Ohio Legislative Service Commission

Bill Analysis

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H.B. 176

130th General Assembly
(As Introduced)

Rep. Sears

BILL SUMMARY

- Requires the Medical Assistance Director, subject to any necessary federal approval, to implement reforms to the Medicaid program that are intended to meet specified goals.
- Requires the Director to submit to the General Assembly annual reports on the progress being made in implementing the reforms.
- Regarding the eligibility group authorized by the Patient Protection and Affordable Care Act that is popularly known as the Medicaid expansion, expressly permits Medicaid to cover the group or one or more subgroups if the federal match available for the group or subgroup is at least the amount specified in federal law as of March 30, 2010, and the Medicaid program is able to cover the group or subgroup in a manner that causes per recipient Medicaid expenditures to be reduced.
- Requires Medicaid to stop covering the Medicaid expansion group, and any subgroup, if the federal match available for the group or subgroup is reduced below the amount specified in federal law as of March 30, 2010.
- Creates the Ohio Medicaid Reform Fund and requires that all federal funds the state receives for the federal share of Medicaid expenditures for the expansion group or subgroups be deposited into the Fund.
- Specifies that the reforms to be implemented under the bill are the reforms that the Joint Legislative Committee on Medicaid Technology and Reform is to give priority in studying or reviewing.
- Requires the Committee to meet at least once each quarter.
- Makes an appropriation.

CONTENT AND OPERATION

Medicaid reforms

Subject to any necessary federal approval, the bill requires the Medical Assistance Director to implement reforms to the Medicaid program that do all of the following:

(1) Improve the health of Medicaid recipients while reducing the cost of health care and uncompensated health care costs;

(2) Control Medicaid expenditures and reduce the rate of increase in expenditures;

(3) Enroll at least 80% of Medicaid recipients in any of the following: (a) the Medicaid care management system, (b) group health plans, (c) a Medicaid component that provides premium assistance for qualified employer-sponsored coverage to Medicaid recipients under age 19 and their parents, (d) a Medicaid component established in accordance with the federal definition of "medical assistance" that provides payments for insurance premiums for medical or other remedial care for Medicaid recipients (other than recipients who are at least age 65 and recipients who are disabled and entitled to health insurance benefits under the Medicare program but not enrolled under Medicare Part B), and (e) a Medicaid waiver component that provides premium assistance for Medicaid recipients to purchase qualified health plans through a Health Benefits Exchange set up under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (referred to collectively as the Affordable Care Act (ACA));[1]

(4) Require Medicaid recipients to assume greater personal responsibility under both the cost-sharing program instituted under continuing law and a Medicaid component that incorporates the objectives of health savings accounts through value-based insurance designs;

(5) Ensure that Medicaid recipients who abuse narcotics receive proper treatment and are unable to access the narcotics they abuse through the health care system;

(6) Promote employment-related services and job training available under Medicaid and other programs to lower Medicaid caseloads by assisting able-bodied, adult Medicaid recipients into the workforce;

[1] Pub. Law 111-148 and Pub. Law 111-152.

(7) Make the administration of the Medicaid program more efficient and establish the state as a national leader in preventing Medicaid fraud and abuse;

(8) Support health care payment innovations in the private sector by assisting other purchasers of health care services and health care providers by leveraging the Medicaid program's purchasing power.[2]

Implementation of reforms

The Director is required to implement these reforms in accordance with (1) the Medicaid state plan (including amendments to the plan), (2) federal Medicaid waivers (including amendments to such waivers), (3) other types of federal approval (including demonstration grants) that establish requirements for the reforms, (4) except as otherwise authorized by a federal Medicaid waiver, all applicable federal statutes, regulations, and policy guidances, and (5) all applicable state statutes. The Director must seek federal approval for all of the reforms that require federal approval. None of the reforms that require federal approval are to be implemented without it; however, a reform that requires federal approval may begin to be implemented before approval if federal law permits implementation to begin before approval. Implementation must stop if federal approval is ultimately denied.[3]

Reporting requirement

The Director must prepare reports on the progress being made in implementing the reforms. A report may include recommendations for legislation that would support the reforms. The first report is to be submitted to the General Assembly not later than December 31, 2014, and subsequent reports are to be submitted to the General Assembly not later than the last day of each calendar year thereafter.[4]

Medicaid expansion

The ACA includes a major expansion of the Medicaid program. As enacted, the ACA required state Medicaid programs to cover, beginning January 1, 2014, individuals who are (1) under age 65, (2) not pregnant, (3) not entitled to (or enrolled for) benefits under Medicare Part A, (4) not enrolled for benefits under Medicare Part B, (5) not otherwise eligible for Medicaid, and (6) have incomes not exceeding 133% of the federal poverty line (138% after using individuals' modified adjusted gross incomes).[5]

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[2] R.C. 5111.80.

[3] R.C. 5111.801.

[4] R.C. 5111.802.

[5] 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) and (e)(14).

Although the ACA made Medicaid expansion mandatory, the U.S. Supreme Court effectively made expansion optional by prohibiting the U.S. Secretary of Health and Human Services from withholding all or part of a state's federal Medicaid funds for failure to implement the expansion.[6]

The bill permits the Medicaid program to cover the expansion group (or one or more subgroups of the group) if (1) the federal match for the expenditures for Medicaid services provided to the group or subgroup is at least the amount specified in federal law as of March 30, 2010 (the date the ACA was ultimately signed into law), and (2) the Medicaid program is able to cover the group or subgroup in a manner that causes per recipient Medicaid expenditures to be reduced.[7] The following are the applicable amounts of the federal match:

(1) 100% of the expenditures for calendar years 2014, 2015, and 2016;

(2) 95% of the expenditures for calendar year 2017;

(3) 94% of the expenditures for calendar year 2018;

(4) 93% of the expenditures for calendar year 2019;

(5) 90% of the expenditures for calendar year 2020 and each calendar year thereafter.[8]

Under the bill, the Medicaid program must stop covering the expansion group, and any subgroup of the group, if the federal match for expenditures for Medicaid services provided to the group or subgroup is lowered to an amount below the amount described above. An individual's disenrollment from the Medicaid program is not subject to appeal when the disenrollment is the result of this provision of the bill.

Ohio Medicaid Reform Fund

The bill creates in the state treasury the Ohio Medicaid Reform Fund.[9] All federal funds the state receives for the federal share of Medicaid expenditures for the expansion group or subgroups must be deposited into the Fund. All money in the Fund is to be used as the federal share of Medicaid expenditures for the expansion group or subgroups.

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[6] *National Federation of Independent Business v. Sebelius* (2012), 132 S.Ct. 2566.

[7] R.C. 5111.0126.

[8] 42 U.S.C. 1396d(y).

[9] R.C. 5111.947.

Joint Legislative Committee on Medicaid Technology and Reform

The bill revises existing law governing the Joint Legislative Committee on Medicaid Technology and Reform.[10] Currently, the Committee consists of five members from the House of Representatives appointed by the Speaker of the House and five members from the Senate appointed by the Senate President. The bill specifies that the Speaker and President are to appoint three members each from the majority party and two members each from the minority party.

The Committee is permitted by continuing law to study any matter that it considers relevant to the operation of the Medicaid program. Current law requires the Committee to give priority to the study or review of (1) mechanisms to enhance Medicaid's effectiveness through improved technology systems and (2) program reform. The bill specifies that the reforms that are to receive priority are the reforms to be implemented under the bill.

The bill requires the Speaker of the House to designate one of the House members of the Committee from the majority party to serve as a co-chairperson of the Committee. The Senate President is required to designate one of the Senate members of the Committee from the majority party to serve as the other co-chairperson. The co-chairpersons are required by the bill to call the Committee to meet at least once each quarter. The co-chairpersons also must arrange for the Medical Assistance Director to testify periodically (but not more than once each quarter) before the Committee regarding the reforms to be implemented under the bill. The co-chairpersons are permitted to request assistance and staff support for the Committee from the Legislative Service Commission.

HISTORY

ACTION	DATE
Introduced	05-28-13

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[10] R.C. 101.391.