As Introduced

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Cosponsors: Representatives Luckie, Hagan, Mallory, Harris, Pryor, Foley

A B I L L

To amend sections 5111.019 and 5111.16 and to enact sections 5111.83, 5111.831, 5111.832, 5112.22, 5112.23, 5112.24, 5112.25, 5112.26, and 5112.27 of the Revised Code to require the Director of Job and Family Services to seek federal permission to establish the Family Health Plus component of the Medicaid program, to impose a new assessment on hospitals, and to earmark the proceeds from the new assessment for the Family Health Plus component.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 5111.019 and 5111.16 be amended and sections 5111.83, 5111.831, 5111.832, 5112.22, 5112.23, 5112.24, 5112.25, 5112.26, and 5112.27 of the Revised Code be enacted to read as follows:

Sec. 5111.019. (A) The director of job and family services shall submit to the United States secretary of health and human services an amendment to the state medicaid plan to make an individual eligible for medicaid who meets all of the following requirements:

~~(A)~~(1) The individual is the parent of a child under nineteen years of age and resides with the child;

~~(B)~~(2) The individual's family income does not exceed ninety per cent of the federal poverty guidelines;

~~(C)~~(3) The individual is not otherwise eligible for medicaid;

~~(D)~~(4) The individual satisfies all relevant requirements established by rules adopted under division (D) of section 5111.01 of the Revised Code.

(B) The director shall terminate this component of the medicaid program on the date that all individuals who would qualify for the medicaid program under the component can instead qualify for the medicaid program by participating in the family health plus component established under section 5111.83 of the Revised Code.

Sec. 5111.16. (A) As part of the medicaid program, the department of job and family services shall establish a care management system. The department shall submit, if necessary, applications to the United States department of health and human services for waivers of federal medicaid requirements that would otherwise be violated in the implementation of the system.

(B) The department shall implement the care management system in some or all counties and shall designate the medicaid recipients who are required or permitted to participate in the system. In the department's implementation of the system and designation of participants, all of the following apply:

(1) In the case of individuals who receive medicaid on the basis of being included in the category identified by the department as covered families and children or on the basis of participation in the family health plus component established under section 5111.83 of the Revised Code, the department shall

implement the care management system in all counties. All individuals included in the category or participating in the component shall be designated for participation in the care management system, except for ~~indivduals~~ individuals included in one or more of the medicaid recipient groups specified in 42 C.F.R. 438.50(d). ~~The department shall designate the participants not later than January 1, 2006. Beginning not later than December 31, 2006, the~~ The department shall ensure that all such participants of the care management system are enrolled in health insuring corporations under contract with the department pursuant to section 5111.17 of the Revised Code.

(2) In the case of individuals who receive medicaid on the basis of being aged, blind, or disabled, as specified in division (A)(2) of section 5111.01 of the Revised Code, the department shall implement the care management system in all counties. All individuals included in the category shall be designated for participation, except for the individuals specified in divisions (B)(2)(a) to (e) of this section. Beginning not later than December 31, 2006, the department shall ensure that all participants are enrolled in health insuring corporations under contract with the department pursuant to section 5111.17 of the Revised Code.

In designating participants who receive medicaid on the basis of being aged, blind, or disabled, the department shall not include any of the following:

(a) Individuals who are under twenty-one years of age;

(b) Individuals who are institutionalized;

(c) Individuals who become eligible for medicaid by spending down their income or resources to a level that meets the medicaid program's financial eligibility requirements;

(d) Individuals who are dually eligible under the medicaid

program and the medicare program established under Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended;

(e) Individuals to the extent that they are receiving medicaid services through a medicaid waiver component, as defined in section 5111.85 of the Revised Code.

(3) Alcohol, drug addiction, and mental health services covered by medicaid shall not be included in any component of the care management system when the nonfederal share of the cost of those services is provided by a board of alcohol, drug ~~adiction~~ addiction, and mental health services or a state agency other than the department of job and family services, but the recipients of those services may otherwise be designated for participation in the system.

(C) Subject to division (B) of this section, the department may do both of the following under the care management system:

(1) Require or permit participants in the system to obtain health care services from providers designated by the department;

(2) Require or permit participants in the system to obtain health care services through managed care organizations under contract with the department pursuant to section 5111.17 of the Revised Code.

(D)(1) The department shall prepare an annual report on the care management system. The report shall address the department's ability to implement the system, including all of the following components:

(a) The required designation of participants included in the category identified by the department as covered families and children;

(b) The required designation of participants included in the

aged, blind, or disabled category of medicaid recipients;

(c) ~~The conduct of the pilot program for chronically ill children established under section 5111.163 of the Revised Code;~~

~~(d)~~ The use of any programs for enhanced care management.

(2) The department shall submit each annual report to the general assembly. The first report shall be submitted not later than October 1, 2007.

(E) The director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section.

Sec. 5111.83. The director of job and family services shall submit a request to the United States secretary of health and human services for a federal medicaid waiver that authorizes the family health plus component of the medicaid program. The director shall implement the family health plus component if the United States secretary issues a federal medicaid waiver authorizing the component. In implementing the family health plus component, the director shall do all of the following:

(A) Provide for an individual to qualify to participate in the family health plus component if the individual meets all of the following requirements:

(1) The individual resides in this state.

(2) The individual is at least eighteen years of age but less than sixty-five years of age.

(3) The individual is ineligible for all other components of the medicaid program solely due to having income or resources exceeding the other components' eligibility requirements.

(4) The individual does not have equivalent health care coverage under insurance or equivalent mechanisms as determined in

accordance with rules adopted under section 5111.85 of the Revised Code.

(5) The individual is not a federal, state, county, municipal corporation, or school district employee who is eligible for health care coverage through the individual's employer.

(6) Subject to division (B) of this section, the individual was not covered by a group health plan offered by the employer of the individual or a family member of the individual during the nine-month period preceding the date the individual applies to participate in the family health plus component unless the individual lost coverage under the group health plan due to any of the following circumstances:

(a) Except as otherwise provided by division (A)(6) of this section, the individual or family member ceased to work for the employer for any reason other than voluntary separation.

(b) The individual or family member ceased to work for the employer to care for a child or disabled household member or relative.

(c) The family member's death;

(d) The individual or family member moved to a new residence.

(e) The individual or family member obtained new employment with a different employer and the new employer does not offer comprehensive health benefits coverage as defined in rules adopted under section 5111.85 of the Revised Code.

(f) The employer of the individual or family member terminated comprehensive health benefits coverage for all the employer's employees.

(g) The individual's eligibility for continuation of coverage under Title X of the "Consolidated Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 U.S.C. 1161, as amended, expired.

(h) The individual's or family member's wages were reduced or the cost of coverage under the group health plan increased making the coverage no longer affordable or available.

(i) The individual's or family member's long-term disability.

(7) The individual has gross family income not exceeding two hundred per cent of the federal poverty guidelines.

(8) The individual meets all other eligibility requirements for the family health plus component established in rules adopted under section 5111.85 of the Revised Code, including the resource eligibility requirement.

(B) Provide that no individual shall be denied eligibility to participate in the family health plus component on the basis of division (A)(6) of this section unless the director determines that medical assistance provided under the component is substituting for coverage under group health plans in excess of a percentage specified by the United States secretary of health and human services.

(C) Permit an individual who ceases to meet the eligibility requirements for the family health plus component not later than six months after initially beginning to participate in the component to continue to participate in the component until the date that is six months after the date the individual initially began to participate in the component.

(D) Provide for the family health plus component to cover all of the following in an amount, duration, and scope specified in rules adopted under section 5111.85 of the Revised Code:

(1) Inpatient and outpatient physician services;

(2) Inpatient and outpatient nursing services;

(3) Inpatient and outpatient services of other health-care professionals specified in the rules;

(4) Inpatient hospital services;

(5) Hospital emergency department services;

(6) Prehospital emergency medical services by ambulance service providers;

(7) Laboratory tests;

(8) Diagnostic x-rays;

(9) Prescription drugs;

(10) Nonprescription smoking cessation products and devices;

(11) Durable medical equipment;

(12) Radiation therapy;

(13) Chemotherapy;

(14) Hemodialysis;

(15) Diabetic supplies and equipment;

(16) Inpatient and outpatient mental health, alcohol, and substance abuse services;

(17) Emergency, preventive, and routine dental care to the extent offered by a health insuring corporation under contract with the department pursuant to section 5111.17 of the Revised Code to provide, or arrange the provision of, health care services to participants of the family health plus component who are enrolled in the health insuring corporation, but excluding orthodontia and cosmetic surgery;

(18) Emergency vision care;

(19) Preventive and routine vision care as limited to the following in a twenty-four month period:

(a) One eye examination;

(b) Either of the following:

(i) One pair of prescription eyeglass lenses and a frame;

(ii) When medically necessary, prescription contact lenses.

(c) One pair of medically necessary occupational eyeglasses.

(20) Speech and hearing services;

(21) Hospice services;

(22) Services as necessary to comply with 42 U.S.C. 1396d(a)(4)(B) and (r).

(E) Establish locally tailored outreach strategies targeted to individuals who may qualify to participate in the family health plus component, including outreach strategies that inform the public about the family health plus component.

(F) Adopt rules under section 5111.85 of the Revised Code that do all of the following:

(1) For the purpose of division (A)(4) of this section, establish the process for determining whether an individual has equivalent health care coverage under insurance or equivalent mechanisms;

(2) Define "comprehensive health benefits coverage" for the purpose of division (A)(6)(e) and (f) of this section;

(3) For the purpose of division (A)(9) of this section, establish additional eligibility requirements for the family health plus component, including a resource requirement.

Sec. 5111.831. There is hereby created in the state treasury the family health plus fund. The fund shall consist of money deposited into the fund pursuant to section 5112.25 of the Revised Code. The department of job and family services shall use money in the fund to pay the state share of the costs of the family health plus component of the medicaid program established under section 5111.83 of the Revised Code.

Sec. 5111.832. Each year, the director of job and family services shall determine the total amount of money needed to pay the state's share of the cost of the family health plus component.

Sec. 5112.22. (A) As used in sections 5112.22 to 5112.27 of the Revised Code:

(1)(a) "Hospital" means a nonfederal hospital to which either of the following applies:

(i) The hospital is registered under section 3701.07 of the Revised Code as a general medical and surgical hospital or a pediatric general hospital and provides inpatient hospital services as defined in 42 C.F.R. 440.10.

(ii) The hospital is recognized under the medicare program established by Title XVIII of the "Social Security Act of 1935" as a cancer hospital and is exempt from the medicare prospective payment system.

(b) "Hospital" does not include a hospital operated by a health insuring corporation that has been issued a certificate of authority under section 1751.05 of the Revised Code or a hospital that does not charge patients for services.

(2) "Program year" means a period of time specified in rules adopted under section 5112.26 of the Revised Code.

(B) For the purpose of funding the family health plus component of the medicaid program established under section 5111.83 of the Revised Code and subject to section 5112.27 of the Revised Code, there is hereby imposed an assessment on all hospitals. Each hospital's assessment under this section shall be determined in accordance with rules adopted under section 5112.26 of the Revised Code. In assessing hospitals under this section, the department of job and family services shall do both of the following:

(1) Comply with 42 U.S.C. 1396b(w) and federal regulations adopted thereunder;

(2) Set the amount of each hospital's assessment at an amount that yields, when the total of all hospital assessments under this section is combined, a sufficient amount of funds to pay the state share of the costs of the family health plus component as determined under section 5111.832 of the Revised Code.

Sec. 5112.23. (A) Except as provided in division (B) of this section, each hospital shall pay the assessment imposed under section 5112.22 of the Revised Code in periodic installments in accordance with a schedule established in rules adopted under section 5112.26 of the Revised Code. The installments shall be equal in amount, unless the director of job and family services determines that adjustments in the amounts of installments are necessary for the administration of sections 5112.22 to 5112.27 of the Revised Code and that unequal installments will not create cash flow difficulties for hospitals.

(B) The director may adopt rules under section 5112.26 of the Revised Code establishing alternate schedules for hospitals to pay assessments imposed under section 5112.22 of the Revised Code in order to reduce hospitals' cash flow difficulties.

Sec. 5112.24. (A) Before or during each program year, the department of job and family services shall mail to each hospital by certified mail, return receipt requested, the preliminary determination of the amount that the hospital is assessed under section 5112.22 of the Revised Code during the program year. The preliminary determination of a hospital's assessment shall be calculated for a cost reporting period that is specified in rules adopted under section 5112.26 of the Revised Code.

The department shall consult with hospitals each year when

determining the date on which it will mail the preliminary determinations in order to minimize hospitals' cash flow difficulties.

If no hospital submits a request for reconsideration under division (B) of this section, the preliminary determination constitutes the final reconciliation of each hospital's assessment under section 5112.22 of the Revised Code.

(B) Not later than fourteen days after the preliminary determinations are mailed, any hospital may submit to the department a written request to reconsider the preliminary determinations. The request shall be accompanied by written materials setting forth the basis for the reconsideration. If one or more hospitals submit a request, the department shall hold a public hearing not later than thirty days after the preliminary determinations are mailed to reconsider the preliminary determinations. The department shall mail to each hospital a written notice of the date, time, and place of the hearing at least ten days prior to the hearing. On the basis of the evidence submitted to the department or presented at the public hearing, the department shall reconsider and may adjust the preliminary determinations. The result of the reconsideration is the final reconciliation of the hospital's assessment under section 5112.22 of the Revised Code.

(C) The department shall mail to each hospital a written notice of its assessment for the program year under the final reconciliation. A hospital may appeal the final reconciliation of its assessment to the court of common pleas of Franklin county. While a judicial appeal is pending, the hospital shall pay, in accordance with the schedules required by section 5112.23 of the Revised Code, any amount of its assessment that is not in dispute.

Sec. 5112.25. All payments of assessments imposed on

hospitals by section 5112.22 of the Revised Code shall be deposited into the family health plus fund created by section 5111.831 of the Revised Code.

Sec. 5112.26. The director of job and family services shall adopt, and may amend and rescind, rules in accordance with Chapter 119. of the Revised Code as necessary to implement sections 5112.22 to 5112.27 of the Revised Code, including rules that do the following:

(A) Specify the period of time that a program year shall be for the purpose of the assessment imposed by section 5112.22 of the Revised Code;

(B) For the purpose of section 5112.22 of the Revised Code, establish the method of determining the amount of the assessment;

(C) For the purpose of section 5112.23 of the Revised Code, establish schedules for hospitals to pay installments on their assessments;

(D) For the purpose of section 5112.24 of the Revised Code, specify the cost reporting period for calculating hospitals' assessments.

Sec. 5112.27. The department of job and family services shall cease implementation of sections 5112.22 to 5112.27 of the Revised Code if the United States secretary of health and human services determines that the assessment imposed on hospitals by section 5112.22 of the Revised Code is an impermissible health care-related tax under 42 U.S.C. 1396b(w).

Section 2. That existing sections 5111.019 and 5111.16 of the Revised Code are hereby repealed.