As Introduced

130th General Assembly
Regular Session **S. B. No. 166**
2013-2014

Senator Cafaro

Cosponsors: Senators Schiavoni, Turner, Skindell, Sawyer, Kearney, Smith, Brown, Tavares, Gentile

A B I L L

To amend sections 5162.01, 5162.20, 5165.15, and 5167.01, to enact sections 103.41, 103.411, 103.412, 103.413, 5162.70, 5162.71, 5163.04, 5164.16, 5164.882, 5164.94, 5167.15, and 6301.15, and to repeal sections 101.39 and 101.391 of the Revised Code to revise the law governing the Medicaid program, to create the Joint Medicaid Oversight Committee, to abolish the Joint Legislative Committee on Health Care Oversight and the Joint Legislative Committee on Medicaid Technology and Reform, and to make appropriations.

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

Section 1. That sections 5162.01, 5162.20, 5165.15, and 5167.01 be amended and sections 103.41, 103.411, 103.412, 103.413, 5162.70, 5162.71, 5163.04, 5164.16, 5164.882, 5164.94, 5167.15, and 6301.15 of the Revised Code be enacted to read as follows:

Sec. 103.41. (A) In this section:

"Rule" includes a new rule or the amendment or rescission of an existing rule. If a state agency revises a proposed rule, the

revised rule is a "rule" for purposes of this section.

"Workforce development activity" has the same meaning as in section 6301.01 of the Revised Code.

(B) On the same day that a state agency files a rule under division (D) of section 111.15 or division (H) of section 119.03 of the Revised Code, the state agency also shall file a copy of the rule with the joint medicaid oversight committee if the rule concerns either of the following:

(1) The administration of, eligibility requirements for, services covered by, service delivery methods of, or other aspects of the medicaid program;

(2) A workforce development activity that could reasonably be expected to impact medicaid recipients.

(C) The joint medicaid oversight committee, not later than thirty days after it receives the original version of a proposed rule or not later than fifteen days after it receives a revised version of a proposed rule, shall review the rule and determine whether the rule is likely to improve the administration of the medicaid program or the ability of medicaid recipients to achieve greater financial independence. The committee, based on its determination, shall form an opinion whether it views the rule favorably, unfavorably, or neutrally. The committee shall prepare a memorandum that states the committee's opinion and includes a concise explanation of the committee's reasoning that supports its opinion. The committee promptly shall transmit a copy of the rule and the memorandum to the state agency and joint committee on agency rule review.

The committee may give notice of and conduct a public hearing in the course of its review of a rule.

Sec. 103.411. (A) As used in this section, "medicaid waiver"

means the authority, granted by the United States department of health and human services, for the medicaid director to implement, and receive federal financial participation for, a component of the medicaid program for which federal financial participation is not available without the waiver. "Medicaid waiver" includes all of the following:

(1) A waiver for the medicaid program issued under section 1115, 1115A, or 1915 of the "Social Security Act," 42 U.S.C. 1315, 1315a, or 1396n, or any other federal statute;

(2) An amendment to a medicaid waiver; (3) An application for renewal, with or without changes, of an existing medicaid waiver.

(B) Before the medicaid director submits a request for a medicaid waiver to the United States department of health and human services, the director shall submit a copy of the requested medicaid waiver to the joint medicaid oversight committee. The committee may recommend that the director revise a medicaid waiver request.

Sec. 103.412. There is a joint medicaid oversight committee. The committee is comprised of ten members. The president of the senate and the speaker of the house of representatives each shall appoint five members to the committee from their respective houses, three of whom are members of the majority party and two of whom are members of the minority party. Vacancies on the committee shall be filled in the same manner as the original appointment.

In odd-numbered years, the president shall designate the chairperson of the committee from among the senate members of the committee. In even-numbered years, the speaker shall designate the chairperson of the committee from among the house members of the committee. In odd-numbered years, the speaker shall designate one of the minority members from the house as ranking minority member.

In even-numbered years, the president shall designate one of the minority members from the senate as ranking minority member.

In appointing members from the minority, and in designating ranking minority members, the president and speaker shall consult with the minority leader of their respective houses.

The committee shall meet at the call of the chairperson, but not less often than once each calendar month.

The committee shall employ professional, technical, and clerical employees as are necessary for the committee to be able successfully and efficiently to perform its duties. The employees are in the unclassified service and serve at the pleasure of the committee.

The committee may contract for the services of persons who are qualified by education and experience to advise, consult with, or otherwise assist the committee in the performance of its duties.

The chairperson of the committee, when authorized by the committee and by the president and speaker, may issue subpoenas and subpoenas duces tecum in aid of the committee's performance of its duties. A subpoena may require a witness in any part of the state to appear before the committee at a time and place designated in the subpoena to testify. A subpoena duces tecum may require witnesses or other persons in any part of the state to produce books, papers, records, and other tangible evidence before the committee at a time and place designated in the subpoena duces tecum. A subpoena or subpoena duces tecum shall be issued, served, and returned, and has consequences, as specified in sections 101.41 to 101.45 of the Revised Code.

The chairperson of the committee may administer oaths to witnesses appearing before the committee.

Sec. 103.413. The joint medicaid oversight committee shall conduct a continuing study of the medicaid program and workforce development activities related to the medicaid program.

The committee may plan, advertise, organize, and conduct forums, conferences, and other meetings at which representatives of state agencies and other individuals having expertise in the medicaid program and workforce development activities may participate to increase knowledge and understanding of, and to develop and propose improvements in, the medicaid program and workforce development activities. The director of job and family services shall submit to the committee relevant statistics on workforce development activities to assist the committee.

The committee may prepare and issue reports on its continuing studies. The committee may solicit written comments on, and may conduct public hearings at which persons may offer verbal comments on, drafts of its reports.

The committee may recommend improvements in rules affecting the medicaid program and workforce development activities related to the medicaid program, and may recommend legislation for improvement of statutes regarding those issues.

Sec. 5162.01. (A) As used in the Revised Code:

(1) "Medicaid" and "medicaid program" mean the program of medical assistance established by Title XIX of the "Social Security Act," 42 U.S.C. 1396 et seq., including any medical assistance provided under the medicaid state plan or a federal medicaid waiver granted by the United States secretary of health and human services.

(2) "Medicare" and "medicare program" mean the federal health insurance program established by Title XVIII of the "Social Security Act," 42 U.S.C. 1395 et seq.

(B) As used in this chapter:

(1) "CPI inflation rate" means the inflation rate as specified in the consumer price index for all urban consumers as published by the United States bureau of labor statistics.

(2) "Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.

~~(2)~~(3) "Federal financial participation" has the same meaning as in section 5160.01 of the Revised Code.

~~(3)~~(4) "Federal poverty line" means the official poverty line defined by the United States office of management and budget based on the most recent data available from the United States bureau of the census and revised by the United States secretary of health and human services pursuant to the "Omnibus Budget Reconciliation Act of 1981," section 673(2), 42 U.S.C. 9902(2).

~~(4)~~(5) "Healthy start component" means the component of the medicaid program that covers pregnant women and children and is identified in rules adopted under section 5162.02 of the Revised Code as the healthy start component.

~~(5)~~(6) "ICF/IID" has the same meaning as in section 5124.01 of the Revised Code.

~~(6)~~(7) "Medicaid managed care organization" has the same meaning as in section 5167.01 of the Revised Code.

~~(7)~~(8) "Medicaid provider" has the same meaning as in section 5164.01 of the Revised Code.

~~(8)~~(9) "Medicaid services" has the same meaning as in section 5164.01 of the Revised Code.

~~(9)~~(10) "Medicaid transition population" means both of the following:

(a) Medicaid recipients whose countable family incomes are within the top twenty-five percentage points of the income

eligibility threshold for the eligibility group under which they qualify for medicaid;

(b) Medicaid recipients whose countable family incomes are not less than the federal poverty line.

(11) "Nursing facility" has the same meaning as in section 5165.01 of the Revised Code.

~~(10)~~(12) "Political subdivision" means a municipal corporation, township, county, school district, or other body corporate and politic responsible for governmental activities only in a geographical area smaller than that of the state.

~~(11)~~(13) "Prescribed drug" has the same meaning as in section 5164.01 of the Revised Code.

~~(12)~~(14) "Provider agreement" has the same meaning as in section 5164.01 of the Revised Code.

~~(13)~~(15) "Qualified medicaid school provider" means the board of education of a city, local, or exempted village school district, the governing authority of a community school established under Chapter 3314. of the Revised Code, the state school for the deaf, and the state school for the blind to which both of the following apply:

(a) It holds a valid provider agreement.

(b) It meets all other conditions for participation in the medicaid school component of the medicaid program established in rules authorized by section 5162.364 of the Revised Code.

~~(14)~~(16) "State agency" means every organized body, office, or agency, other than the department of medicaid, established by the laws of the state for the exercise of any function of state government.

~~(15)~~(17) "Vendor offset" means a reduction of a medicaid payment to a medicaid provider to correct a previous, incorrect

medicaid payment to that provider.

Sec. 5162.20. (A) The department of medicaid shall institute cost-sharing requirements for the medicaid program in a manner consistent with the "Social Security Act," sections 1916 and 1916A, 42 U.S.C. 1396o and 1396o-1. ~~The cost-sharing~~ In instituting the requirements the department shall ~~include a copayment requirement for at least dental services, vision services, nonemergency emergency department services, and prescribed drugs~~ do all of the following:

(1) Apply the requirements to all medicaid recipients to whom the requirements may be applied;

(2) Apply the requirements to all medicaid services to which the requirements may be applied;

(3) Establish premiums, deductibles, copayments, coinsurance, and all other types of cost-sharing charges that may be established;

(4) Set the amounts of the premiums, deductibles, copayments, coinsurance, and all other types of cost-sharing charges at the maximum amounts permitted. ~~The cost-sharing requirements also shall include requirements regarding premiums, enrollment fees, deductions, and similar charges.~~

(B)(1) No provider shall refuse to provide a service to a medicaid recipient who is unable to pay a required copayment for the service.

(2) Division (B)(1) of this section shall not be considered to do either of the following with regard to a medicaid recipient who is unable to pay a required copayment:

(a) Relieve the medicaid recipient from the obligation to pay a copayment;

(b) Prohibit the provider from attempting to collect an

unpaid copayment.

(C) Except as provided in division (F) of this section, no provider shall waive a medicaid recipient's obligation to pay the provider a copayment.

(D) No provider or drug manufacturer, including the manufacturer's representative, employee, independent contractor, or agent, shall pay any copayment on behalf of a medicaid recipient.

(E) If it is the routine business practice of a provider to refuse service to any individual who owes an outstanding debt to the provider, the provider may consider an unpaid copayment imposed by the cost-sharing requirements as an outstanding debt and may refuse service to a medicaid recipient who owes the provider an outstanding debt. If the provider intends to refuse service to a medicaid recipient who owes the provider an outstanding debt, the provider shall notify the recipient of the provider's intent to refuse service.

(F) In the case of a provider that is a hospital, the cost-sharing program shall permit the hospital to take action to collect a copayment by providing, at the time services are rendered to a medicaid recipient, notice that a copayment may be owed. If the hospital provides the notice and chooses not to take any further action to pursue collection of the copayment, the prohibition against waiving copayments specified in division (C) of this section does not apply.

(G) The department of medicaid may collaborate with a state agency that is administering, pursuant to a contract entered into under section 5162.35 of the Revised Code, one or more components, or one or more aspects of a component, of the medicaid program as necessary for the state agency to apply the cost-sharing requirements to the components or aspects of a component that the

state agency administers.

Sec. 5162.70. (A) The medicaid director shall implement reforms to the medicaid program that do all of the following:

(1) Provide for the growth in the per member per month cost of the medicaid program, as determined on an aggregate basis for all eligibility groups, for the six-month period immediately preceding the first day of each January and the six-month period immediately preceding the first day of each July to be not more than the average annual increase in the CPI inflation rate for medical care for the most recent three-year period for which the necessary data is available as of that first day of January or July;

(2) Achieve the limit in the growth of the per member per month cost of the medicaid program required by division (A)(1) of this section in a manner that does all of the following:

(a) Improves the physical and mental health of medicaid recipients;

(b) Provides for medicaid recipients to receive medicaid services in the most cost-effective and sustainable manner;

(c) Removes barriers that impede medicaid recipients' ability to transfer to lower cost, and more appropriate, medicaid services.

(3) Reduce the relative number of individuals who need medicaid that is achieved in a manner that utilizes both of the following:

(a) Programs that have been demonstrated to be effective and have one or more of the following features:

(i) Have low costs;

(ii) Utilize volunteers;

(iii) Utilize incentives;

(iv) Are led by peers.

(b) The identification and elimination of medicaid eligibility requirements that are barriers to achieving greater financial independence.

(4) Provide medicaid recipients with information about the actual costs of medicaid services and the amounts the medicaid program pays for the services so that recipients are able to use this information when choosing medicaid providers;

(5) Reduce the number of times that medicaid recipients are readmitted to hospitals or utilize emergency department services when the readmissions or utilizations are avoidable;

(6) Reduce a nursing facility's medicaid payment rate if its residents utilize hospital emergency department services at higher than average rates;

(7) Reduce a nursing facility's medicaid payment rate if its residents who are dual eligible individuals have higher than average hospital admission rates;

(8) Establish standards for medicaid managed care organizations to promote compliance with primary care requirements applicable to medicaid recipients for whom the organizations provide, or arrange for the provision of, medicaid services;

(9) Provide for medicaid managed care organizations to receive, beginning not later than December 31, 2014, medicaid payments based on reductions in medicaid costs that they help achieve;

(10) Require managed care organizations, as a condition of becoming medicaid managed care organizations, to do both of the following:

(a) Obtain accreditation from the national committee for

quality assurance or another accrediting organization the director determines has accreditation standards that are similar to the national committee for quality assurance's accreditation standards;

(b) Utilize the healthcare effectiveness data and information set established by the national committee for quality assurance or a similar performance measuring tool that the director determines is similar to the healthcare effectiveness data and information set.

(11) Gather data about the medicaid transition population's utilization of workforce development activities administered by the department of job and family services to determine all of the following:

(a) The length of time they utilize the activities;

(b) When their employment status changes;

(c) The events that cause them to cease to be eligible for medicaid.

(B) The reforms implemented under this section shall, without making the medicaid program's eligibility requirements more restrictive, reduce the relative number of individuals enrolled in the medicaid program who have the greatest potential to obtain the income and resources that would enable them to cease enrollment in medicaid and instead obtain health care coverage through employer-sponsored health insurance or the health insurance marketplace.

(C) Each quarter, the medicaid director shall transmit the data gathered under the reform implemented pursuant to division (A)(11) of this section to the joint medicaid oversight committee. The director also shall submit an annual report to the committee regarding the findings made from the data.

Sec. 5162.71. The medicaid director shall implement within the medicaid program systems that have the goal of reducing both of the following:

(A) Health disparities among medicaid recipients who are members of minority populations;

(B) The incidence among medicaid recipients of alcoholism, drug addiction, tobacco use, and abuse of other substances the director specifies in rules adopted under section 5162.02 of the Revised Code.

Sec. 5163.04. The medicaid program shall not cover 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), unless the federal medical assistance percentage for expenditures for medicaid services provided to the group 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. If the medicaid program covers the group and the federal medical assistance percentage for such expenditures is reduced below the amount so specified, the medicaid program shall cease to cover the group. Notwithstanding section 5160.31 of the Revised Code, an individual's disenrollment from the medicaid program is not subject to appeal under that section when the disenrollment is the result of the medicaid program ceasing to cover the individual's group under this section.

Sec. 5164.16. As used in this section, "telemedicine" means the delivery of a medicaid service to a medicaid recipient through the use of an interactive, electronic communication device that enables the medicaid provider to communicate in an audible or visual manner, or both manners, with the medicaid recipient or another medicaid provider of the medicaid recipient from a site

other than the site at which the medicaid recipient or other medicaid provider is located.

The medicaid program may cover telemedicine to the extent, and in the manner, authorized by rules adopted under section 5164.02 of the Revised Code.

Sec. 5164.882. The medicaid director shall implement within the medicaid program a system designed to reduce the rate of chronic conditions among medicaid recipients. The system implemented under this section shall be in addition to the systems required by sections 5164.88 and 5164.881 of the Revised Code. The system shall include features that enable medicaid providers to share with the medicaid program savings achieved by reducing rates of chronic conditions among medicaid recipients.

Sec. 5164.94. The medicaid director shall establish a system within the medicaid program that encourages medicaid providers to provide medicaid services to medicaid recipients in culturally and linguistically appropriate manners.

Sec. 5165.15. (A) Except as otherwise provided by sections 5162.70, 5165.151 to 5165.156, and 5165.34 of the Revised Code, the total per medicaid day payment rate that the department of medicaid shall pay a nursing facility provider for nursing facility services the provider's nursing facility provides during a fiscal year shall equal the sum of all of the following:

(1) The per medicaid day payment rate for ancillary and support costs determined for the nursing facility under section 5165.16 of the Revised Code;

(2) The per medicaid day payment rate for capital costs determined for the nursing facility under section 5165.17 of the Revised Code;

(3) The per medicaid day payment rate for direct care costs determined for the nursing facility under section 5165.19 of the Revised Code;

(4) The per medicaid day payment rate for tax costs determined for the nursing facility under section 5165.21 of the Revised Code;

(5) If the nursing facility qualifies as a critical access nursing facility, the nursing facility's critical access incentive payment paid under section 5165.23 of the Revised Code;

(6) The quality incentive payment paid to the nursing facility under section 5165.25 of the Revised Code.

(B) In addition to paying a nursing facility provider the nursing facility's total rate determined under division (A) of this section for a fiscal year, the department shall pay the provider a quality bonus under section 5165.26 of the Revised Code for that fiscal year if the provider's nursing facility is a qualifying nursing facility, as defined in that section, for that fiscal year. The quality bonus shall not be part of the total rate.

Sec. 5167.01. As used in this chapter:

~~(A)~~ "Controlled substance" has the same meaning as in section 3719.01 of the Revised Code.

~~(B)~~ "Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.

~~(C)~~ "Emergency services" has the same meaning as in the "Social Security Act," section 1932(b)(2), 42 U.S.C. 1396u-2(b)(2).

~~(D)~~ "Home and community-based services medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code.

~~(E)~~ "Medicaid managed care organization" means a managed care organization under contract with the department of medicaid pursuant to section 5167.10 of the Revised Code.

~~(F)~~ "Medicaid transition population" has the same meaning as in section 5162.01 of the Revised Code.

"Medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code.

~~(G)~~ "Nursing facility" has the same meaning as in section 5165.01 of the Revised Code.

~~(H)~~ "Prescribed drug" has the same meaning as in section 5164.01 of the Revised Code.

~~(I)~~ "Provider" means any person or government entity that furnishes services to a medicaid recipient enrolled in a medicaid managed care organization, regardless of whether the person or entity has a provider agreement.

~~(J)~~ "Provider agreement" has the same meaning as in section 5164.01 of the Revised Code.

"Workforce development activity" has the same meaning as in section 6301.01 of the Revised Code.

Sec. 5167.15. (A) Each contract the department of medicaid enters into with a managed care organization under section 5167.10 of the Revised Code shall require the managed care organization to provide, or arrange for the provision of, case management services to all medicaid recipients who enroll in the managed care organization and are part of the medicaid transition population. The case management services shall include all of the following:

(1) A clinical assessment of the recipient to determine whether the recipient has a medical or other condition to which both of the following apply:

(a) The condition may impede the recipient's ability to gain or maintain employment or improve the recipient's employment situation;

(b) The condition may be reasonably remediated through medical, mental health, or substance abuse treatment.

(2) A care plan for the recipient that includes services designed to address the barriers to self-sufficiency that the recipient has been identified as having;

(3) Referrals to employment-related programs that will assist the recipient in gaining access to, and maintaining, optimal employment, including the following programs:

(a) On-the-job training programs;

(b) Workforce investment activities;

(c) Programs that enable individuals seeking employment to find employment opportunities listed on internet web sites;

(d) Other programs administered by the department of job and family services or the opportunities for Ohioans with disabilities agency.

(4) Referrals from employment-related programs that are administered by the department of job and family services, the opportunities for Ohioans with disabilities agency, or workforce investment boards and provide services designed to treat any medical or other problems the recipient has that hinder the recipient's ability to gain or maintain employment or improve the recipient's employment situation.

(B) The department of job and family services shall provide workforce investment boards any technical guidance the boards need for the purpose of the referrals made under division (B)(4) of this section.

Sec. 6301.15. The director of job and family services shall implement reforms to workforce development activities that do both of the following:

(A) Reduce the relative number of individuals who need medicaid that is achieved in a manner that utilizes all of the following:

(1) Programs that have been demonstrated to be effective and have one or more of the following features:

(a) Have low costs;

(b) Utilize volunteers;

(c) Utilize incentives;

(d) Are led by peers.

(2) Educational and training opportunities;

(3) Employment opportunities;

(4) Other initiatives the director considers appropriate.

(B) Enhance the relationship between educational facilities, workforce development activities, and employers.

Section 2. That existing sections 5162.01, 5162.20, 5165.15, and 5167.01 of the Revised Code are hereby repealed.

Section 3. That sections 101.39 and 101.391 of the Revised Code are repealed.

Section 4. The Joint Medicaid Oversight Committee shall prepare a report with recommendations for legislation regarding Medicaid payment rates for Medicaid services. The goal of the recommendations shall be to provide the Medicaid Director statutory authority to implement innovative methodologies for

setting Medicaid payment rates that limit the growth in Medicaid costs and protect, and establish guiding principles for, Medicaid providers and recipients. The Medicaid Director shall assist the Committee with the report. The Committee shall submit the report to the General Assembly in accordance with section 101.68 of the Revised Code not later than January 1, 2014.

Section 5. (A) As used in this section, "Medicaid transition population" has the same meaning as in section 5162.01 of the Revised Code.

(B) The Joint Medicaid Oversight Committee shall prepare a report with recommendations for legislation that would create a comprehensive pilot program under which peer mentors assist Medicaid recipients who are part of the Medicaid transition population, and the families of such recipients, to develop and implement plans for overcoming barriers to both achieving greater financial independence and successfully accessing employment opportunities. The recommendations shall provide for the pilot program to have all of the following features:

(1) A mechanism under which local, nonprofit community organizations compete to participate in the pilot program in a manner that is similar to the manner in which entities compete to serve as navigators under a grant program established by an Exchange under the "Patient Protection and Affordable Care Act," section 1311(i), 42 U.S.C. 18031(i);

(2) Requirements for the local, nonprofit community organizations participating in the pilot program to do both of the following:

(a) Provide for individuals who are to serve as peer mentors under the pilot program to be trained in a uniform manner across the state on at least both of the following:

(i) Workforce development activity eligibility requirements and opportunities;

(ii) Methods for peer mentors to work with Medicaid recipients who are part of the Medicaid transition population and the families of such recipients in culturally competent ways.

(b) Make the trained peer mentors available to work with Medicaid recipients who are part of the Medicaid transition population and the families of such recipients.

(C) The Committee's report shall recommend that the pilot program do all of the following:

(1) Begin operation not later than January 1, 2015;

(2) Continue operation for not less than six months;

(3) Be operated in urban, suburban, and rural counties;

(4) Provide for the Medicaid Director to submit to the General Assembly, in accordance with section 101.68 of the Revised Code, recommendations for adjustments that should be made before the pilot program is expanded statewide.

(D) The Committee shall submit the report to the General Assembly in accordance with section 101.68 of the Revised Code not later than June 30, 2014.

Section 6. (A) The Joint Medicaid Oversight Committee shall prepare a report regarding all of the following:

(1) The appropriate roles of the different types of health care professionals in the Medicaid program and different service delivery systems within the Medicaid program;

(2) Regulatory models for all health care professionals who must obtain a license, certificate, or other form of approval from the state to practice in this state;

(3) Other issues regarding health care professionals that the

Committee considers appropriate for the report.

(B) The Executive Director of the Governor's Office of Health Transformation, Medicaid Director, Director of Mental Health and Addiction Services, Director of Health, Director of Aging, and Director of Developmental Disabilities shall assist the Committee with the report. The Committee may request that members of the public and interested parties with expertise in the issue of health care professionals also assist the Committee with the report. The Committee shall submit the report to the General Assembly in accordance with section 101.68 of the Revised Code not later than March 1, 2014.

Section 7. 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	
JMO JOINT MEDICAID OVERSIGHT COMMITTEE			
General Revenue Fund			
GRF 048321 Operating Expenses	$ 350,000	$ 500,000	
TOTAL GRF General Revenue Fund	$ 350,000	$ 500,000	
TOTAL ALL BUDGET FUND GROUPS	$ 350,000	$ 500,000	

OPERATING EXPENSES

The foregoing appropriation item 048321, Operating Expenses, shall be used to support expenses related to the Joint Medicaid Oversight Committee established in section 103.412 of the Revised Code.

		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	
	Total	$ 499,665,563	$ 1,815,000,192	
TOTAL ALL BUDGET FUND GROUPS		$ 499,665,563	$ 1,815,000,192	

MEDICAID/HEALTH CARE SERVICES

Of the foregoing appropriation item 651525, Medicaid/Health Care Services, $499,665,563 in fiscal year 2014 and $1,815,000,192 in fiscal year 2015 shall be used to cover the eligibility expansion group authorized by the Patient Protection and Affordable Care Act.

Section 8. 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.