**As Introduced**

**130th General Assembly**
**Regular Session** **H. B. No. 125**
**2013-2014**

**Representatives Carney, Antonio**

**Cosponsors: Representatives Lundy, Ramos, Driehaus, Foley, Clyde, Hagan, R., Ashford, Sykes, Phillips, Celebrezze, Boyce, Williams, Reece, Budish, Redfern, Stinziano, Curtin, Fedor, Heard, Rogers, Letson, Mallory, Patterson, Barborak, Bishoff, Boyd, Cera, Gerberry, Milkovich, O'Brien, Pillich, Slesnick, Strahorn, Szollosi**

# A B I L L

To enact sections 5111.0126, 5111.0127, and 5111.0128 of the Revised Code to permit the Medicaid program to cover the eligibility expansion group authorized by the Patient Protection and Affordable Care Act and to make an appropriation.

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

**Section 1.** That sections 5111.0126, 5111.0127, and 5111.0128 of the Revised Code be enacted to read as follows:

**Sec. 5111.0126.** Subject to section 5111.0127 of the Revised Code, the medicaid program may cover the group, or one or more subgroups of the group, described in the "Social Security Act," section 1902(a)(10)(A)(i)(VIII), 42 U.S.C. 1396a(a)(10)(A)(i)(VIII), if the federal medical assistance percentage for expenditures for medicaid services provided to the group or subgroup is at least the amount specified in the "Social Security Act," section 1905(y), 42 U.S.C. 1396d(y), as of March

30, 2010.

**Sec. 5111.0127.** (A) The medicaid program shall cease to cover the group, and any subgroup of the group, specified in section 5111.0126 of the Revised Code if the federal medical assistance percentage for expenditures for medicaid services provided to the group or subgroup is lowered to an amount below the amount specified in the "Social Security Act," section 1905(y), 42 U.S.C. 1396d(y), as of March 30, 2010. If the medicaid program ceases to cover the group, or any subgroup of the group pursuant to this division, each individual enrolled in medicaid as part of the group or subgroup shall be disenrolled from medicaid on the first day of the month following the effective date of the federal medical assistance percentage's reduction unless the individual meets the eligibility requirements for another eligibility group or subgroup.

(B)(1) If federal law or the United States department of health and human services requires the state to reduce or eliminate any tax, the medical assistance director may do either of the following regarding the eligibility group, and any subgroup of the group, specified in section 5111.0126 of the Revised Code:

(a) Terminate the medicaid program's coverage of the eligibility group or subgroup;

(b) Alter the eligibility requirements for the group or subgroup in a manner that causes fewer individuals to meet the eligibility requirements.

(2) If the medical assistance director terminates the medicaid program's coverage of the group or subgroup pursuant to division (B)(1)(a) of this section, each individual enrolled in medicaid as part of the group or subgroup shall be disenrolled from medicaid on a date the director specifies unless the

individual meets the eligibility requirements for another eligibility group or subgroup.

(3) If the medical assistance director alters the group's or subgroup's eligibility requirements pursuant to division (B)(1)(b) of this section, each individual enrolled in medicaid as part of the group or subgroup shall be disenrolled from medicaid on a date the director specifies unless the individual meets the altered eligibility requirements or meets the eligibility requirements for another eligibility group or subgroup.

(C) Notwithstanding section 5101.35 of the Revised Code, an individual's disenrollment from medicaid pursuant to this section is not subject to appeal under that section.

**Sec. 5111.0128.** (A) If the medicaid program covers the group, or any subgroup of the group, specified in section 5111.0126 of the Revised Code, the cost-sharing requirements instituted under section 5111.0112 of the Revised Code do not apply to any member of the group or subgroup who has countable income exceeding one hundred per cent of the federal poverty line. Instead, the office of medical assistance shall institute cost-sharing requirements for such members of the group or subgroup in accordance with this section.

(B) In instituting cost-sharing requirements under this section, all of the following apply:

(1) The requirements shall not apply to any individual exempt from the requirements pursuant to the "Social Security Act," sections 1916 and 1916A, 42 U.S.C. 1396o and 1396o-1.

(2) The copayment amounts for drugs shall be not less than the copayment amounts for drugs established under the cost-sharing requirements instituted under section 5111.0112 of the Revised Code.

(3) The copayment amount for nonemergency emergency department services shall be higher than the copayment amount for nonemergency emergency department services established under the cost-sharing requirements instituted under section 5111.0112 of the Revised Code.

(4) Copayments shall be established for at least all other types of medicaid services that are subject to copayments included in the cost-sharing requirements instituted under section 5111.0112 of the Revised Code, and the copayment amounts for those services may be higher than the copayment amounts for those services under the cost-sharing requirements established under that section.

(C) All of the following apply to the cost-sharing requirements instituted under this section:

(1) Subject to division (C)(2) of this section, a medicaid provider may refuse to provide a medicaid service to a medicaid recipient who fails to pay the copayment for the service if the recipient is subject to the copayment requirement.

(2) Before refusing to provide a medicaid service under division (C)(1) of this section, a medicaid provider shall inform the medicaid recipient whether an alternative medicaid service for which there is no copayment is available.

(3) A medicaid provider may attempt to collect unpaid copayments.

(4) A medicaid provider shall not waive a medicaid recipient's obligation to pay a copayment.

(5) In the case of a medicaid provider that is a hospital, the provider may take action to collect a copayment by providing, at the time the provider provides hospital services to a medicaid recipient subject to the copayment requirement, notice that a copayment may be owed.

**Section 2.** All items in this section are hereby appropriated as designated out of any moneys in the state treasury to the credit of the designated fund. For all appropriations made in this act, those in the first column are for fiscal year 2014 and those in the second column are for fiscal year 2015. The appropriations made in this act are in addition to any other appropriations made for the FY 2014-FY 2015 biennium.

| | | | Appropriations | |
|---|---|---|---|---|
| | | MCD DEPARTMENT OF MEDICAID | | |
| General Revenue Fund | | | | |
| GRF | 651525 | Medicaid/Health Care Services | | |
| | | State | $ 0 | $ 0 |
| | | Federal | $ 499,665,563 | $ 1,815,000,192 |
| | | Medicaid/Health Care Services Total | $ 499,665,563 | $ 1,815,000,192 |
| TOTAL GRF General Revenue Fund | | | | |
| | | State | $ 0 | $ 0 |
| | | Federal | $ 499,665,563 | $ 1,815,000,192 |
| | | GRF Total | $ 499,665,563 | $ 1,815,000,192 |
| TOTAL ALL BUDGET FUND GROUPS | | | $ 499,665,563 | $ 1,815,000,192 |

**Section 3.** Within the limits set forth in this act, the Director of Budget and Management shall establish accounts indicating the source and amount of funds for each appropriation made in this act, and shall determine the form and manner in which appropriation accounts shall be maintained. Expenditures from appropriations contained in this act shall be accounted for as though made in the main operating appropriations act of the 130th General Assembly.

The appropriations made in this act are subject to all provisions of the main operating appropriations act of the 130th

General Assembly that are generally applicable to such appropriations.