



Ohio Legislative Service Commission

Bill Analysis

Bob Bennett

S.B. 206

130th General Assembly
(As Introduced)

Sen. Burke

BILL SUMMARY

- Provides that Medicaid may not cover the expansion group authorized by the Patient Protection and Affordable Care Act unless the enhanced federal match for the group is at least the amount specified in federal law as of March 30, 2010.
- Requires the Medicaid Director to implement a reform to the Medicaid program that provides for the annual growth in the per recipient per month cost of the program to be not more than the lesser of (1) the average annual increase in the inflation rate for medical care for the most recent five-year period for which the necessary data is available or (2) 3%.
- Requires the Medicaid Director to implement a reform to the Medicaid program that reduces the prevalence of comorbid health conditions among, and the mortality rates of, Medicaid recipients.
- Requires the Medicaid Director to establish a system within the Medicaid program that encourages providers to provide services to recipients in culturally and linguistically appropriate manners.
- Requires the Medicaid Director to implement within the Medicaid program systems that improve the health of recipients through the use of population health measures and reduce health disparities.
- Creates the Joint Medicaid Oversight Committee (JMOC) to oversee the Medicaid program on a continuing basis.
- Requires JMOC to (1) review how the Medicaid program relates to the public and private provision of health care coverage, (2) review the reforms the Medicaid Director is to implement, and (3) recommend policies and strategies that encourage

self-sufficiency and less use of the program and improvements in statutes and rules concerning the program.

- Permits JMOC to hold meetings to increase knowledge and understanding of, and to develop and propose improvements in, the Medicaid program.
- Requires JMOC to prepare a report with recommendations for legislation regarding Medicaid payment rates for Medicaid services.
- Abolishes the Joint Legislative Committee for Unified Long-Term Services and Supports (JLCULTSS) and authorizes JMOC to examine the issues that JLCULTSS examines.
- Abolishes the Joint Legislative Committee on Health Care Oversight, the Joint Legislative Committee on Medicaid Technology and Reform, and the Medicaid Buy-In Advisory Council.

CONTENT AND OPERATION

Restriction on Medicaid eligibility expansion

Federal law requires a state that participates in the Medicaid program to cover certain groups (mandatory eligibility groups) and permits a participating state to cover certain other groups (optional eligibility groups).¹ The federal health care reform laws enacted in 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, include a major expansion of the Medicaid program. As enacted, those laws require a state's Medicaid program to cover, beginning January 1, 2014, individuals who (1) are 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% (138% after using individuals' modified adjusted gross incomes) of the federal poverty line.² This is often called the expansion group. Although the federal health care reform laws made the expansion group a mandatory eligibility group, the U.S. Supreme Court, in its 2012 ruling on the reforms, effectively made the expansion an optional eligibility group by prohibiting the U.S. Secretary of Health and Human Services from withholding all or part of a state's other federal Medicaid funds for failure to implement the expansion.³

¹ 42 United States Code (U.S.C.) 1396a(a)(10)(A).

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

³ *National Federation of Independent Business v. Sebelius* (2012), 132 S.Ct. 2566.



Continuing state law provides that the Medicaid program may cover any optional eligibility group if state statutes expressly permit Medicaid to cover the group or state statutes do not address whether Medicaid may cover the group. Medicaid may not cover any eligibility group that state statutes prohibit Medicaid from covering.⁴

The bill provides that the Medicaid program may not cover the expansion group unless the enhanced federal match for expenditures for Medicaid services provided to the group is at least the amount specified in federal law as of March 30, 2010. The following are the amounts of the federal match as of that date:

(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.⁵

If Medicaid covers the expansion group and the enhanced federal match for the group is reduced below the amounts specified above, Medicaid must cease covering the group. An individual's disenrollment from Medicaid is not subject to appeal when the disenrollment is the result of Medicaid ceasing to cover the expansion group due to a reduction in the enhanced federal match.⁶

Medicaid reforms

The bill requires the Medicaid Director to implement certain reforms to the Medicaid program. The Director must implement the reforms in accordance with evidence-based strategies that include measurable goals. The reforms must 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 established under the Patient Protection and Affordable Care Act. This is to be achieved without making the Medicaid

⁴ R.C. 5163.03.

⁵ 42 U.S.C. 1396d(y).

⁶ R.C. 5163.04.



program's eligibility requirements more restrictive.⁷ The following are the reforms the bill requires.

Limit the growth in Medicaid's per member per month cost

The first reform must provide for the annual growth in the per recipient per month cost of the Medicaid program to be not more than the lesser of (1) the average annual increase in the inflation rate for medical care as reported in the Consumer Price Index for the most recent five-year period for which the necessary data is available as of the first day of each calendar year or (2) 3%. The per recipient per month cost is to be determined on an aggregate basis for all eligibility groups.

This reform is to be achieved in a manner that (1) improves the physical and mental health of Medicaid recipients, (2) provides for Medicaid recipients to receive Medicaid services in the most cost-effective and sustainable manner, (3) removes barriers that impede Medicaid recipients' ability to transfer to lower cost, and more appropriate, Medicaid services, including home and community-based services, (4) establishes Medicaid payment rates that encourage value over volume and result in Medicaid services being provided in the most efficient and effective manner possible, (5) implements fraud prevention and cost avoidance mechanisms to the fullest extent possible, and (6) integrates the delivery of physical and behavioral health services covered by Medicaid to the fullest extent possible.⁸

Reduce comorbid health conditions

The second reform is to reduce the prevalence of comorbid health conditions among, and the mortality rates of, Medicaid recipients.⁹

Services provided in culturally and linguistically appropriate manners

The bill requires the Medicaid Director to implement within the Medicaid program a system that encourages providers to provide Medicaid services to Medicaid recipients in culturally and linguistically appropriate manners.¹⁰

⁷ R.C. 5162.70.

⁸ R.C. 5162.01(B)(2) and 5162.70(A) and (B)(1) and (2).

⁹ R.C. 5162.70(B)(3).

¹⁰ R.C. 5164.94.

Population health measures and reduction in health disparities

The bill requires the Medicaid Director to implement within the Medicaid program systems that do both of the following:

- (1) Improve the health of Medicaid recipients through the use of population health measures;
- (2) Reduce health disparities.¹¹

Joint Medicaid Oversight Committee

The bill creates the Joint Medicaid Oversight Committee (JMOC). Funds are appropriated for JMOC's fiscal years 2014 and 2015 expenses.¹²

Composition and chairperson

JMOC is to consist of the following ten 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, three of whom are members of the majority party and two of whom are members of the minority party.

The term of each JMOC member is to begin on the day of appointment and end on the day that the member's successor on JMOC is appointed. The Senate President and Speaker are required to make the initial appointments not later than 15 days after the effective date of this provision of the bill. They are to make subsequent appointments not later than 15 days after the commencement of the first regular session of each General Assembly. JMOC members may be reappointed. A vacancy must be filled in the same manner as the original appointment.

In odd-numbered years, the Speaker must designate one of the majority members from the House as the JMOC chairperson and the Senate President must designate one of the minority members from the Senate as the JMOC ranking minority member. In even-numbered years, the Senate President must designate one of the majority members from the Senate as the JMOC chairperson and the Speaker must

¹¹ R.C. 5162.71.

¹² R.C. 103.41; Sections 7 and 8.



designate one of the minority members from the House as the JMOC ranking minority member.

The Senate President and Speaker are required to consult with the minority leader of their respective houses when appointing members from the minority and designating ranking minority members.

JMOC must meet at the call of the chairperson, but not less often than once each month.¹³

Employees and contractors

The bill requires JMOC to employ the professional, technical, and clerical employees that are necessary for JMOC to be able successfully and efficiently to perform its duties. The employees are to be in the unclassified service and serve at JMOC's pleasure. JMOC is permitted to 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.¹⁴

Subpoenas and oaths

The JMOC chairperson, when authorized by JMOC and the Senate 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 Ohio to appear before JMOC to testify at a time and place designated in the subpoena. A subpoena duces tecum may require witnesses or other persons in any part of Ohio 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 is to be issued, served, and returned, and has consequences, as specified in continuing law governing subpoenas issued by the chairperson of a standing or select committee of the Senate or House.

The bill permits the JMOC chairperson to administer oaths to witnesses appearing before JMOC.¹⁵

¹³ R.C. 103.41(A) through (F).

¹⁴ R.C. 103.41(G).

¹⁵ R.C. 103.41(H) and (I).

Continuing oversight of the Medicaid program

The bill requires JMOC to oversee the Medicaid program on a continuing basis. As part of its oversight, JMOC must do all of the following:

- (1) Review how the Medicaid program relates to the public and private provision of health care coverage in Ohio and the United States;
- (2) Review the reforms that the bill requires the Medicaid Director to implement and evaluate the reforms' successes in achieving their objectives; (See "**Medicaid reforms**," above.)
- (3) Recommend policies and strategies to encourage Medicaid recipients becoming more self-sufficient and to encourage less use of the Medicaid program;
- (4) Recommend, to the extent JMOC determines appropriate, improvements in statutes and rules concerning the Medicaid program.¹⁶

JMOC is permitted to 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 JMOC's reports.¹⁷

Medicaid Director to appear before JMOC

JMOC is permitted by the bill to request that the Medicaid Director appear before JMOC to provide information and answer questions about the Medicaid program. If so requested, the Director must appear before JMOC at the time and places specified in the request.¹⁸

¹⁶ R.C. 103.411(A).

¹⁷ R.C. 103.411(B).

¹⁸ R.C. 103.412.

Report regarding Medicaid payment rates

The bill requires JMOC to prepare a report with recommendations for legislation regarding Medicaid payment rates for Medicaid services. The goal of the recommendations is to give 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 must assist JMOC with the report. JMOC is to submit the report to the General Assembly not later than January 1, 2014.¹⁹

JMOC to assume duties regarding unified long-term care services

The Joint Legislative Committee for Unified Long-Term Services and Supports is created in state statute and permitted to examine the following issues:

(1) The implementation of the Dual Eligible Integrated Care Demonstration Project;

(2) The implementation of a unified long-term services and support Medicaid waiver program;

(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) Subjecting county and district homes to the nursing home franchise permit fee;

(5) Other issues of interest to the Committee.

The bill abolishes the Committee and authorizes JMOC to examine these issues.²⁰

JMOC to receive Department of Medicaid reports

Continuing law requires the Department of Medicaid and the Medicaid Director to prepare reports on the following:

(1) The effectiveness of the Medicaid program in meeting the health care needs of low-income pregnant women, infants, and children;

¹⁹ Section 6. An amendment may be needed to change the report's January 1, 2014, due date.

²⁰ Sections 4 and 5.



(2) The establishment and implementation of programs designed to control the increase of the Medicaid program's costs, increase the Medicaid program's efficiency, and promote better health outcomes;

(3) The Department's efforts to minimize fraud, waste, and abuse in the Medicaid program;

(4) The Medicaid Buy-In for Workers with Disabilities program;

(5) The Integrated Care Delivery System.

The bill requires that JMOC receive copies of these reports. The bill also conforms provisions of current law regarding submission of the reports to members of the General Assembly with continuing law that establishes a general procedure for submitting reports to the General Assembly.²¹

Committees and council abolished

The bill abolishes the Joint Legislative Committee on Health Care Oversight, the Joint Legislative Committee on Medicaid Technology and Reform, and the Medicaid Buy-In Advisory Council.²²

Under current law, the Joint Legislative Committee on Health Care Oversight is permitted to review or study any matter related to the provision of health care services that it considers of significance to the citizens of Ohio, including the availability of health care, the quality of health care, the effectiveness and efficiency of managed care systems, and the operation of the Medicaid program or other government health programs.

The Joint Legislative Committee on Medicaid Technology and Reform is authorized by current law to review or study any matter that it considers relevant to the operation of the Medicaid program. Priority must be given to the review or study of mechanisms to enhance the program's effectiveness through improved technology systems and program reform.

The Medicaid Buy-In Advisory Council was created to consult with the Department of Job and Family Services before the adoption, amendment, or rescission of rules governing the Medicaid Buy-In for Workers with Disabilities program. (The Department of Medicaid is now responsible for Medicaid rules.) The Council also was

²¹ R.C. 5162.13, 5162.131, 5162.132, 5162.133, 5162.134, 5163.01, 5163.06, 5163.09, and 5164.911.

²² R.C. 101.39, 101.391, and 5163.099 (all repealed).



charged with providing the Department suggestions for improving the program. Sub. S.B. 171 of the 129th General Assembly previously repealed the laws creating the Council and governing its duties. However, a few days after enacting S.B. 171, the 129th General Assembly enacted the biennial budget act, Am. Sub. H.B. 153, which amended the law creating the Council, but did not amend the law governing the Council's duties. The Legal Review and Technical Services staff of the Legislative Service Commission has concluded that the law creating the Council was not repealed because H.B. 153 is the later enactment. (There is no dispute that the law governing the Council's duties has been repealed.) This means that the Council exists in current law but has no specified duties.

HISTORY

ACTION	DATE
Introduced	10-10-13

S0206-I-130.docx/ks

