Ohio Revised Code

Section 5162.70 Reforms to medicaid program.

Effective: October 3, 2023
Legislation: House Bill 33

(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 member 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 member 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.

(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) When determining the growth in the per member per month cost of the medicaid program for purposes of the reforms required by this section, the medicaid director shall not exclude any medicaid eligibility group, provider wages, or service. The director may exclude one-time expenses or expenses that are not directly related to enrollees.

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

(E) By October first of each calendar year, the medicaid director shall submit to the joint medicaid oversight committee a report detailing the reforms implemented under this section. In even-numbered years, the report shall include the department's historical and projected medicaid program expenditure and utilization trend rates by medicaid program and service category for each year of the upcoming fiscal biennium and an explanation of how the trend rates were calculated.

(F) 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.