Ohio Legislative Service Commission

Bill Analysis

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Sub. S.B. 206*

130th General Assembly
(As Reported by S. Finance)

Sen. Burke

BILL SUMMARY

- Requires the Medicaid Director to implement a reform to the Medicaid program that limits the growth in the per recipient per month cost of the program.
- States that the General Assembly encourages the Department of Medicaid to achieve greater cost savings for the Medicaid program than is required to be achieved under the reform and that it is the General Assembly's intent that any amounts saved under the reform not be expended for any other purpose.
- 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.
- Eliminates requirements that the Medicaid cost-sharing program include (1) copayments for at least dental services, vision services, nonemergency emergency department services, and prescribed drugs and (2) premiums, enrollment fees, deductions, and similar charges.

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* This analysis was prepared before the report of the Senate Finance Committee appeared in the Senate Journal. Note that the list of co-sponsors and the legislative history may be incomplete.

- Prohibits the Medicaid cost-sharing program from being instituted in a manner that disproportionately impacts the ability of Medicaid recipients with chronic illnesses to obtain medically necessary Medicaid services.

- 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.

- Permits JMOC to investigate the Department of Medicaid, Office of Health Transformation, and each other government agency of the state or a political subdivision that administers part of the Medicaid program and, as necessary for the conduct of an investigation, to inspect the offices of the Department, Office, or agency if the JMOC chairperson gives prior approval for the inspection.

- Permits JMOC to review bills and resolutions regarding the Medicaid program and to submit a report of its review that includes JMOC's determination regarding the bill's or resolution's desirability as a matter of public policy.

- 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.

- Requires the Executive Director of the Office of Health Transformation to adopt strategies that prioritize employment as a goal for individuals participating in government programs providing public benefits.

- States that nothing in the bill is to be construed as the General Assembly endorsing, validating, or otherwise approving the Medicaid program's coverage of the expansion group authorized by the Patient Protection and Affordable Care Act.

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CONTENT AND OPERATION

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 program's eligibility requirements more restrictive.[1] The following are the reforms the bill requires.

[1] R.C. 5162.70.

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

The first reform must provide for the growth in the per recipient per month cost of the Medicaid program for a fiscal biennium to be not more than the lesser of (1) the average annual increase in the inflation rate for medical care for the Midwest Region as reported in the Consumer Price Index 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 or (2) the projected medical inflation rate determined by an actuary under contract with the Joint Medicaid Oversight Committee or, if the Committee disagrees with the actuary's rate, the projected medical inflation rate the Committee determines. (See "**Joint Medicaid Oversight Committee**," below.) 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 and abuse prevention and cost avoidance mechanisms to the fullest extent possible, and (6) integrates in the Medicaid care management system the delivery of physical, health, behavioral health, nursing facility, and home and community-based services covered by Medicaid.[2] (See **COMMENT**.)

The bill states that the General Assembly encourages the Department of Medicaid to achieve greater cost savings for the Medicaid program than is required to be achieved under the reform. The bill also states that it is the General Assembly's intent that any amounts saved under the reform not be expended for any other purpose.[3]

Reduce comorbid health conditions

The second reform is to reduce the prevalence of comorbid health conditions among, and the mortality rates of, Medicaid recipients.[4]

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[2] R.C. 5162.70(A) and (B)(1) and (2) (primary) and 5162.01.

[3] Section 7.

[4] R.C. 5162.70(B)(3).

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.[5]

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, including, but not limited to, those within racial and ethnic populations.[6]

Medicaid cost sharing requirements

Current law requires the Department of Medicaid to institute a cost-sharing program for the Medicaid program. The bill eliminates requirements that the cost-sharing program include (1) a copayment requirement for at least dental services, vision services, nonemergency emergency department services, and prescribed drugs and (2) requirements regarding premiums, enrollment fees, deductions, and similar charges. Additionally, the bill prohibits the Department from instituting the cost-sharing program in a manner that disproportionately impacts the ability of Medicaid recipients with chronic illnesses to obtain medically necessary Medicaid services.[7]

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.[8]

Composition and chairperson

JMOC is to consist of the following ten members:

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[5] R.C. 5164.94.

[6] R.C. 5162.71.

[7] R.C. 5162.20.

[8] R.C. 103.41; Sections 9 and 10.

(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 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 Senate President) during the General Assembly for which the member 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. However, if this provision's effective date is before January 1, 2014, the Senate President and Speaker must make the initial appointments during the period beginning January 1, 2014, and ending January 15, 2015. 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 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. The chairperson must call JMOC to meet not less often than once each month, unless the chairperson and ranking minority member agree that the chairperson should not call JMOC to meet for a particular month.[9]

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[9] R.C. 103.41(A) through (F).

Employees and contractors

The bill permits 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.[10]

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.[11]

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.[12]

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:

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[10] R.C. 103.41(G).

[11] R.C. 103.41(H) and (I).

[12] R.C. 103.411.

(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 (a) Medicaid recipients being physically and mentally able to join and stay in the workforce and ultimately becoming more self-sufficient and (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.[13]

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.[14]

JMOC investigations of government Medicaid agencies

The bill permits JMOC to investigate the Department of Medicaid, the Office of Health Transformation, and each other government agency of the state or a political subdivision that administers part of the Medicaid program. JMOC, including its employees, may inspect the offices of the Department, Office, or agency as necessary for the conduct of an investigation if the JMOC chairperson grants prior approval. The chairperson may not grant such approval unless JMOC, the Senate President, and Speaker authorize the chairperson to grant the approval. The bill prohibits persons from denying JMOC or a JMOC employee access to the office of the Department, Office, or agency when access is needed for an inspection.

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[13] R.C. 103.412(A).

[14] R.C. 103.412(B).

Neither JMOC nor a JMOC employee is required to give advance notice of, or to make prior arrangements before, an inspection. An inspection must be conducted during normal business hours of the office being inspected, unless the JMOC 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 such a determination is made, the chairperson must specify the reason in the grant of prior approval for the inspection.[15]

Determination of projected medical inflation rate

The bill requires JMOC, before the beginning of each fiscal biennium, to contract with an actuary to determine the projected medical inflation rate for the upcoming fiscal biennium. The contract must require the actuary to make the determination using the same types of classifications and sub-classifications of medical care that the U.S. Bureau of Labor Statistics uses in determining the inflation rate for medical care in the Consumer Price Index. The contract also must require the actuary to provide JMOC a report with its determination at least 120 days before the Governor is required, under continuing law, to submit to the General Assembly a state budget for the fiscal biennium.

JMOC is required, on receipt of the actuary's report, to determine whether it agrees with the actuary's projected medical inflation rate. If JMOC disagrees, JMOC must 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 must determine the projected medical inflation rate for Ohio unless that is not practicable. If it is not practicable, the determination is to be made for the Midwest Region.

Regardless of whether JMOC agrees with the actuary's projected medical inflation rate or determines a different rate, JMOC is required to complete a report regarding the rate. JMOC must include a copy of the actuary's report in its report and state whether JMOC agrees with the actuary's projected medical inflation rate and, if JMOC disagrees, the reason why JMOC disagrees and the different rate JMOC determined. At least 90 days before the Governor must submit a state budget to the

[15] R.C. 103.413 (primary) and 103.41(A)(2).

General Assembly for the upcoming fiscal biennium, JMOC is to submit a copy of the JMOC report to the General Assembly, Governor, and Medicaid Director.[16]

Review of bills and resolutions

JMOC is permitted to review bills and resolutions regarding the Medicaid program that are introduced in the General Assembly. JMOC may submit a report of its review to the General Assembly and the report may include JMOC's determination regarding the bill's or resolution's desirability as a matter of public policy. The bill specifies that 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.[17]

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, 2015.[18]

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;

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[16] R.C. 103.414.

[17] R.C. 103.415.

[18] Section 6.

(5) Other issues of interest to the Committee.

The bill abolishes the Committee and authorizes JMOC to examine these issues.[19]

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;

(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.[20]

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.[21]

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

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[19] Sections 4 and 5.

[20] R.C. 5162.13, 5162.131, 5162.132, 5162.133, 5162.134, 5163.01, 5163.06, 5163.09, and 5164.911.

[21] R.C. 101.39, 101.391, and 5163.099 (all repealed).

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 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.

Government programs to prioritize employment goal

The bill requires the Executive Director of the Office of Health Transformation to adopt strategies that prioritize employment as a goal for individuals participating in government programs providing public benefits. Continuing law requires the Executive Director to identify such government programs.[22]

Construction of bill regarding Medicaid eligibility expansion

The bill states that nothing in it is to be construed as the General Assembly endorsing, validating, or otherwise approving the Medicaid program's coverage of the expansion group authorized by the Patient Protection and Affordable Care Act.[23] That group consists of 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

[22] R.C. 191.08 (primary) and 191.02.

[23] Section 8.

exceeding 133% (138% after using individuals' modified adjusted gross incomes) of the federal poverty line.[24]

COMMENT

The bill's provision regarding the integration of home and community-based services in the Medicaid care management system conflicts to a degree with current law that the bill does not amend. Current law limits the Department of Medicaid's authority to designate which eligibility groups and services are to be part of the care management system. The Department may not designate individuals who receive Medicaid on the basis of being aged, blind, or disabled to the extent they receive Medicaid services through a Medicaid waiver program. However, the Department may designate individuals who, as an alternative to receiving nursing facility services, participate in a Medicaid waiver program providing home and community-based services.[25] To give simultaneous effect to the bill's provision and current law, it appears that only home and community-based services provided under a Medicaid waiver program as an alternative to nursing facility services may be integrated into the care management system as part of achieving the bill's reform limiting cost growth.

HISTORY

ACTION	DATE
Introduced	10-10-13
Reported, S. Finance	---

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[24] 42 United States Code 1396a(a)(10)(A)(i)(VIII) and (e)(14).

[25] R.C. 5167.03(C), not in the bill.