As Reported by the House Finance and Appropriations Committee

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Am. Sub. S. B. No. 206

Senators Burke, Cafaro

Cosponsors: Senators Coley, LaRose, Tavares, Bacon, Balderson, Beagle, Eklund, Jones, Lehner, Manning, Peterson, Schaffer, Widener
Representative Amstutz

A B I L L

To amend sections 191.02, 5162.01, 5162.13, 5162.131, 5162.132, 5162.20, 5163.01, 5163.06, 5163.09, 5163.0910, and 5164.911; to amend, for the purpose of adopting a new section number as indicated in parentheses, section 5163.0910 (5162.133); to enact sections 103.41, 103.411, 103.412, 103.413, 103.414, 103.415, 191.08, 193.01, 193.02, 193.03, 193.04, 193.05, 193.06, 193.07, 5162.134, 5162.70, 5162.71, and 5164.94; and to repeal sections 101.39, 101.391, and 5163.099 of the Revised Code; to amend Section 323.90 of Am. Sub. H.B. 59 of the 130th General Assembly; to require implementation of certain Medicaid revisions, reform systems, and program oversight; to provide for government programs that provide public benefits to prioritize employment goals; to create the Ohio Healthier Buckeye Council and the Ohio Healthier Buckeye Grant Program; and to make an appropriation.

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

Section 1. That sections 191.02, 5162.01, 5162.13, 5162.131, 5162.132, 5162.20, 5163.01, 5163.06, 5163.09, 5163.0910, and 5164.911 be amended; section 5163.0910 (5162.133) be amended for the purpose of adopting a new section number as indicated in parentheses; and sections 103.41, 103.411, 103.412, 103.413, 103.414, 103.415, 191.08, 193.01, 193.02, 193.03, 193.04, 193.05, 193.06, 193.07, 5162.134, 5162.70, 5162.71, and 5164.94 of the Revised Code be enacted to read as follows:

Sec. 103.41. (A) As used in sections 103.41 to 103.415 of the Revised Code:

(1) "JMOC" means the joint medicaid oversight committee created under this section.

(2) "State and local government medicaid agency" means all of the following:

(a) The department of medicaid;

(b) The office of health transformation;

(c) Each state agency and political subdivision with which the department of medicaid contracts under section 5162.35 of the Revised Code to have the state agency or political subdivision administer one or more components of the medicaid program, or one or more aspects of a component, under the department's supervision;

(d) Each agency of a political subdivision that is responsible for administering one or more components of the medicaid program, or one or more aspects of a component, under the supervision of the department or a state agency or political subdivision described in division (A)(2)(c) of this section.

(B) There is hereby created the joint medicaid oversight committee. JMOC shall consist of the following members:

(1) Five members of the senate appointed by the president of the senate, three of whom are members of the majority party and two of whom are members of the minority party;

(2) Five members of the house of representatives appointed by the speaker of the house of representatives, three of whom are members of the majority party and two of whom are members of the minority party.

(C) The term of each JMOC member shall begin on the day of appointment to JMOC and end on the last day that the member serves in the house (in the case of a member appointed by the speaker) or senate (in the case of a member appointed by the president) during the general assembly for which the member is appointed to JMOC. The president and speaker shall make the initial appointments not later than fifteen days after the effective date of this section. However, if this section takes effect before January 1, 2014, the president and speaker shall make the initial appointments during the period beginning January 1, 2014, and ending January 15, 2014. The president and speaker shall make subsequent appointments not later than fifteen days after the commencement of the first regular session of each general assembly. JMOC members may be reappointed. A vacancy on JMOC shall be filled in the same manner as the original appointment.

(D) In odd-numbered years, the speaker shall designate one of the majority members from the house as the JMOC chairperson and the president shall designate one of the minority members from the senate as the JMOC ranking minority member. In even-numbered years, the president shall designate one of the majority members from the senate as the JMOC chairperson and the speaker shall designate one of the minority members from the house as the JMOC ranking minority member.

(E) 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.

(F) JMOC shall meet at the call of the JMOC chairperson. The chairperson shall call JMOC to meet not less often than once each calendar month, unless the chairperson and ranking minority member agree that the chairperson should not call JMOC to meet for a particular month.

(G) JMOC may employ professional, technical, and clerical employees as are necessary for JMOC to be able successfully and efficiently to perform its duties. All such employees are in the unclassified service and serve at JMOC's pleasure. JMOC may contract for the services of persons who are qualified by education and experience to advise, consult with, or otherwise assist JMOC in the performance of its duties.

(H) The JMOC chairperson, when authorized by JMOC and the president and speaker, may issue subpoenas and subpoenas duces tecum in aid of JMOC's performance of its duties. A subpoena may require a witness in any part of the state to appear before JMOC 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 JMOC 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.

(I) The JMOC chairperson may administer oaths to witnesses appearing before JMOC.

Sec. 103.411. The JMOC chairperson may request that the medicaid director appear before JMOC to provide information and answer questions about the medicaid program. If so requested, the

medicaid director shall appear before JMOC at the time and place specified in the request.

Sec. 103.412. (A) JMOC shall oversee the medicaid program on a continuing basis. As part of its oversight, JMOC shall do all of the following:

(1) Review how the medicaid program relates to the public and private provision of health care coverage in this state and the United States;

(2) Review the reforms implemented under section 5162.70 of the Revised Code and evaluate the reforms' successes in achieving their objectives;

(3) Recommend policies and strategies to encourage both of the following:

(a) Medicaid recipients being physically and mentally able to join and stay in the workforce and ultimately becoming self-sufficient;

(b) Less use of the medicaid program.

(4) Recommend, to the extent JMOC determines appropriate, improvements in statutes and rules concerning the medicaid program;

(5) Develop a plan of action for the future of the medicaid program.

(B) JMOC may do all of the following:

(1) 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 may participate to increase knowledge and understanding of, and to develop and propose improvements in, the medicaid program;

(2) Prepare and issue reports on the medicaid program;

(3) Solicit written comments on, and conduct public hearings at which persons may offer verbal comments on, drafts of its reports.

Sec. 103.413. (A) JMOC may investigate state and local government medicaid agencies. Subject to division (B) of this section, all of the following apply to an investigation:

(1) JMOC, including its employees, may inspect the offices of a state and local government medicaid agency as necessary for the conduct of the investigation.

(2) No person shall deny JMOC or a JMOC employee access to such an office when access is needed for such an inspection.

(3) Neither JMOC nor a JMOC employee is required to give advance notice of, or to make prior arrangements before, such an inspection.

(B) Neither JMOC nor a JMOC employee shall conduct an inspection under this section unless the JMOC chairperson grants prior approval for the inspection. The chairperson shall not grant such approval unless JMOC, the president of the senate, and the speaker of the house of representatives authorize the chairperson to grant the approval. Each inspection shall be conducted during the normal business hours of the office being inspected, unless the chairperson determines that the inspection must be conducted outside of normal business hours. The chairperson may make such a determination only due to an emergency circumstance or other justifiable cause that furthers JMOC's mission. If the chairperson makes such a determination, the chairperson shall specify the reason for the determination in the grant of prior approval for the inspection.

Sec. 103.414. Before the beginning of each fiscal biennium,

JMOC shall contract with an actuary to determine the projected medical inflation rate for the upcoming fiscal biennium. The contract shall require the actuary to make the determination using the same types of classifications and sub-classifications of medical care that the United States bureau of labor statistics uses in determining the inflation rate for medical care in the consumer price index. The contract also shall require the actuary to provide JMOC a report with its determination at least one hundred twenty days before the governor is required to submit a state budget for the fiscal biennium to the general assembly under section 107.03 of the Revised Code.

On receipt of the actuary's report, JMOC shall determine whether it agrees with the actuary's projected medical inflation rate. If JMOC disagrees with the actuary's projected medical inflation rate, JMOC shall determine a different projected medical inflation rate for the upcoming fiscal biennium.

The actuary and, if JMOC determines a different projected medical inflation rate, JMOC shall determine the projected medical inflation rate for the state unless that is not practicable in which case the determination shall be made for the midwest region.

Regardless of whether it agrees with the actuary's projected medical inflation rate or determines a different projected medical inflation rate, JMOC shall complete a report regarding the projected medical inflation rate. JMOC shall include a copy of the actuary's report in JMOC's report. JMOC's report shall state whether JMOC agrees with the actuary's projected medical inflation rate and, if JMOC disagrees, the reason why JMOC disagrees and the different medical inflation rate JMOC determined. At least ninety days before the governor is required to submit a state budget for the upcoming fiscal biennium to the general assembly under section 107.03 of the Revised Code, JMOC shall submit a copy of the report

to the general assembly in accordance with section 101.68 of the Revised Code and to the governor and medicaid director.

Sec. 103.415. JMOC may review bills and resolutions regarding the medicaid program that are introduced in the general assembly. JMOC may submit a report of its review of a bill or resolution to the general assembly in accordance with section 101.68 of the Revised Code. The report may include JMOC's determination regarding the bill's or resolution's desirability as a matter of public policy.

JMOC's decision on whether and when to review a bill or resolution has no effect on the general assembly's authority to act on the bill or resolution.

Sec. 191.02. The executive director of the office of health transformation, in consultation with all of the following individuals, shall identify each government program administered by a state agency that is to be considered a government program providing public benefits for purposes of ~~section~~ sections 191.04 and 191.08 of the Revised Code:

(A) The director of administrative services;

(B) The director of aging;

(C) The director of development services;

(D) The director of developmental disabilities;

(E) The director of health;

(F) The director of job and family services;

(G) The ~~director of~~ medicaid director;

(H) The director of mental health and addiction services;

(I) The director of rehabilitation and correction;

(J) The director of veterans services;

(K) The director of youth services;

(L) The executive director of the opportunities for Ohioans with disabilities agency;

(M) The administrator of workers' compensation;

(N) The superintendent of insurance;

(O) The superintendent of public instruction;

(P) The tax commissioner.

Sec. 191.08. The executive director of the office of health transformation shall adopt strategies that prioritize employment as a goal for individuals participating in government programs providing public benefits.

Sec. 193.01. As used in this chapter:

"Care coordination" means assisting an individual to access available physical health, behavioral health, social, employment, education, and housing services the individual needs.

"Care coordinator" means a person who provides care coordination.

"Political subdivision" has the same meaning as in section 2744.01 of the Revised Code.

"Publicly funded assistance programs" include physical health, behavioral health, social, employment, education, and housing programs funded or provided by the state or a political subdivision of the state.

Sec. 193.02. (A) There is hereby created the Ohio healthier buckeye council. The council shall consist of the following members:

(1) The director of development services, or the director's designee;

(2) The auditor of state, or the auditor's designee;

(3) Two members representing administrative departments enumerated in section 121.02 of the Revised Code, appointed by the governor;

(4) One member representing a law enforcement agency, appointed by the governor;

(5) One member representing the interests of nongovernmental economic development entities, appointed by the governor;

(6) Two members of the senate, one of whom shall be appointed by the president of the senate and the other shall be appointed by the minority leader of the senate;

(7) One member representing health care providers, appointed by the president of the senate;

(8) One member representing the interests of business and development, appointed by the president of the senate;

(9) Two members of the house of representatives, one of whom shall be appointed by the speaker of the house of representatives and the other shall be appointed by the minority leader of the house of representatives;

(10) One member representing health care insurers, appointed by the speaker of the house of representatives;

(11) One member representing faith-based organizations, appointed by the speaker of the house of representatives;

(12) One member representing the judicial branch of government, appointed by the chief justice of the supreme court.

(B) Initial appointments to the council shall be made not later than March 31, 2014.

The members appointed under divisions (A)(4) and (5) of this section shall serve an initial term of one year. The members

appointed under divisions (A)(7) and (8) of this section shall serve an initial term of two years. The members appointed under divisions (A)(10), (11), and (12) of this section shall serve an initial term of three years. Thereafter, each member appointed under those divisions shall serve a four-year term. Each member appointed under division (A)(3) of this section shall serve a four-year term. A member appointed under divisions (A)(6) and (9) of this section shall serve a four-year term or during the member's tenure in the general assembly, whichever period is shorter. Members may be reappointed to the council.

Vacancies on the council shall be filled in the same manner as the original appointments.

(C) At its first meeting, the council shall select a chairperson from among its members. After the first meeting, the council shall meet at the call of the chairperson or upon the request of a majority of the council's members. A majority of the council constitutes a quorum.

(D) The development services agency shall provide administrative assistance to the council until June 30, 2015. Starting July 1, 2015, the joint medicaid oversight committee established in section 103.41 of the Revised Code shall provide administrative assistance to the council.

(E) Council members shall receive no compensation but shall be reimbursed for actual and necessary expenses incurred in the performance of council duties.

Sec. 193.03. The Ohio healthier buckeye council shall do all of the following:

(A) Promote the establishment of county healthier buckeye councils throughout this state through whatever means the council determines to be most efficient;

(B) Develop and promote means by which the county councils

may reduce the reliance of individuals on publicly funded assistance programs using both of the following:

(1) Programs that have been demonstrated to be effective and:

(a) Have low costs;

(b) Use volunteer workers;

(c) Use incentives to encourage designated behaviors; and

(d) Are led by peers.

(2) Identification and elimination of eligibility requirements for publicly funded assistance programs that are barriers to achieving greater financial independence for participants in those programs.

(C) Establish eligibility criteria, application processes, and maximum grant amounts for the Ohio healthier buckeye grant program established in section 193.04 of the Revised Code and award grants under the program;

(D) Collect and analyze the data submitted to the council under section 193.07 of the Revised Code;

(E) Develop the best practices for the administration of publicly funded assistance programs in the state;

(F) Issue the annual reports required under section 193.05 of the Revised Code.

Sec. 193.04. (A) There is hereby created the Ohio healthier buckeye grant program to be administered by the Ohio healthier buckeye council. The program shall provide grants to county healthier buckeye councils for the following:

(1) To assist county councils with costs associated with gathering data regarding enrollment and outcome information related to publicly funded assistance programs;

(2) To provide funding to county councils to enable care

coordinators to seek relevant certification.

(B) Not later than June 30, 2014, the council shall establish all of the following:

(1) The application processes, eligibility criteria, and grant amounts to be awarded under the program;

(2) The form and manner to be used by county councils when submitting enrollment and outcome data to the council;

(3) Eligible certification programs for which county council care coordinators may receive a grant.

Sec. 193.05. Not later than January 31, 2015, and every year thereafter, the Ohio healthier buckeye council shall submit a report to the joint medicaid oversight committee established in section 103.41 of the Revised Code. A copy of the report shall be submitted to each county healthier buckeye council. The report shall include the following:

(A) Information regarding the enrollment and outcome data submitted by county healthier buckeye councils under section 193.07 of the Revised Code, including information comparing past data, if available;

(B) Recommendations developed by the council regarding the best practices for the administration of publicly funded assistance programs.

Sec. 193.06. Each board of county commissioners may adopt a resolution to establish a county healthier buckeye council. The board may invite any public or private agency or group that funds, advocates, or provides care coordination services or operates publicly funded assistance programs to individuals to become a member of the county council.

Sec. 193.07. A county healthier buckeye council shall do all of the following:

(A) Promote care coordination among physical health, behavioral health, social, employment, education, and housing service providers within the county;

(B) Report to the Ohio healthier buckeye council enrollment and outcome data related to publicly funded assistance programs provided within the county;

(C) Seek care coordination certification for individuals within the county.

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

(2) "Exchange" has the same meaning as in 45 C.F.R. 155.20.

(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) "Home and community-based services" means services provided under a home and community-based services medicaid waiver component.

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

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

~~(6)~~(9) "Medicaid managed care organization" has the same meaning as in section 5167.01 of the Revised Code.

~~(7)~~(10) "Medicaid provider" has the same meaning as in section 5164.01 of the Revised Code.

~~(8)~~(11) "Medicaid services" has the same meaning as in section 5164.01 of the Revised Code.

~~(9)~~(12) "Nursing facility" ~~has~~ and "nursing facility services" have the same ~~meaning~~ meanings as in section 5165.01 of the Revised Code.

~~(10)~~(13) "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)~~(14) "Prescribed drug" has the same meaning as in section 5164.01 of the Revised Code.

~~(12)~~(15) "Provider agreement" has the same meaning as in section 5164.01 of the Revised Code.

~~(13)~~(16) "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)~~(17) "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)~~(18) "Vendor offset" means a reduction of a medicaid payment to a medicaid provider to correct a previous, incorrect medicaid payment to that provider.

Sec. 5162.13. On or before the first day of January of each year, the department of medicaid shall ~~submit to the speaker and minority leader of the house of representatives and the president and minority leader of the senate, and shall make available to the public,~~ complete a report on the effectiveness of the medicaid program in meeting the health care needs of low-income pregnant women, infants, and children. The report shall include: the estimated number of pregnant women, infants, and children eligible for the program; the actual number of eligible persons enrolled in the program; the number of prenatal, postpartum, and child health visits; a report on birth outcomes, including a comparison of low-birthweight births and infant mortality rates of medicaid recipients with the general female child-bearing and infant population in this state; and a comparison of the prenatal,

delivery, and child health costs of the program with such costs of similar programs in other states, where available. The department shall submit the report to the general assembly in accordance with section 101.68 of the Revised Code and to the joint medicaid oversight committee. The department also shall make the report available to the public.

Sec. 5162.131. Semiannually, the medicaid director shall ~~submit to the president and minority leader of the senate, speaker and minority leader of the house of representatives, and the chairpersons of the standing committees of the senate and house of representatives with primary responsibility for legislation making biennial appropriations~~ complete a report on the establishment and implementation of programs designed to control the increase of the cost of the medicaid program, increase the efficiency of the medicaid program, and promote better health outcomes. The director shall submit the report to the general assembly in accordance with section 101.68 of the Revised Code and to the joint medicaid oversight committee. In each calendar year, one report shall be submitted not later than the last day of June and the subsequent report shall be submitted not later than the last day of December.

Sec. 5162.132. Annually, the department of medicaid shall prepare a report on the department's efforts to minimize fraud, waste, and abuse in the medicaid program.

Each report shall be made available on the department's web site. The department shall submit a copy of each report to the governor, general assembly, and~~,~~ joint medicaid oversight committee. The copy to the general assembly shall be submitted in accordance with section 101.68 of the Revised Code~~, the general assembly~~. Copies of the report also shall be made available to the public on request.

Sec. ~~5163.0910~~ 5162.133. Not less than once each year, the medicaid director shall submit a report on the medicaid buy-in for workers with disabilities program to the governor, ~~speaker and minority leader of the house of representatives, president and minority leader of the senate, and chairpersons of the house and senate committees to which the biennial operating budget bill is referred~~ general assembly, and joint medicaid oversight committee. The copy to the general assembly shall be submitted in accordance with section 101.68 of the Revised Code. The report shall include all of the following information:

(A) The number of individuals who participated in the medicaid buy-in for workers with disabilities program;

(B) The cost of the program;

(C) The amount of revenue generated by premiums that participants pay under section 5163.094 of the Revised Code;

(D) The average amount of earned income of participants' families;

(E) The average amount of time participants have participated in the program;

(F) The types of other health insurance participants have been able to obtain.

Sec. 5162.134. Not later than the first day of each July, the medicaid director shall complete a report of the evaluation conducted under section 5164.911 of the Revised Code regarding the integrated care delivery system. The director shall provide a copy of the report to the general assembly and joint medicaid oversight committee. The copy to the general assembly shall be provided in accordance with section 101.68 of the Revised Code. The director also shall make the report available to the public.

Sec. 5162.20. (A) The department of medicaid shall institute cost-sharing requirements for the medicaid program. ~~The cost-sharing requirements shall include a copayment requirement for at least dental services, vision services, nonemergency emergency department services, and prescribed drugs. The cost-sharing requirements also shall include requirements regarding premiums, enrollment fees, deductions, and similar charges~~ The department shall not institute cost-sharing requirements in a manner that disproportionately impacts the ability of medicaid recipients with chronic illnesses to obtain medically necessary medicaid services.

(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) As used in this section:

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

(2) "CPI medical inflation rate" means the inflation rate for medical care, or the successor term for medical care, for the midwest region as specified in the CPI.

(3) "JMOC projected medical inflation rate" means the

following:

(a) The projected medical inflation rate for a fiscal biennium determined by the actuary with which the joint medicaid oversight committee contracts under section 103.414 of the Revised Code if the committee agrees with the actuary's projected medical inflation rate for that fiscal biennium;

(b) The different projected medical inflation rate for a fiscal biennium determined by the joint medicaid oversight committee under section 103.414 of the Revised Code if the committee disagrees with the projected medical inflation rate determined for that fiscal biennium by the actuary with which the committee contracts under that section.

(4) "Successor term" means a term that the United States bureau of labor statistics uses in place of another term in revisions to the CPI.

(B) The medicaid director shall implement reforms to the medicaid program that do all of the following:

(1) Limit the growth in the per recipient per month cost of the medicaid program, as determined on an aggregate basis for all eligibility groups, for a fiscal biennium to not more than the lesser of the following:

(a) The average annual increase in the CPI medical inflation rate for the most recent three-year period for which the necessary data is available as of the first day of the fiscal biennium, weighted by the most recent year of the three years;

(b) The JMOC projected medical inflation rate for the fiscal biennium.

(2) Achieve the limit in the growth of the per recipient per month cost of the medicaid program under division (B)(1) of this section by doing all of the following:

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

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

(c) Removing barriers that impede medicaid recipients' ability to transfer to lower cost, and more appropriate, medicaid services, including home and community-based services;

(d) Establishing medicaid payment rates that encourage value over volume and result in medicaid services being provided in the most efficient and effective manner possible;

(e) Implementing fraud and abuse prevention and cost avoidance mechanisms to the fullest extent possible;

(f) Integrating in the care management system established under section 5167.03 of the Revised Code the delivery of physical health, behavioral health, nursing facility, and home and community-based services covered by medicaid.

(3) Reduce the prevalence of comorbid health conditions among, and the mortality rates of, medicaid recipients;

(4) Reduce infant mortality rates among medicaid recipients.

(C) The medicaid director shall implement the reforms under this section in accordance with evidence-based strategies that include measurable goals.

(D) 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 an exchange.

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

(A) Improve the health of medicaid recipients through the use of population health measures;

(B) Reduce health disparities, including, but not limited to, those within racial and ethnic populations.

Sec. 5163.01. As used in this chapter:

"Caretaker relative" has the same meaning as in 42 C.F.R. 435.4 as that regulation is amended effective January 1, 2014.

"Children's hospital" has the same meaning as in section 2151.86 of the Revised Code.

"Federal financial participation" has the same meaning as in section 5160.01 of the Revised Code.

"Federally qualified health center" has the same meaning as in the "Social Security Act," section 1905(l)(2)(B), 42 U.S.C. 1396d(l)(2)(B).

"Federally qualified health center look-alike" has the same meaning as in section 3701.047 of the Revised Code.

"Federal poverty line" has the same meaning as in section 5162.01 of the Revised Code.

"Healthy start component" has the same meaning as in section 5162.01 of the Revised Code.

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

"Intermediate care facility for individuals with intellectual disabilities" and "ICF/IID" have the same meanings as in section 5124.01 of the Revised Code.

"Mandatory eligibility groups" means the groups of

individuals that must be covered by the medicaid state plan as a condition of the state receiving federal financial participation for the medicaid program.

"Medicaid buy-in for workers with disabilities program" means the component of the medicaid program established under sections 5163.09 to ~~5163.0910~~ 5163.098 of the Revised Code.

"Medicaid services" has the same meaning as in section 5164.01 of the Revised Code.

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

"Nursing facility" and "nursing facility services" have the same meanings as in section 5165.01 of the Revised Code.

"Optional eligibility groups" means the groups of individuals who may be covered by the medicaid state plan or a federal medicaid waiver and for whom the medicaid program receives federal financial participation.

"Other medicaid-funded long-term care services" has the meaning specified in rules adopted under section 5163.02 of the Revised Code.

"Supplemental security income program" means the program established by Title XVI of the "Social Security Act," 42 U.S.C. 1381 et seq.

Sec. 5163.06. The medicaid program shall cover all of the following optional eligibility groups:

(A) The group consisting of children placed with adoptive parents who are specified in the "Social Security Act," section 1902(a)(10)(A)(ii)(VIII), 42 U.S.C. 1396a(a)(10)(A)(ii)(VIII);

(B) Subject to section 5163.061 of the Revised Code, the group consisting of women during pregnancy and the sixty-day

period beginning on the last day of the pregnancy, infants, and children who are specified in the "Social Security Act," section 1902(a)(10)(A)(ii)(IX), 42 U.S.C. 1396a(a)(10)(A)(ii)(IX);

(C) Subject to sections 5163.09 to ~~5163.0910~~ 5163.098 of the Revised Code, the group consisting of employed individuals with disabilities who are specified in the "Social Security Act," section 1902(a)(10)(A)(ii)(XV), 42 U.S.C. 1396a(a)(10)(A)(ii)(XV);

(D) Subject to sections 5163.09 to ~~5163.0910~~ 5163.098 of the Revised Code, the group consisting of employed individuals with medically improved disabilities who are specified in the "Social Security Act," section 1902(a)(10)(A)(ii)(XVI), 42 U.S.C. 1396a(a)(10)(A)(ii)(XVI);

(E) The group consisting of independent foster care adolescents who are specified in the "Social Security Act," section 1902(a)(10)(A)(ii)(XVII), 42 U.S.C. 1396a(a)(10)(A)(ii)(XVII);

(F) The group consisting of women in need of treatment for breast or cervical cancer who are specified in the "Social Security Act," section 1902(a)(10)(A)(ii)(XVIII), 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII);

(G) The group consisting of nonpregnant individuals who may receive family planning services and supplies and are specified in the "Social Security Act," section 1902(a)(10)(A)(ii)(XXI), 42 U.S.C. 1396a(a)(10)(A)(ii)(XXI).

Sec. 5163.09. (A) As used in sections 5163.09 to ~~5163.0910~~ 5163.098 of the Revised Code:

"Applicant" means an individual who applies to participate in the medicaid buy-in for workers with disabilities program.

"Earned income" has the meaning established by rules authorized by section 5163.098 of the Revised Code.

"Employed individual with a medically improved disability" has the same meaning as in the "Social Security Act," section 1905(v), 42 U.S.C. 1396d(v).

"Family" means an applicant or participant and the spouse and dependent children of the applicant or participant. If an applicant or participant is under eighteen years of age, "family" also means the parents of the applicant or participant.

"Health insurance" has the meaning established by rules authorized by section 5163.098 of the Revised Code.

"Income" means earned income and unearned income.

"Participant" means an individual who has been determined eligible for the medicaid buy-in for workers with disabilities program and is participating in the program.

"Resources" has the meaning established by rules authorized by section 5163.098 of the Revised Code.

"Spouse" has the meaning established ~~in~~ by rules authorized by section 5163.098 of the Revised Code.

"Unearned income" has the meaning established by rules authorized by section 5163.098 of the Revised Code.

(B) The medicaid program's coverage of the optional eligibility groups specified in the "Social Security Act," section 1902(a)(10)(A)(ii)(XV) and (XVI), 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and (XVI) shall be known as the medicaid buy-in for workers with disabilities program.

Sec. 5164.911. (A) If the medicaid director implements the integrated care delivery system and except as provided in division ~~(D)~~(C) of this section, the director shall annually evaluate all of the following:

(1) The health outcomes of ICDS participants;

(2) How changes to the administration of the ICDS affect all of the following:

(a) Claims processing;

(b) The appeals process;

(c) The number of reassessments requested;

(d) Prior authorization requests for services.

(3) The provider panel selection process used by medicaid managed care organizations participating in the ICDS.

(B) When conducting an evaluation under division (A) of this section, the director shall do all of the following:

(1) For the purpose of division (A)(1) of this section, do both of the following:

(a) Compare the health outcomes of ICDS participants to the health outcomes of individuals who are not ICDS participants;

(b) Use both of the following:

(i) A control group consisting of ICDS participants who receive health care services from providers not participating in ICDS;

(ii) A control group consisting of ICDS participants who receive health care services from alternative providers that are not part of a participating medicaid managed care organization's provider panel but provide health care services in the geographic service area in which ICDS participants receive health care services.

(2) For the purpose of division (A)(2) of this section, do all of the following:

(a) To the extent the data is available, use data from all of the following:

(i) The fee-for-service component of the medicaid program;

(ii) Medicaid managed care organizations;

(iii) Managed care organizations participating in the medicare advantage program established under Part C of Title XVIII of the "Social Security Act," 42 U.S.C. 1395w-21 et seq.

(b) Identify all of the following:

(i) Changes in the amount of time it takes to process claims and the number of claims denied and the reasons for the changes;

(ii) The impact that changes to the administration of the ICDS had on the appeals process and number of reassessments requested;

(iii) The number of prior authorization denials that were overturned and the reasons for the overturned denials.

(3) Require medicaid managed care organizations participating in the ICDS to submit to the director any data the director needs for the evaluation.

(C) ~~Not later than the first day of each July, the director shall complete a report of the evaluation conducted under this section. The director shall provide a copy of the report to the general assembly in accordance with section 101.68 of the Revised Code and make the report available to the public.~~

~~(D)~~ The director is not required to conduct an evaluation under this section for a year if the same evaluation is conducted for that year by an organization under contract with the United States department of health and human services.

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

Section 2. That existing sections 191.02, 5162.01, 5162.13,

5162.131, 5162.132, 5162.20, 5163.01, 5163.06, 5163.09, 5163.0910, and 5164.911 of the Revised Code are hereby repealed.

Section 3. That sections 101.39, 101.391, and 5163.099 of the Revised Code are hereby repealed.

Section 4. That Section 323.90 of Am. Sub. H.B. 59 of the 130th General Assembly be amended to read as follows:

Sec. 323.90. JOINT ~~LEGISLATIVE~~ MEDICAID OVERSIGHT COMMITTEE ~~FOR UNIFIED LONG-TERM SERVICES AND SUPPORTS~~ STUDY

(A) ~~The Joint Legislative Committee for Unified Long-Term Services and Supports created under section 309.30.73 of Am. Sub. H.B. 153 of the 129th General Assembly, as subsequently amended, shall continue to exist during fiscal year 2014 and fiscal year 2015. The Committee shall consist of the following members:~~

~~(1) Two members of the House of Representatives from the majority party, appointed by the Speaker of the House of Representatives;~~

~~(2) One member of the House of Representatives from the minority party, appointed by the Speaker of the House of Representatives;~~

~~(3) Two members of the Senate from the majority party, appointed by the President of the Senate;~~

~~(4) One member of the Senate from the minority party, appointed by the President of the Senate.~~

~~(B) The Speaker of the House of Representatives shall designate one of the members of the Committee appointed under division (A)(1) of this section to serve as co-chairperson of the Committee. The President of the Senate shall designate one of the members of the Committee appointed under division (A)(3) of this~~

~~section to serve as the other co-chairperson of the Committee. The Committee shall meet at the call of the co-chairpersons. The co-chairpersons may request assistance for the Committee from the Legislative Service Commission.~~

~~(C)~~ The Joint Medicaid Oversight Committee may examine the following issues:

(1) The implementation of the dual eligible integrated care demonstration project authorized by section 5164.91 of the Revised Code;

(2) The implementation of a unified long-term services and support Medicaid waiver component under section 5166.14 of the Revised Code;

(3) Providing consumers choices regarding a continuum of services that meet their health-care needs, promote autonomy and independence, and improve quality of life;

(4) Ensuring that long-term care services and supports are delivered in a cost-effective and quality manner;

(5) Subjecting county homes, county nursing homes, and district homes operated pursuant to Chapter 5155. of the Revised Code to the franchise permit fee under sections 5168.40 to 5168.56 of the Revised Code;

(6) Other issues of interest to the committee.

~~(D)~~(B) The ~~co-chairpersons of the~~ Committee chairperson shall provide for the Medicaid Director to testify before the Committee at least quarterly regarding the issues that the Committee examines.

Section 5. That existing Section 323.90 of Am. Sub. H.B. 59 of the 130th General Assembly is hereby repealed.

Section 6. 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, 2015.

Section 7. The General Assembly encourages the Department of Medicaid to achieve greater cost savings for the Medicaid program than required by section 5162.70 of the Revised Code. It is the intent of the General Assembly that any amounts saved under that section not be expended for any other purpose.

Section 8. Nothing in this act shall be construed as the General Assembly endorsing, validating, or otherwise approving the Medicaid program's coverage 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).

Section 9. 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 created by section 103.41 of the Revised Code.

Section 10. 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.