To: The Joint Medicaid Oversight Committee

From: David E. Burke, R.Ph. MBA

Date: June 26, 2025

Re: Origin and Background of JMOC

Chairman Holmes and Members of the Joint Medicaid Oversight Committee,

I am David Burke, and I had the privilege of serving in both the Ohio House and Senate. Having served on the Finance Committee in both the House and Senate plus my background as a pharmacist and Medicaid provider, I was uniquely positioned to assist my colleagues with the challenges and opportunities of a large health system such as Medicaid. That service peaked with the creation of The Joint Medicaid Oversight Committee.

The Joint Medicaid Oversight Committee (JMOC) was started by Senator Capri Cafaro and I through Senate Bill 206 of the 130th General Assembly and effective date March 20, 2014. As you know, JMOC is a bicameral and bipartisan oversight committee.

The origin of JMOC resulted from actions taken by then Governor Kasich in October 2013 which expanded Medicaid coverage under the Affordable Care Act. However, the groundwork for JMOC rests upon the limited engagement of the General Assembly in dealing with Medicaid outside of a budget process. To give you a historic prospective, I would ask you to look past my testimony and into an LSC document from 2018 with the initial page titled *Department of Medicaid Disburses the Majority of Payments for Ohio Medicaid* with starting page number 69 noted in the lower right corner. Using that page reference, if you could then turn to page 71 and the chart titled *Medicaid Caseloads Continue to Increase* followed by page 74 and the chart titled *Medicaid Expenditures Almost Doubled Since FY 2008*. Both these charts give you a quick glance into historic data within the 2008 to 2018 time period. Please know this is a Legislative Service Commission (LSC) document. Next, I would ask you to look at the following document titled *Ohio's Medicaid Financial Landscape and FMAP* from January 2, 2025. If you turn to page 4 with the title *Historical Medicaid spending* and examine the chart titled *Medicaid Expenditures* (in billions), FY 2015 to 2024 gives you a more recent view of Medicaid spending. Again, this is another LSC document.

As you saw in the first document, Medicaid spending was experiencing a substantial growth rate until FY16, when the first JMOC rate tools effect. Moving forward and turning to the second document and same chart parameters, you can also see where this rate of

spending somewhat levels through FY20 then resumes its prior growth rate in FY21forward. The point in reviewing these documents is not to criticize Medicaid policy or debate caseloads. Rather, as was the case in 2013, it is to reawaken the authority of the General Assembly in the budget and policy process.

My time in the General Assembly began in 2009. Serving on House Finance and the Finance Medicaid Subcommittee on the budget, I can tell you firsthand the legislature had limited knowledge and engagement with the Medicaid budget. This was true regardless of who was Governor or who controlled a chamber. It was not until the Affordable Care Act (ACA) that a true interest occurred. Governor Kasich's use of the ACA to extend Medicaid coverage to more Ohioans caused a recoil by some members of the House and Senate. There was handwringing over future costs, increased expenditures after the enhanced Federal match (eFMP) degraded, and concern on how state share spending would be impacted in future years.

The ACA expansion did occur, and the General Assembly was now positioned to handle the impact of the Governor's policy in the subsequent budget. Thinking back to the prior chart with Medicaid expenses before the Medicaid expansion, the rate of annual growth significantly exceeded the rate of inflation, year after year. This rate of growth projected forward became known as the "do nothing line" if pictured on a chart. The question then became whether the expanded population remained in Medicaid and if the rate of growth of Medicaid could be tamed to match the medical rate of inflation, what would that line look like and would it ever drop below the 'do nothing line'. While my notes of a decade ago escaped me today, I can tell you those lines did cross, and it occurred around FY19.

This is why the JMOC rate is a critical component to maintain a reasonable rate of growth within Medicaid. Having your own actuarial rate and not that of the Medicaid Department is a vital component of keeping spending under control. While much legislative discussion is cast upon Medicaid spending by the Department itself, I have never encountered a state budget where the General Assembly lowered Medicaid spending versus the Governor's proposed budget. The JOMC rate serves both an internal and external function in maintaining state spending, maximizing taxpayer value, and driving recipient outcomes. The burden rests with both Medicaid and the General Assembly itself to oversee the program.

Fiscal impacts aside, Medicaid is a complex administrative department. Term Limits and legislator turnover have deeply harmed the institutional knowledge that once existed in the General Assembly. Overcoming this was another function of JMOC. For legislators with an interest in Medicaid, JMOC provides a venue beyond the budget process for them to learn and understand. Medicaid operates under state law, both funding and policy. The General

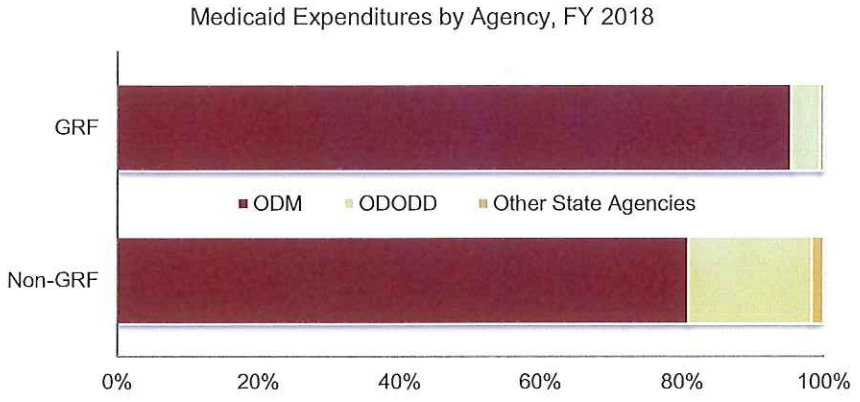
Assembly often adds programs to Medicaid but rarely looks back to measure if the desired outcome was achieved. JMOC gives legislators the information they need to make critical choices of continuing, altering or ending programs outside of Federal law.

Legislators, Medicaid Directors, and Governors change, but processes that encourage informed choices with standardized metrics should be preserved beyond our own tenure of public service. Maintaining the JMOC rate using your own actuary is critical to hold both the Department and the General Assembly accountable. Having the Medicaid Director explain policy outcomes, enrollment and utilization data, and to answer your questions are key to gaining a working knowledge and relationship with Medicaid. This is not personal, its people: those who receive and those who pay taxes. While Republicans and Democrats often differ on Medicaid program efficiency and use different metrics in that judgement, we both agree a functional and sustainable system is required to drive any outcome. Such a task owes itself to a cooperative environment to which JMOC was originally established.

Most respectfully,

David E. Burke, R.Ph, MBA

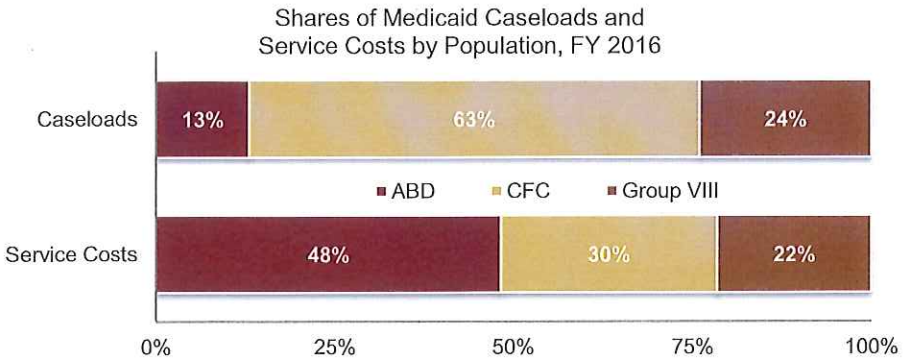
Department of Medicaid Disburses the Majority of Payments for Ohio Medicaid



Source: Ohio Administrative Knowledge System

- GRF Medicaid expenditures were $14.48 billion in FY 2018, of which 95.3% ($13.81 billion) was disbursed by the Ohio Department of Medicaid (ODM). Non-GRF Medicaid expenditures were $11.86 billion in FY 2018, of which 80.9% ($9.59 billion) was disbursed by ODM. Across all funds, Medicaid expenditures totaled $26.34 billion. ODM accounted for 88.8% of this total.
- Ohio Medicaid is administered by ODM with the assistance of seven other state agencies – Developmental Disabilities, Job and Family Services, Mental Health and Addiction Services, Health, Aging, Education, and the Pharmacy Board – as well as various local entities.
- The Ohio Department of Developmental Disabilities (ODODD) had the second largest share of Medicaid expenditures, accounting for 4.0% ($583.2 million) of the GRF total, 17.4% ($2.07 billion) of the non-GRF total, and 10.1% of the all funds total. Together, ODM and ODODD accounted for 98.9% of the all funds total. The remaining 1.1% was accounted for by the other six agencies.
- GRF Medicaid expenditures are paid with a combination of state and federal resources. Of the $14.48 billion GRF Medicaid expenditures in FY 2018, $9.48 billion (65.5%) came from federal reimbursements and $5.00 billion (34.5%) was funded with state resources.
- The practice of depositing federal Medicaid reimbursements into the GRF started in FY 1976. Since then, GRF appropriations for Medicaid include both state and federal dollars.
- In FY 2018, the federal government reimbursed about 68.3% of all Medicaid expenditures. The state was responsible for the remaining 31.7%.

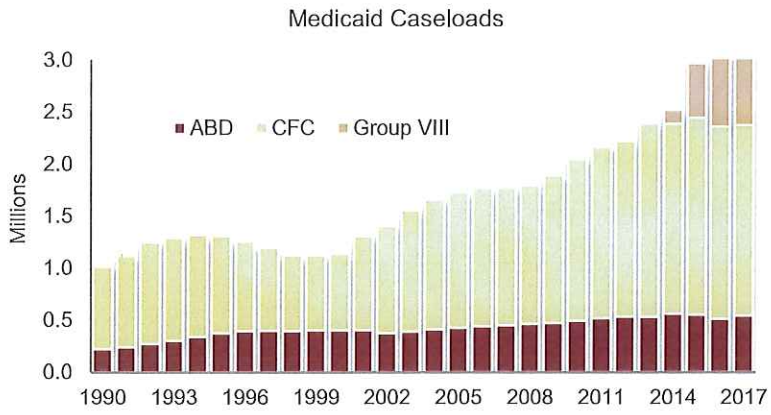
Aged, Blind, and Disabled Account for 13% of Medicaid Caseloads but 48% of Service Costs



Source: Ohio Department of Medicaid

- In FY 2016, the aged, blind, and disabled (ABD) population made up 13% of the Medicaid caseloads in Ohio, but accounted for 48% of the service costs. In contrast, the covered families and children (CFC) population made up 63% of caseloads, but only contributed 30% of the service costs. Lastly, the Medicaid expansion population (Group VIII) represented 24% of caseloads and 22% of service costs.
- In FY 2016, Ohio Medicaid caseloads totaled about 2.9 million, excluding individuals that receive only partial Medicaid coverage (e.g., premium assistance). Of this number, approximately 386,000 were ABD, 1.8 million were CFC, and 685,000 were Group VIII. Of the $21.41 billion in total Medicaid service costs for these populations, $10.34 billion was expended on the ABD population, while $6.45 billion and $4.62 billion was expended on the CFC and Group VIII populations, respectively.
- The ABD population includes low-income elderly who are age 65 or older and individuals with disabilities. The CFC population consists of low-income children and adults who are age 64 or younger. The Group VIII population includes recipients made newly eligible in 2014 who are age 19 to 64 with incomes at or below 138% of the federal poverty level.
- The average monthly Medicaid service cost was approximately $2,235 for an ABD member, compared to $300 for a CFC member and $562 for a Group VIII member in FY 2016.
- The cost of long-term care, which is provided primarily to the ABD population, is one of the main reasons for the higher expense. Long-term care includes services provided in institutions, such as nursing facilities, or in the home or community through Medicaid waiver programs, such as PASSPORT or Individual Options.

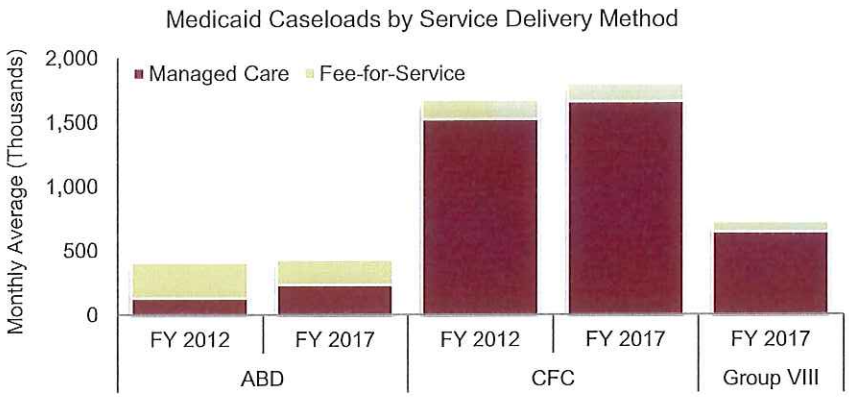
Medicaid Caseloads Continue to Increase



Source: Ohio Department of Medicaid

- In FY 2017, total Medicaid caseloads grew by 1.6% (49,000) to 3.1 million. The majority of the increases in recent fiscal years were the result of the Medicaid expansion that started in January 2014, which allowed previously ineligible adults between the ages of 19 to 64 with incomes below 138% of the federal poverty level to qualify for coverage (Group VIII). During the four-year period leading up to the Medicaid expansion (FY 2011-FY 2014) total caseloads grew at an average annual rate of 5.3% as the economy gradually improved following the Great Recession.
- CFC (covered families and children) caseloads experienced an increase in the four-year period after the Great Recession (FY 2011-FY 2014), growing on average 4.1% per year. This increase is partially due to the addition of family planning services as a limited Medicaid benefit, which was available from 2012 through 2015. CFC caseloads have remained relatively constant from FY 2015 to FY 2017, increasing at an average annual rate of 0.1%.
- ABD (aged, blind, and disabled) caseloads also experienced growth following the Great Recession, with caseloads increasing 3.3% on average from FY 2011 to FY 2014. Average annual ABD caseload growth has decreased over the following three-year period (FY 2015-FY 2017) at an average annual rate of 0.9%.
- Due to the Great Recession, total caseloads increased by 5.4% in FY 2009 and another 8.4% in FY 2010. Medicaid caseloads also increased rapidly in the early 2000s as a result of the economic slowdown and several eligibility expansions for family and child coverage. From FY 2000 to FY 2004, total caseloads increased by 8.2% per year on average.
- From FY 1990 to FY 2017, total caseloads tripled from 1.0 million to 3.1 million.

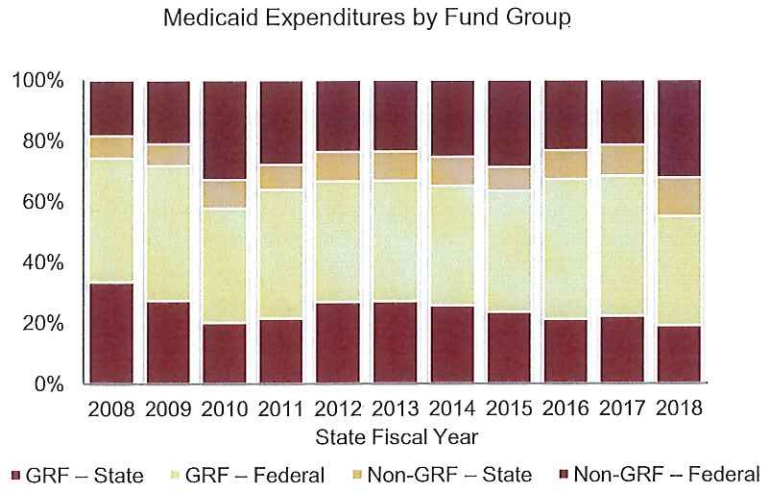
Medicaid Managed Care Caseloads Continue to Expand



Source: Ohio Department of Medicaid

- Following expansions in Medicaid coverage in FY 2014, Medicaid managed care caseloads increased from 1.6 million in FY 2012 to 2.5 million in FY 2017. As a share of total Medicaid caseloads, the managed care portion increased from 79% in FY 2012 to 86% in FY 2017.
- Under the managed care system, the state pays a fixed monthly premium per enrollee for any health care included in the benefit package, regardless of the amount of services actually used. Under the fee-for-service system, Medicaid reimburses service providers based on set fees for the specific types of services rendered.
- For the aged, blind, and disabled (ABD) category, managed care caseloads grew from 127,000 to 232,000, increasing its share from 31% to 55%. This is due in part to the implementation of the MyCare Program in 2014. MyCare is a system of managed care plans that coordinate physical, behavioral, and long-term care services for individuals eligible for both Medicaid and Medicare (dual-eligibles). This includes older adults, individuals with disabilities, and individuals who receive behavioral health services.
- For the covered families and children (CFC) category, managed care caseloads grew from 1.5 million in FY 2012 to 1.7 million in FY 2017, increasing its share from 91% to 92%.
- Medicaid expansion through the federal Affordable Care Act began in January 2014 in Ohio. These individuals (Group VIII) are generally enrolled in managed care, but can receive services through fee-for-service until they choose a Medicaid managed care plan. Under the Group VIII category, managed care caseloads were 640,000 in FY 2017, or 89% of the Group VIII caseload total.

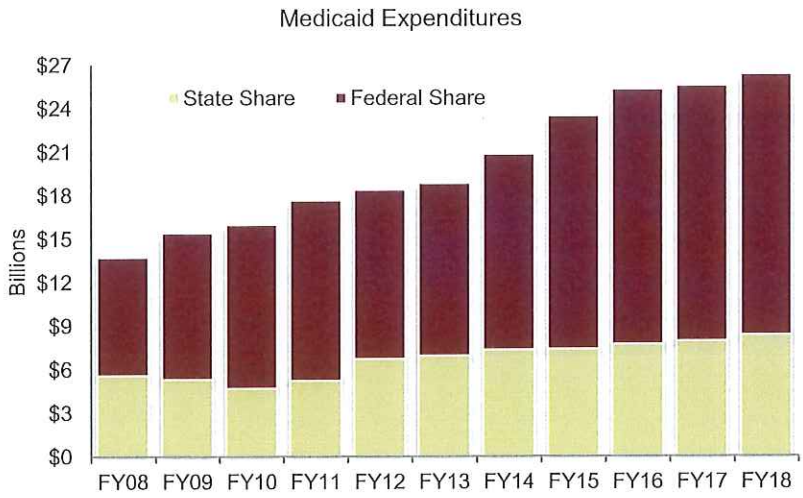
The GRF Is the Main Funding Source for Ohio Medicaid



Sources: Ohio Department of Medicaid; Ohio Administrative Knowledge System

- Ohio Medicaid is primarily funded by the GRF, but it is also supported by various non-GRF funds. From FY 2008 to FY 2018, on average, approximately two-thirds of Medicaid expenditures were made from the GRF, which consists of state tax receipts, state nontax receipts, and federal grants. The vast majority of federal grants deposited into the GRF are federal reimbursements for Medicaid.
- The lowest GRF share during this 11-year period was 55.0%, which was recorded in FY 2018. This shift in expenditures from GRF to non-GRF funds is largely due to the replacement of the sales tax on Medicaid managed care organizations with a franchise fee on all health insuring corporations (HICs). The sales tax was deposited into the GRF, whereas the HIC tax is deposited into a non-GRF fund.
- The GRF share increased from 63.3% in FY 2015 to 67.2% in FY 2016 due largely to an accounting practice change related to Group VIII individuals who became eligible for Ohio Medicaid beginning in January 2014 through the ACA expansion. Medicaid expenditures for these individuals were accounted for in non-GRF funds in FY 2014 and FY 2015 but in the GRF beginning in FY 2016.
- State non-GRF funds for Medicaid come from sources such as hospital assessments, HIC franchise fees, and nursing facilities franchise fees that are used for specific purposes. Federal non-GRF funds for Medicaid consist of federal reimbursements for expenditures made with these non-GRF funds.

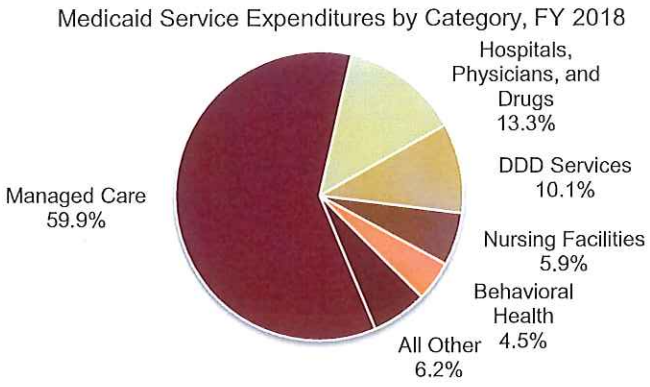
Medicaid Expenditures Almost Doubled Since FY 2008



Source: Ohio Administrative Knowledge System

- From FY 2008 to FY 2018, Medicaid expenditures almost doubled, increasing from $13.7 billion to $26.3 billion. The average annual growth rate during this period was 6.8%.
- Medicaid expenditures increased by 10.6% from FY 2013 to FY 2014 and by 12.5% from FY 2014 to FY 2015. This is primarily due to the expansion in coverage for the Group VIII population, which began in January 2014.
- Medicaid expenditures are affected by policy, the economy, population, and health care prices. Due to the Great Recession, total Medicaid expenditures increased by 12.2% in FY 2009. In contrast, expenditures grew by 5.2% per year from FY 2010 to FY 2013 as the economy gradually expanded.
- The federal government typically reimburses more than 60% of Ohio's Medicaid expenditures. The federal share is determined annually based on the most recent per capita income for Ohio relative to that of the nation. However, from October 1, 2008 to June 30, 2011, federal reimbursement was enhanced under the American Recovery and Reinvestment Act of 2009 and P.L. 111-226.
- The federal share for certain Medicaid programs is higher than the typical share. For instance, the federal reimbursement for Group VIII was 100% through 2016 and 95% for 2017. It is 94% in 2018, 93% in 2019, and 90% in 2020 and beyond. In addition, the State Children's Health Insurance Program rate was about 74% through FFY 2015. Beginning in FFY 2016, the rate increased to about 97% as a result of Affordable Care Act provisions.

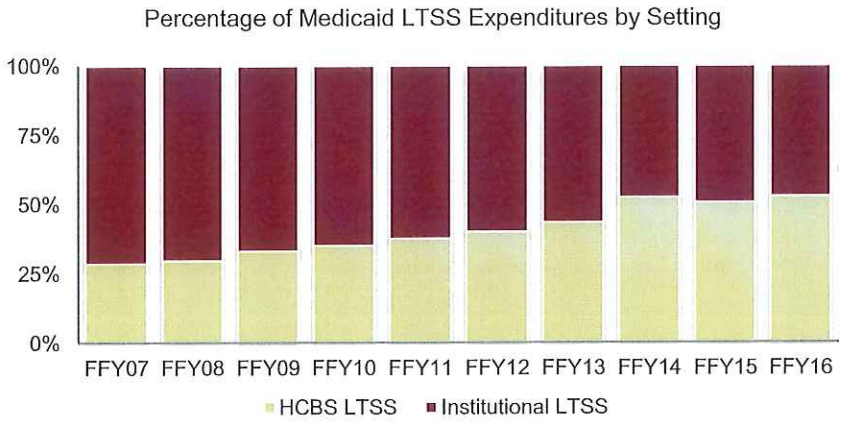
Managed Care Comprises Over Half of Total Medicaid Service Expenditures



Source: Ohio Administrative Knowledge System

- In FY 2018, Medicaid service (excluding administration) expenditures totaled $25.42 billion. Managed Care comprised the largest share at $15.24 billion (59.9%), including $4.07 billion for the Group VIII population. The Group VIII caseload averaged 692,000 in FY 2018. The federal reimbursement rate for this group is 94% in 2018, 93% in 2019, and 90% in 2020 and beyond.
- In FY 2018, spending totaled $3.39 billion (13.3%) for the Hospitals, Physicians, and Drugs category. This figure represents spending for individuals that receive services through the fee-for-service Medicaid delivery system. Expenses for these services for individuals enrolled in Medicaid managed care are accounted for in the Managed Care category.
- Spending for DDD services totaled $2.57 billion (10.1%) in FY 2018 and funds services for individuals with intellectual disabilities.
- Spending on Nursing Facilities (NF) totaled $1.50 billion (5.9%) in FY 2018. This represents expenditures for 50,000 NF residents. NF expenditures for the MyCare Program, which serves recipients eligible for both Medicaid and Medicare (dual-eligibles), are included in the Managed Care category. Approximately 20,000 NF residents are enrolled on the MyCare Program.
- Behavioral Health spending, which totaled $1.14 billion (4.5%) in FY 2018, supports enrollees with mental health or addiction-related needs.
- The $1.58 billion (6.2%) spending in the All Other category includes expenditures for the following: Medicare Buy-In, which assists with premiums and coinsurance payments; Medicare Part D, which repays the federal government the amount the state would have spent on Medicaid prescription drugs for dual-eligibles; and Medicaid waiver programs, which allow individuals to receive home and community-based services.

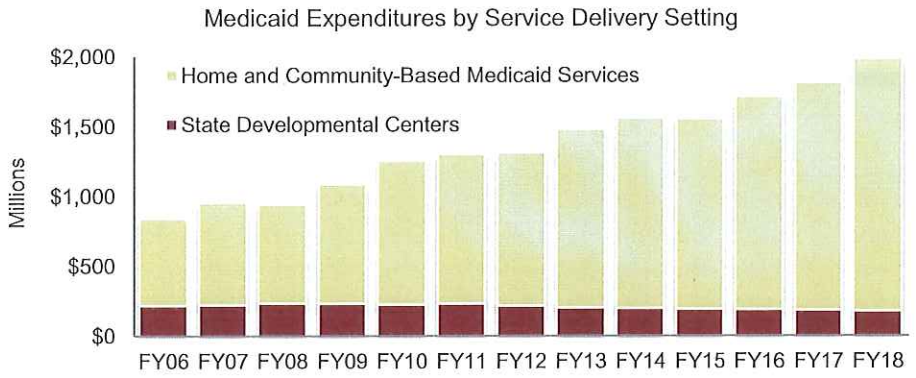
Percentage of Medicaid Expenditures for Home and Community-Based Services Increases Steadily



Sources: Centers for Medicare & Medicaid Services; Kaiser Family Foundation

- The home and community-based services (HCBS) share of Medicaid long-term services and supports (LTSS) expenditures increased from 28.5% in FFY 2007 to 52.7% in FFY 2016. In contrast, the percentage expended on institutional LTSS decreased from 71.5% to 47.3% during this time period.
- LTSS are medical and personal care services provided to individuals who have limitations in their capacity for self-care due to a physical, cognitive, or mental disability. LTSS are provided in institutional facilities (nursing facilities or intermediate care facilities for individuals with intellectual disabilities) or in the home or community through programs such as PASSPORT or Individual Options.
- LTSS spending for HCBS has increased for several reasons, including: recipient preference, HCBS are generally less expensive than institutional care, states are required by the Americans with Disabilities Act to provide persons with disabilities access to HCBS, and federal support for new initiatives to expand HCBS, such as the Balancing Incentive Program (BIP).
- BIP required at least 50% of a state's total Medicaid LTSS expenditures to be for HCBS by September 30, 2015 in return for additional Medicaid reimbursements. Ohio achieved this milestone on September 10, 2014. In total, Ohio received a total of $169.1 million in BIP reimbursements.
- Between FFY 2012 (the first year of BIP operations) and FFY 2016, Ohio experienced a 12.7% increase in HCBS expenditures as a percentage of total Medicaid LTSS expenditures. This was the third highest increase in the nation. Only Missouri and Massachusetts had higher increases with 14.9% and 14.1%, respectively.

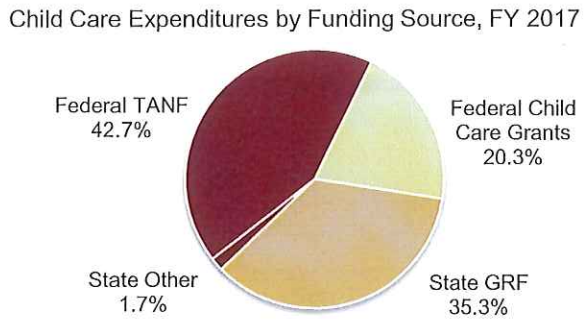
Spending on Community-Based Services Increases as Spending on State Developmental Centers Decreases



Source: Ohio Department of Developmental Disabilities

- From FY 2006 to FY 2018, Medicaid expenditures for home and community-based services (HCBS) for individuals with developmental disabilities increased 191% from $621.7 million to $1.81 billion, while expenditures for individuals in state developmental centers (DCs) decreased 19% from $217.6 million to $175.9 million.
- The Ohio Department of Developmental Disabilities (ODODD) administers three Medicaid HCBS waiver programs that enable individuals with developmental disabilities to remain in their homes or community settings. These programs provide services to increase skills, competencies, and self-reliance to maximize quality of life while ensuring health and safety.
- Enrollment in ODODD's HCBS waiver programs grew from about 18,200 in FY 2006 to 39,200 in FY 2018, an increase of 115%.
- ODODD currently operates eight regional DCs that provide habilitative environments for individuals with severe disabilities. Two DCs (Montgomery and Youngstown) closed near the end of FY 2017. In FY 2006, there were about 1,605 residents living in DCs. By FY 2018, the number of residents was 648, a decrease of roughly 60%.
- In FY 2018, the average monthly cost of an individual in a DC was about $22,500, while the average monthly cost of an individual on an HCBS waiver was about $900 for Level 1, $5,900 for Individual Options, and $1,000 for the Self-Empowered Life Funding waivers.
- In addition to state developmental centers and HCBS waiver services, Medicaid also pays for individuals in private intermediate care facilities. In FY 2006, payments to these facilities totaled $516.5 million. By FY 2018, payments to these facilities totaled $496.1 million, a decrease of about 4%.

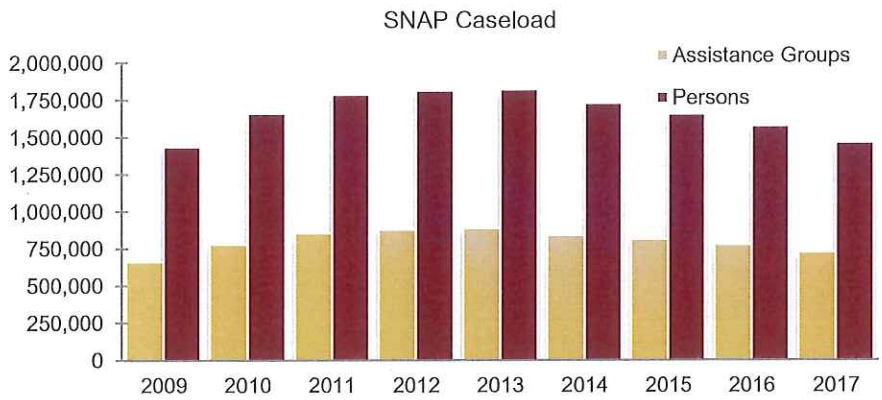
Majority of Subsidized Child Care Was Funded by Federal Grants in FY 2017



Sources: Ohio Department of Job and Family Services; Public Assistance Monthly Statistics

- Of the $639.6 million Ohio spent on subsidized child care in FY 2017, $403.3 million (63.0%) was from federal funds. A monthly average of 130,642 children received care, at an average monthly cost of $408 per child.
- The federal Temporary Assistance for Needy Families (TANF) Block Grant portion totaled $273.3 million, accounting for 67.8% of federal child care funding and 42.7% of the combined state-federal total. Ohio's TANF Block Grant is $728 million per year and is also used for cash assistance and other programs for the indigent.
- Federal Child Care and Development Fund (CCDF) grants accounted for $130.0 million (20.3%) of the total. There are three separate CCDF grants: a discretionary grant, a mandatory grant, and a matching grant. In addition to direct child care spending, the grants are also used for administration, quality activities (e.g., rating program quality), and other nondirect services.
- State dollars accounted for the remaining $236.4 million (37.0%), including $225.5 million in GRF and $10.8 million in other state funds paid by casino operators. Ohio is required by the federal government to annually expend approximately $84.7 million to receive the CCDF mandatory and matching grants and $416.9 million to meet the maintenance of effort requirements for TANF. Childcare spending makes up a significant portion of the required TANF spending.
- For families enrolled in, or transitioning out of, the Ohio Works First Program, child care is guaranteed. However, for most families, eligibility is based on income level. Families with incomes up to 130% of the federal poverty level (FPL) ($27,014 for a family of three in 2018) are eligible for initial services if funding is available; families may remain eligible until their incomes rise above 300% FPL ($62,340 for a family of three in 2018). Families pay copayments to providers on a sliding scale based on income.

Ohio's Supplemental Nutrition Assistance Program Caseload Drops for the 4th Consecutive Year



Sources: Ohio Department of Job and Family Services; Public Assistance Monthly Statistics

- The federal Supplemental Nutrition Assistance Program (SNAP) has seen a drop in the number of people and assistance groups receiving benefits in Ohio since 2013. In 2013, Ohio had an average monthly caseload of 1.82 million individuals in 888,000 assistance groups. By 2017, this decreased to 1.46 million individuals in 723,000 assistance groups.
- In 2017, Ohio disbursed $2.17 billion in SNAP benefits, with an average benefit of $124 per recipient per month. Benefits are paid entirely by the federal government and are transmitted directly to the processer Ohio contracts with to distribute benefits. This amount is never considered part of the state treasury and is not appropriated by the General Assembly.
- Determinations for SNAP benefits are made by county departments of job and family services. The federal government reimburses state and local administration costs at a rate of 50%.
- To qualify for benefits, recipients must earn less than 130% of the federal poverty level ($27,014 annually for an assistance group of three in 2018). The benefit amount varies based on the income and size of the assistance group.
- An assistance group's monthly benefit is automatically loaded onto their Ohio Direction Card, which can be used like a debit card to purchase eligible food items. Most grocery stores accept the Ohio Direction Card.
- SNAP is a United States Department of Agriculture/Food and Nutrition Service program that assists low-income households to purchase food from authorized merchants. A household that receives benefits under the program is a group of people who purchase and prepare meals together. This would generally be a family, but may also include unrelated adults who share a home and meals.

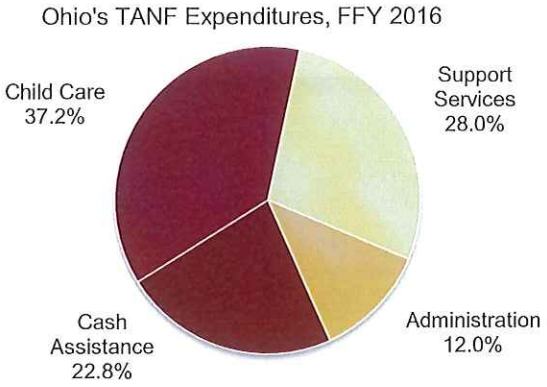
Ohio's Percentage of Preterm Births and Infant Mortality Rate Exceed National Statistics

Ohio and United States Population Statistics		
Category	**Ohio**	**United States**
% of Preterm Births, 2016	**10.4%**	**9.9%**
Non-Hispanic White	9.6%	9.0%
Non-Hispanic Black	14.6%	13.8%
Hispanic	11.0%	9.5%
Infant Mortality Rate (per 1,000 births), 2015	**7.2**	**5.9**
Non-Hispanic White	5.7	4.8
Non-Hispanic Black	15.1	11.7
Hispanic	6.0	5.2

Sources: Kaiser Family Foundation; Centers for Disease Control and Prevention

- In 2016, 10.4% of all births in Ohio were preterm births (less than 37 weeks of gestation) compared to the national average of 9.9%. Similar to the national pattern, the percentage of preterm births in Ohio for non-Hispanic black infants (14.6%) was higher than the percentage for both non-Hispanic white (9.6%) and Hispanic (11.0%) infants.
- In 2016, there were a total of 14,388 preterm births in Ohio. Preterm birth makes infants more vulnerable to developmental delays and both short-term and long-term medical problems. The average health care cost in the first year of life for a premature infant is about $55,400 as compared to $5,100 for a full-term, healthy infant.
- Factors that increase the risk of preterm birth include: having a previous preterm birth or a chronic medical condition, sustaining a physical injury, being very overweight or underweight before pregnancy, smoking or substance use, and having a birth interval shorter than 18 months.
- During 2015, Ohio's overall infant mortality rate of 7.2 (infant deaths per 1,000 live births) was higher than the national rate of 5.9. The rate for non-Hispanic blacks in Ohio and in the United States was more than twice the rate for non-Hispanic white infants.
- The leading causes of infant mortality are preterm birth, birth defects, sudden infant death syndrome, maternal pregnancy complications, and injury, such as accidental rollover or suffocation.

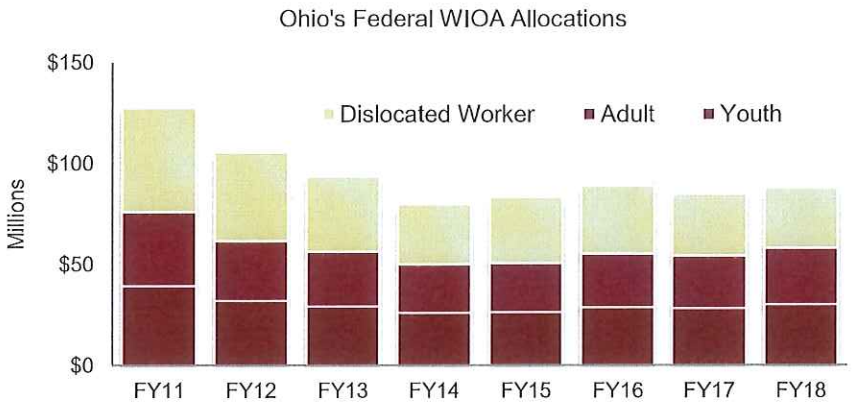
Child Care Accounted for Over a Third of Ohio's TANF Expenditures in Federal Fiscal Year 2016



Source: U.S. Department of Health and Human Services

- In FFY 2016, subsidized child care accounted for $419.2 million (37.2%) of Ohio's $1.13 billion in total Temporary Assistance for Needy Families (TANF) expenditures. Subsidized child care is available to children in families with incomes up to 130% of the federal poverty level (FPL). An average of 117,000 children received subsidized child care each month in state fiscal year 2016. In addition to TANF dollars, other state and federal funds are also used to pay child care providers.
- Cash assistance payments provided under the Ohio Works First (OWF) program accounted for $256.5 million (22.8%) of total TANF expenditures. In state fiscal year 2016, an average of 58,000 assistance groups per month received OWF benefits with an average benefit of $194 per recipient.
- OWF assistance groups must include a minor child or pregnant woman and have income of no more than 50% of the FPL. Heads-of-household must sign a self-sufficiency contract that includes a work plan. Benefits are limited to 36 consecutive months (with a lifetime limit of 60 months), but time and income limits and work requirements do not apply to "child-only" cases, in which a relative caregiver receives the benefit on behalf of a child.
- Support services ($315.0 million, 28.0%) are short-term noncash benefits provided at the local level and may include shelter, job-required clothing, household necessities, transportation, and other services allowable under federal law. Administration ($135.2 million, 12.0%) includes both state and local activities such as eligibility determination and case management.
- Ohio's TANF resources total about $1.15 billion each year: $728 million from the federal TANF Block Grant and $417 million in state funds to meet the TANF maintenance of effort requirement.

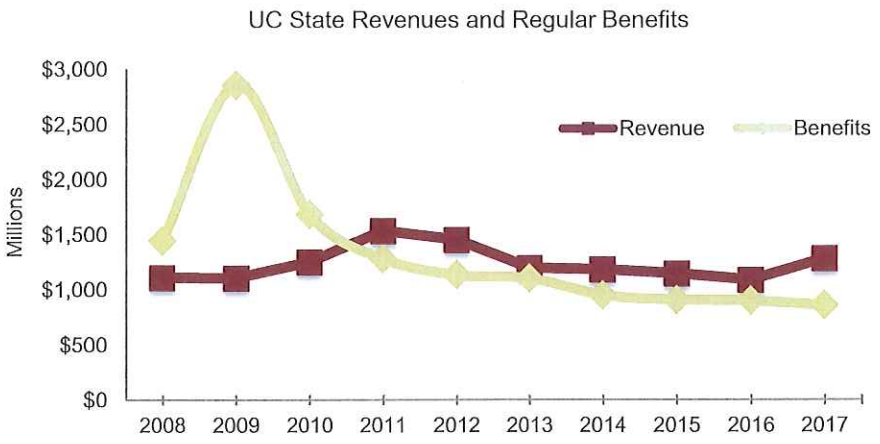
Ohio's Federal Workforce Innovation and Opportunity Act Grants Remained Fairly Stable Since FY 2014



Sources: U.S. Department of Labor; Federal Funds Information for States; ODJFS

- Ohio's federal Workforce Innovation and Opportunity Act (WIOA) grants, which superseded the Workforce Investment Act, fell from $127.6 million in FY 2011 to $87.9 million in FY 2018, a decrease of 31.1%. Grants decreased steadily from FY 2011 through FY 2014, but have remained fairly stable since that time.
- Ohio's WIOA grants in FY 2018 totaled $87.9 million, including $30.1 million for youth, $28.0 million for adults, and $29.8 million for dislocated workers.
- WIOA grants are largely distributed based on each state's share of the total unemployed and economically disadvantaged nationwide.
- WIOA is administered at the state level by the Ohio Department of Job and Family Services (ODJFS) and locally by 20 regional workforce investment boards. Service delivery is provided by 88 local OhioMeansJobs (One-Stop) centers, with one center in each county.
- ODJFS is required to distribute 85% of the state's total annual WIOA grants to Ohio's workforce investment boards for service delivery. Boards have two years to expend WIOA grants. The remaining WIOA dollars are used by ODJFS to help areas in the state that experience mass layoffs (10%) and for administration and other statewide workforce programs (5%). ODJFS may expend WIOA funds over three years for these purposes.
- Statewide WIOA activities include support for OhioMeansJobs.com, a statewide job posting board that is free for employers and job seekers.
- In addition to its regular WIOA grants, Ohio can receive Dislocated Worker Grants to respond to large, unexpected, numbers of dislocated workers due to layoffs, international trade effects, and natural disasters.

Ohio's Unemployment Compensation Revenues Exceeded Benefit Payments the Last Seven Years



Source: Ohio Department of Job and Family Services

- The state's regular unemployment compensation (UC) revenues have exceeded benefits every calendar year since 2011. In 2017, UC revenues totaled $1.28 billion, $426.9 million higher than net benefit payments of $854.2 million.
- After depleting the Unemployment Compensation Fund in January 2009, Ohio borrowed $3.39 billion from the federal government to continue paying benefits. The remaining balance of this federal debt was paid in August 2016 with an intrastate loan from the Department of Commerce's unclaimed funds. Since this date, Ohio has not borrowed any additional amounts.
- Of the total 2017 revenue, $274.0 million was used to repay the intrastate loan. H.B. 390 of the 131st General Assembly raised additional revenue for repayment via a 0.6% surcharge on employer UC taxes in 2017. This surcharge will not be in effect in 2018 or in future years.
- Regular state UC revenue is derived from taxes paid by Ohio employers on the first $9,000 of each employee's wages. Rates are set in state law and are based on an employer's "experience" of unemployment. In 2017, tax rates ranged from 0.9% to 9.4% (including the 0.6% surcharge) and averaged about 3.0%, or $270 per employee. S.B. 235 of the 131st General Assembly temporarily increases taxable wages to $9,500 for 2018 and 2019.
- Recipients of UC are eligible to receive amounts equal to half their employed wages up to a maximum amount that is adjusted annually based on the statewide average weekly wage. In 2017, the average recipient received $363 weekly for 14.7 weeks. S.B. 235 of the 131st General Assembly freezes maximum benefit amounts for 2018 and 2019 at the 2017 level.

Workers' Compensation Claims and Benefits Continued to Decline in 2017

Workers' Compensation Benefits and Claims Paid from the State Insurance Fund					
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Benefits ($ in Millions)					
Medical	$705.8	$662.3	$614.4	$580.3	$550.6
Lost Time	$1,076.0	$1,061.4	$1,033.1	$1,021.6	$940.8
Total	$1,781.8	$1,723.7	$1,647.4	$1,601.9	$1,491.4
Number of New Allowed Claims					
Total	97,041	97,572	93,936	88,170	86,290
Number of Open Claims					
Total	958,625	858,773	791,638	752,312	704,756

Source: Ohio Bureau of Workers' Compensation

- Total benefits paid by the Bureau of Workers' Compensation (BWC) for lost time and medical claims declined steadily between FY 2013 and FY 2017. In FY 2017, lost time and medical benefits paid totaled $1.49 billion, 16.3% ($290.4 million) less than the $1.78 billion paid in FY 2013.
- From FY 2013 to FY 2017, medical claims declined by 22.0% ($155.2 million) while lost-time benefits declined by 12.6% ($135.2 million).
- Most claims come from the service industries, with the manufacturing and commercial industries constituting the next largest portion.
- Except for a slight uptick in new allowed claims in FY 2014, the number of claims, both new and open, also declined over this five-year span. Between FY 2013 and FY 2017, new allowed claims dropped 11.1% and open claims dropped 26.5%.
- BWC provided coverage to 242,474 employers in FY 2017, including 3,917 state and local public employers. Slightly fewer than 1,200 employers qualified to self-insure in FY 2017. Premiums and administrative assessments collected from BWC-insured employers totaled $1.55 billion in FY 2017.
- BWC's net assets totaled almost $9.76 billion at the close of FY 2017, 11.5% higher than the $8.75 billion at the close of FY 2016.

Members Brief

An informational brief prepared by the LSC staff for members and staff of the Ohio General Assembly

Author: Nelson V. Lindgren, Senior Economist
Reviewer: Ivy Chen, Division Chief

Volume 136
January 2, 2025

Ohio's Medicaid Financial Landscape and FMAP

Ohio Medicaid, a health insurance program funded jointly by the state and federal governments, provides health insurance to low-income Ohioans through the Ohio Department of Medicaid, with significant programmatic guidance and financial support from the federal government. Financial support from the federal government varies based on the type of service and the category of coverage of a Medicaid recipient.

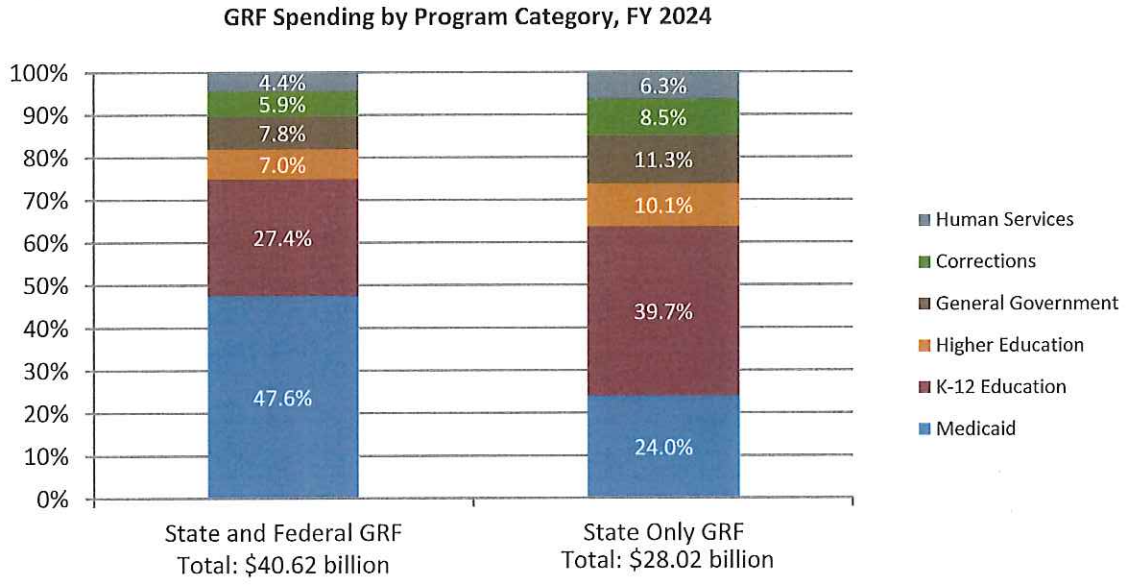
Contents

Overview

Medicaid is a health insurance program for low-income individuals. State governments administer state-specific Medicaid programs subject to federal oversight by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services (HHS). Funding for the program comes primarily from federal and state government sources. The Ohio Department of Medicaid (ODM) administers Ohio's Medicaid program, and provides Medicaid coverage to more than three million eligible individuals in the state. ODM is one of the state's largest government agencies in terms of General Revenue Fund (GRF) spending, and the state's largest health insurer.

Medicaid and Ohio's state budget

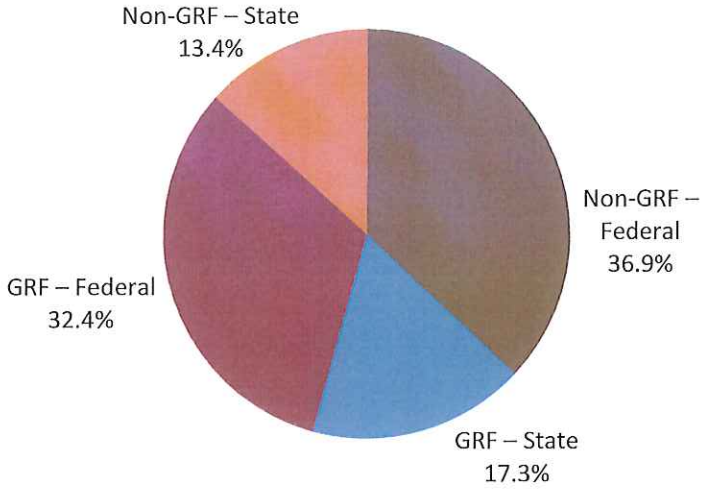
The state of Ohio's budget is dominated by spending on Medicaid and primary and secondary education. In fact, well over half of FY 2024 GRF spending was in these two program categories. The chart below demonstrates this by looking at the state's GRF spending in two different ways. The column on the left shows the state's total GRF spending in FY 2024 by program category. Medicaid accounted for 47.6% of total GRF spending. The column on the right shows the state's state-only GRF spending. Federal reimbursements for Medicaid that are deposited into the GRF are removed in this analysis. Medicaid's share of spending in this view drops, but still remains significant at 24.0%.



Ohio Medicaid spending funding source

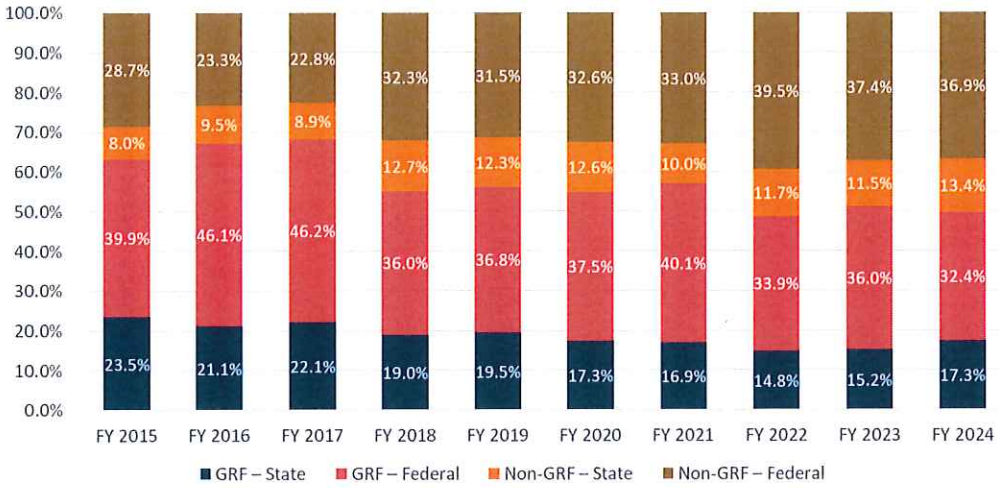
Just under half of the state's Medicaid expenditures come from the GRF ($19.33 billion in FY 2024), and just over half come from non-GRF spending ($19.55 billion in FY 2024). As with GRF spending, non-GRF spending also includes revenue from state and federal sources. The next chart shows the breakdown of Medicaid spending by state and federal GRF and non-GRF sources.

Ohio Medicaid Spending by Funding Source, FY 2024



Of the total $38.88 billion in Medicaid spending in FY 2024, 49.7% was from the GRF – 32.4% from federal GRF funds ($12.60 billion) and 17.3% from state GRF funds ($6.73 billion). The remaining 50.3% was from non-GRF funds – 36.9% from federal funds ($14.35 billion) and 13.4% from state funds ($5.20 billion). The next chart shows historical trends of these shares of Medicaid spending by state and federal GRF and non-GRF sources.

Medicaid Expenditures by Fund Group, FY 2015 to FY 2024

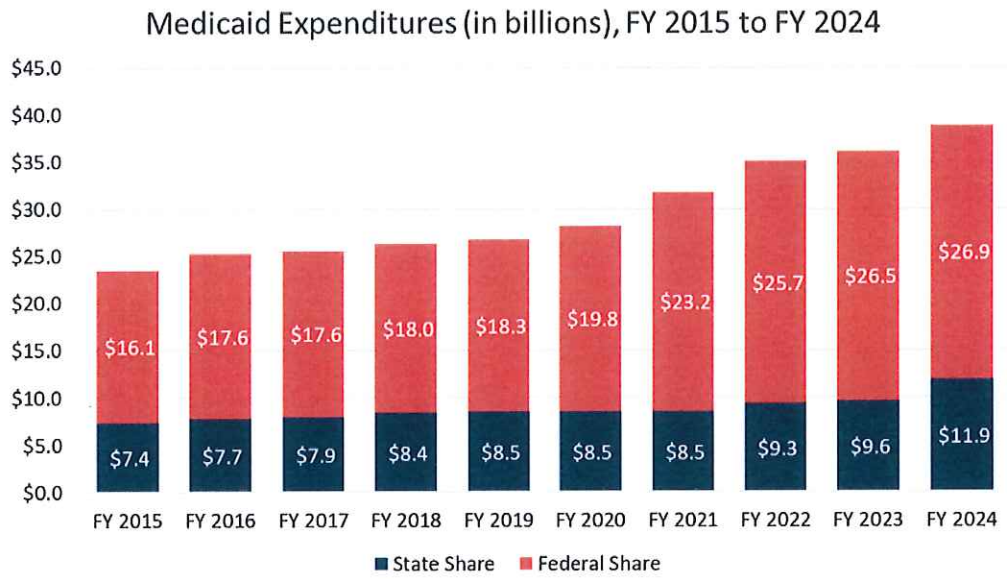


Over the previous decade, non-GRF expenditures, both state and federal, have increased in relative share. Federal expenditures overall have also increased. The increase in non-GRF – State expenditures has been partially due to increasing provider franchise fees and assessments, and the recent implementation of ODM's Medicaid single pharmacy benefit manager program. Increases in the share of federal expenditures were largely due to federal financial support due to the COVID-19 pandemic.

Historical Medicaid spending

The following chart shows Medicaid expenditures over the previous decade, detailed with state and federal shares of total expenditures. Due to many factors, including larger caseloads and increasing healthcare costs, expenditures have trended up over the past decade.

The most significant increases occurred between FY 2020 and FY 2022, primarily due to rising caseloads during the COVID-19 pandemic. These enrollment surges were influenced by the economic impact of the pandemic and the continuous enrollment provision under the Families First Coronavirus Response Act (FFCRA). To qualify for enhanced federal financial support during this period, ODM temporarily suspended routine eligibility redeterminations and disenrollment, resulting in increased caseloads. By meeting these conditions, Ohio received enhanced federal financial support. This is reflected in the expenditure increases during FY 2021 and FY 2022, with both state and federal spending rising. The growth in federal expenditures was driven by higher overall spending and the increased federal match provided to the state.



Federal financial participation (FFP)

Federal medical assistance percentage (FMAP)

For most Medicaid service costs, FFP is determined for each state by the state's federal medical assistance percentage (FMAP). The FMAP is calculated each year for each state based upon the state's per capita income for the three most recently available years relative to the nation's per capita income over the same time period. The formula is:

$$1 - \frac{(state\ per\ capita\ income)^2}{(national\ per\ capita\ income)^2}\ x\ 0.45$$

A state with average per capita income (state per capita income equal to national per capita income) will have an FMAP of 0.55 or 55% (1 - 0.45). States with higher per capita incomes will have lower FMAPs and vice versa. However, the federal government has set a minimum

FMAP at 50% and a maximum at 83%. For federal fiscal year (FFY) 2025, 10 states have the minimum FMAP of 50.0%, while Mississippi has the highest FMAP of 76.9%.[1] The FMAP for Ohio for FFY 2025 is 64.6%. So, for every dollar Ohio spends on most Medicaid services, it receives approximately 64.6¢ back from the federal government. Correspondingly, for every dollar Ohio decreases in spending for most Medicaid services, the state saves approximately 35.4¢. Although most FMAP rates are determined by this formula, there are exceptions for certain states, situations, populations, providers, and services. Some of these exceptions are described in more detail below.

Enhanced federal medical assistance percentage (eFMAP)

An enhanced FMAP is provided for both services and administration under the State Children's Health Insurance Program (SCHIP).[2] Under SCHIP, each state is given an allotment of federal funds. Subject to the availability of funds from the state's allotment, the eFMAP is used to determine the federal share of the cost of SCHIP. Each state's eFMAP is calculated by reducing the state's share under the regular FMAP by 30%. Under the Patient Protection and Affordable Care Act (ACA), each state's eFMAP for most SCHIP expenditures was increased by 23 percentage points, with a maximum of 100%, from FFY 2016 through FFY 2019. The Healthy Kids Act modified the eFMAP for FFY 2020 by specifying an increase of 11.5 percentage points, with a maximum of 100%. These increases were each eliminated beginning in FFY 2021. In FFY 2025, Ohio's eFMAP is 75.22%.[3]

Other exceptions to FMAP

Administration

The costs of administration are, in general, reimbursed at 50%, although some administrative activities have a higher rate. The table below shows the matching rates for various administrative functions.

Federal Matching Rates for Various Administrative Activities	
Activity or Function	**Percentage**
Immigration status verification	100%
Administration of family planning services	90%

[1] Ohio's state fiscal years, abbreviated FY, run from the beginning of July to the end of June. Thus, FY 2025 runs from July 1, 2024 to June 30, 2025. The federal government's fiscal years, abbreviated FFY, run from the beginning of October to the end of September. Thus, FFY 2025 runs from October 1, 2024 to September 30, 2025.

[2] SCHIP is a separate program that covers children who are not eligible under the regular Medicaid Program. Many states, including Ohio, opted to incorporate SCHIP as a Medicaid expansion.

[3] Ohio's state share under the regular FMAP is 35.40% (100% - 64.60%), reducing that by 30% results in a state share under eFMAP of 24.78% (35.40% x 70%), which translates into an eFMAP of 75.22% (100% - 24.78%).

Federal Matching Rates for Various Administrative Activities	
Activity or Function	**Percentage**
Management and operation of claims and information systems	75%
Independent external reviews of managed care plans	75%
Preadmission screening and resident review	75%
Skilled professional medical personnel training	75%
State fraud and abuse control unit activities	75%
State survey and certification of nursing facilities	75%
Translation and interpretation services	75%
Other program administration activities	50%

ACA Expansion Group (Group VIII)

The ACA permits states to expand Medicaid coverage to nondisabled adults under the age of 65 with no dependents and incomes at or below 138%[4] of the federal poverty level (FPL).[5] These adults are often referred to as Group VIII after the section of the law that describes them. The ACA offers states a higher FMAP for services provided to Group VIII individuals. Initially set at 100% for CY 2014, the Group VIII FMAP followed a reduction schedule until reaching 90% in CY 2020, where it has remained since.

Qualifying Individuals Program

States are required to pay Medicare Part B[6] premiums for Medicare beneficiaries with income between 120% and 135% FPL and limited assets. These beneficiaries are referred to as qualifying individuals. The FMAP for this program is 100%.

Family planning services

Since 1973, the federal government has offered states an FMAP of 90% for family planning services and supplies.

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[4] Under the ACA, the eligibility is 133% FPL. However, a 5% income disregard is allowed, which makes the effective minimum threshold 138%.

[5] The federal poverty level (FPL) is a measure of poverty maintained by the federal government that is used as a base measure for many government programs. The guidelines for FPL are updated by the Department of Health and Human Services annually, and account for the number of persons in a family/household.

[6] Medicare Part B covers some medical services not covered by Part A, such as physician services and outpatient care.

Breast and cervical cancer treatment

The cost of the treatment provided under the Medicaid Program's Breast and Cervical Cancer Project (BCCP) is reimbursed at the state's SCHIP eFMAP rate. BCCP services are provided to individuals who meet certain eligibility criteria, among which are being screened for breast or cervical cancer through the Ohio Department of Health (ODH), in need of treatment for breast or cervical cancer or pre-cancerous conditions, uninsured, age 21 to 64, and below 300% FPL in income.

Federal assistance in response to COVID-19

From January 2020 (pandemic legislation from March 2020 was retroactive to the beginning of calendar year 2020) through December 2023, the federal government provided enhanced funding for state Medicaid expenditures, in an effort to increase health care access and decrease state financial burdens during the COVID-19 global pandemic. In exchange for increased federal Medicaid assistance, state Medicaid programs were required to meet five conditions initially set by the Federal Families First Coronavirus Response Act (FFCRA), which were to: (1) maintain eligibility standards or procedures that are no more restrictive than those in place on January 1, 2020, (2) not charge premiums that exceed those in place on January 1, 2020, (3) provide testing, services, and treatments including vaccines, specialized equipment, and therapies related to COVID-19 without cost-sharing requirements, (4) provide continuous coverage to individuals enrolled into the program during the emergency period, and (5) not require local political subdivisions to pay a greater portion of the nonfederal share of expenditures than was required on March 11, 2020.

Ohio maintained compliance with these five requirements and received enhanced federal assistance throughout the federal declaration of emergency for the COVID-19 pandemic, and through a phase-out period of decreasing enhanced federal assistance during the second half of calendar year 2023. Since January 2024, Ohio's federal Medicaid reimbursement has returned to typical levels based on service and spending type, as were described previously.

Certain preventive services and immunizations for adults

Beginning on January 1, 2013, the ACA provides a one percentage point increase in FMAP to states for expenditures for adult vaccines and clinical preventive services if states provide these benefits without requiring a payment from the beneficiary.

Smoking cessation for pregnant women

Beginning on January 1, 2013, the ACA provides a one percentage point increase in FMAP for expenditures for smoking cessation services that are mandatory for pregnant women. This is provided to states that opt to cover the preventive services described above.

Summary

The table below summarizes most of the instances when a reimbursement rate other than the regular FMAP is currently used.

Summary of Current Federal Match Rates	
Population/Services	**Percentage**
Qualifying Individuals Program	100%
Adults under 65 up to 138% FPL	90%
Family Planning Services and Administration	90%
State Children's Health Insurance Program (SCHIP)	eFMAP
Breast and Cervical Cancer Treatment	eFMAP
Duration of the COVID-19 Emergency (since concluded)	FMAP + 6.2%
Certain Preventive Services and Immunizations	FMAP + 1%
Smoking Cessation for Pregnant Women	FMAP + 1%
Administrative Activities	50% to 100%

Ohio's FMAP recent history

The following table shows Ohio's recent FMAP history by fiscal year and fiscal year quarter. As federal reimbursement is updated at the beginning of every federal fiscal year, regular FMAP adjustments, and the rates based off them, are updated during the second quarter of state fiscal years.

Fiscal Year	Quarter	Regular FMAP	SCHIP	FFCRA FMAP	FFCRA SCHIP	Group VIII
2021	1	63.02%	85.61%	69.22%	89.95%	90.00%
2021	2	63.63%	74.54%	69.83%	78.88%	90.00%
2021	3	63.63%	74.54%	69.83%	78.88%	90.00%
2021	4	63.63%	74.54%	69.83%	78.88%	90.00%
2022	1	63.63%	74.54%	69.83%	78.88%	90.00%
2022	2	64.10%	74.87%	70.30%	79.21%	90.00%
2022	3	64.10%	74.87%	70.30%	79.21%	90.00%
2022	4	64.10%	74.87%	70.30%	79.21%	90.00%

Fiscal Year	Quarter	Regular FMAP	SCHIP	FFCRA FMAP	FFCRA SCHIP	Group VIII
2023	1	64.10%	74.87%	70.30%	79.21%	90.00%
2023	2	63.58%	74.51%	69.78%	78.85%	90.00%
2023	3	63.58%	74.51%	69.78%	78.85%	90.00%
2023	4	63.58%	74.51%	68.58%	78.01%	90.00%
2024	1	63.58%	74.51%	66.08%	76.26%	90.00%
2024	2	64.30%	75.01%	65.80%	76.06%	90.00%
2024	3	64.30%	75.01%	N/A	N/A	90.00%
2024	4	64.30%	75.01%	N/A	N/A	90.00%
2025	1	64.30%	75.01%	N/A	N/A	90.00%
2025	2	64.60%	75.22%	N/A	N/A	90.00%
2025	3	64.60%	75.22%	N/A	N/A	90.00%
2025	4	64.60%	75.22%	N/A	N/A	90.00%

From the beginning of this table's timeframe through the second quarter of FY 2024, enhanced federal financial support due to the FFCRA was in effect, and these corresponding adjusted values of FMAP and SCHIP are shown in the fifth and sixth columns of the table above. During the last few quarters, FFCRA enhanced funding was gradually phased out to help smooth budget transitions for state Medicaid programs.

Medicaid provides financial reimbursement to health care professionals and institutions for providing approved medical services, products, and equipment to Medicaid enrollees. Medicaid service expenditures can generally be placed into various payment categories. Total forecasted Medicaid service expenditures are the sum of forecasted expenditures for each of these categories.

LBO Baseline Forecast of Medicaid Service Expenditures by Payment Category (Combined State and Federal Dollars, $ in millions)							
Category	FY 2024 Actuals	FY 2025 Estimates	Growth Rate	FY 2026 Forecast	Growth Rate	FY 2027 Forecast	Growth Rate
Managed Care	**$24,163.3**	**$25,069.4**	**3.7%**	**$26,918.4**	**7.4%**	**$28,417.0**	**5.6%**
CFC	$6,510.3	$6,462.9	-0.7%	$6,744.6	4.4%	$7,082.4	5.0%
Group VIII	$5,728.6	$5,631.6	-1.7%	$5,833.8	3.6%	$6,064.6	4.0%
ABD	$2,608.4	$2,727.5	4.6%	$3,009.2	10.3%	$3,133.3	4.1%
MyCare	$3,342.7	$3,824.3	14.4%	$4,159.4	8.8%	$4,359.7	4.8%
OhioRISE	$461.2	$770.0	66.9%	$1,175.8	52.7%	$1,419.2	20.7%
PBM	$5,512.2	$5,653.2	2.6%	$5,995.6	6.1%	$6,357.9	6.0%
Fee-For-Service	**$5,069.6**	**$5,509.9**	**8.7%**	**$6,172.5**	**12.0%**	**$6,767.5**	**9.6%**
Nursing Facilities	$1,976.3	$2,045.5	3.5%	$2,145.7	4.9%	$2,159.6	0.6%
Hospitals	$839.2	$869.5	3.6%	$1,144.9	31.7%	$1,327.3	15.9%
Aging Waivers	$442.6	$572.7	29.4%	$647.4	13.0%	$760.7	17.5%
Prescription Drugs	$393.4	$417.7	6.2%	$452.1	8.2%	$487.5	7.8%
Home Care Waivers	$191.2	$262.8	37.5%	$273.3	4.0%	$290.0	6.1%
Behavioral Health	$130.1	$138.7	6.6%	$187.7	35.3%	$336.0	79.0%
All Other	$1,096.9	$1,203.1	9.7%	$1,321.5	9.8%	$1,406.3	6.4%
Total	**$29,233**	**$30,579**	**4.6%**	**$33,091**	**8.2%**	**$35,185**	**6.3%**

(130th General Assembly)
(Amended Substitute Senate Bill Number 206)

AN ACT

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, 355.01, 355.02, 355.03, 355.04, 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 permit a board of county commissioners to establish a county Healthier Buckeye council; 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, 355.01, 355.02, 355.03, 355.04, 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;

(6) Receive and consider reports submitted by county healthier buckeye councils under section 355.04 of the Revised Code.

(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. 355.01. 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.

"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. 355.02. Each board of county commissioners may adopt a resolution to establish a county healthier buckeye council. The board may invite any person or entity to become a member of the council, including a public or private agency or group that funds, advocates, or provides care coordination services, provides or promotes private employment or educational services, or otherwise contributes to the well-being of individuals and families.

Sec. 355.03. A county healthier buckeye council may do all of the following:

(A) Promote means by which council members or the entities the members represent may reduce the reliance of individuals and families on publicly funded assistance programs using both of the following:

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

(a) Low costs;

(b) Use volunteer workers;

(c) Use incentives to encourage designated behaviors;

(d) Are led by peers.

(2) Practices that identify and seek to eliminate barriers to achieving greater financial independence for individuals and families who receive services from or participate in programs operated by council members or the entities the members represent.

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

(C) Collect and analyze data regarding individuals or families who receive services from or participate in programs operated by council members or the entities the members represent.

Sec. 355.04. A county healthier buckeye council may report the following information to the joint medicaid oversight committee created in section 103.41 of the Revised Code:

(A) Notification that the county council has been established and information regarding the council's activities;

(B) Information regarding enrollment or outcome data collected under division (C) of section 355.03 of the Revised Code;

(C) Recommendations regarding the best practices for the administration and delivery of publicly funded assistance programs or other services or programs provided by council members or the entities the members represent;

(D) Recommendations regarding the best practices in care coordination.

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.

_____

Speaker _____ *of the House of Representatives.*

_____

President _____ *of the Senate.*

Passed _____, 20____

Approved _____, 20____

_____

Governor.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

_____

Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the ____ day of _____, A. D. 20____.

_____

Secretary of State.

File No. _____ Effective Date _____