E, increase column 4 by $18,600,000 and increase column 5 by $13,800,000

In line F, increase column 4 by $34,500,000 and increase column 5 by $25,700,000

In line H, increase column 4 by $53,100,000 and increase column 5 by $39,800,000

In line AA, increase column 5 by $300,000

In line AD, increase column 5 by $300,000

In line AE, increase column 4 by $53,100,000 and increase column 5 by $40,100,000

Between lines 107853 and 107854, insert:

“**Section 333.310.** LEGISLATIVE INTENT REGARDING HOME AND COMMUNITY-BASED SERVICES 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 portion of the foregoing appropriation items, as determined by the departments, to increase provider rates for the following Medicaid home and community-based services by the percentages specified in division (B) of this section:

(1) The assisted living program;

(2) The PASSPORT program, including at minimum personal care and homemaker services;

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

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

(B) Apply the following percentages for all rate increases provided under division (A) of this section:

(1) For rates beginning January 1, 2026, 3.4 per cent.

(2) For rates beginning January 1, 2027, 2.3 per cent.

(C) Apply the rate increases for payments through both the fee-for-service Medicaid program and a managed care arrangement for dates of service beginning on the dates specified in division (B) of this section.”