Appendix 6

ODJFS Uncodified Law

5S30	600629	MR/DD Medicaid Administration and Oversight	$ 9,252,738	$ 9,147,791
5U30	600654	Health Care Services Administration	$ 24,400,000	$ 24,400,000
5U60	600663	Children and Family Support	$ 4,000,000	$ 4,000,000
6510	600649	Hospital Care Assurance Program Fund	$ 212,526,123	$ 217,008,050
TOTAL SSR State Special Revenue Fund Group			$ 1,194,041,402	$ 1,207,722,286
Agency Fund Group				
1920	600646	Support Intercept - Federal	$ 130,000,000	$ 130,000,000
5830	600642	Support Intercept - State	$ 16,000,000	$ 16,000,000
5B60	600601	Food Assistance Intercept	$ 2,000,000	$ 2,000,000
TOTAL AGY Agency Fund Group			$ 148,000,000	$ 148,000,000
Holding Account Redistribution Fund Group				
R012	600643	Refunds and Audit Settlements	$ 2,200,000	$ 2,200,000
R013	600644	Forgery Collections	$ 10,000	$ 10,000
TOTAL 090 Holding Account Redistribution Fund Group			$ 2,210,000	$ 2,210,000
TOTAL ALL BUDGET FUND GROUPS			$ 22,170,511,132	$ 23,350,617,320

SECTION 309.20. SUPPORT SERVICES

SECTION 309.20.10. ADMINISTRATION AND OPERATING

On July 1, 2011, or as soon as possible thereafter, the Director of Budget and Management may transfer up to $535,300 cash from the TANF Quality Control Reinvestments Fund (Fund 5Z90) to the Administration and Operating Fund (Fund 5DM0). Upon completion of the transfer, Fund 5Z90 is abolished.

Of the foregoing appropriation item 600633, Administration and Operating, the Department of Job and Family Services shall use up to $535,300 to pay for one-time contract expenses.

SECTION 309.20.20. TRANSFER TO STATE AND COUNTY SHARED SERVICES FUND

Within thirty days of the effective date of this act, or as soon as possible thereafter, the Director of Budget and Management shall transfer the unencumbered cash balance in the County Technologies Fund (Fund 5N10) to the State and County Shared Services Fund (Fund 5HL0). The transferred cash is hereby appropriated.

SECTION 309.20.30. AGENCY FUND GROUP

The Agency Fund Group and Holding Account Redistribution Fund Group shall be used to hold revenues until the appropriate fund is determined or until the revenues are directed to the appropriate governmental agency other than the Department of Job and Family Services. If receipts credited to the Support Intercept – Federal Fund (Fund 1920), the Support Intercept – State Fund (Fund 5830), the Food Stamp Offset Fund (Fund 5B60), the Refunds and Audit Settlements Fund (Fund R012), or the Forgery Collections Fund (Fund R013) exceed the amounts appropriated from the fund, the Director of Job and Family Services may request the Director of Budget and Management to authorize expenditures from the fund in excess of the amounts appropriated. Upon the approval of the Director of Budget and Management, the additional amounts are hereby appropriated.

SECTION 309.30. MEDICAID

SECTION 309.30.10. HEALTH CARE/MEDICAID

The foregoing appropriation item 600525, Health Care/Medicaid, shall not be limited by section 131.33 of the Revised Code.

SECTION 309.30.13. MEDICAID RESERVE FUND

There is hereby created in the state treasury the Medicaid Reserve Fund. The Director of Budget and Management may transfer up to $129,113,790 cash from the General Revenue Fund to the Medicaid Reserve Fund during the FY 2012-FY 2013 biennium. Money in the fund may be used for the Medicaid Program upon request of the Director of Job and Family Services and approval of the Director of Budget and Management. As necessary, the Director of Budget and Management is authorized to transfer cash from the Medicaid Reserve Fund to the General Revenue Fund. Appropriations in appropriation item 600525, Health Care/Medicaid, shall be increased by the amounts of such transfers and corresponding federal matching funds. Such amounts are hereby appropriated.

SECTION 309.30.20. UNIFIED LONG TERM CARE

The foregoing appropriation item 600525, Health Care/Medicaid, may

be used to provide the preadmission screening and resident review (PASRR), which includes screening, assessments, and determinations made under sections 5111.204, 5119.061, and 5123.021 of the Revised Code.

The foregoing appropriation item 600525, Health Care/Medicaid, may be used to assess and provide long-term care consultations under section 173.42 of the Revised Code to clients regardless of Medicaid eligibility.

The foregoing appropriation item 600525, Health Care/Medicaid, may be used to provide nonwaiver funded PASSPORT and assisted living services to persons who the state department has determined to be eligible to participate in the nonwaiver funded PASSPORT and assisted living programs, who applied for but have not yet been determined to be financially eligible to participate in the Medicaid waiver component of the PASSPORT Home Care Program or the Assisted Living Program by a county department of job and family services, and to persons who are not eligible for Medicaid but were enrolled in the PASSPORT Program prior to July 1, 1990.

The foregoing appropriation item 600525, Health Care/Medicaid, shall be used to provide the required state match for federal Medicaid funds supporting the Medicaid waiver-funded PASSPORT Home Care Program, the Choices Program, the Assisted Living Program, and the PACE Program.

The foregoing appropriation item 600525, Health Care/Medicaid, shall be used to provide the federal matching share of program costs determined by the Department of Job and Family Services to be eligible for Medicaid reimbursement for the Medicaid waiver-funded PASSPORT Home Care Program, the Choices Program, the Assisted Living Program, and the PACE Program.

SECTION 309.30.21. ESTIMATED EXPENDITURES FOR PASSPORT, CHOICES, ASSISTED LIVING, AND PACE PROGRAMS

(A) Of the funds appropriated to the Department of Job and Family Services for health care services, it is estimated that $618,772,607 in fiscal year 2012 and $662,261,174 in fiscal year 2013 will be expended on the Medicaid waiver-funded PASSPORT Home Care Program, the Choices Program, the Assisted Living Program, and the PACE Program.

(B) The Department of Job and Family Services and the Department of Aging shall jointly monitor the expenditures made under division (A) of this section at regular intervals, and shall use the following criteria in monitoring such expenditures:

(1) For fiscal year 2012 and fiscal year 2013, per member per month spending for PASSPORT and Choices services will be provided at

approximately the same levels as provided during fiscal year 2011;

(2) For fiscal year 2012 and fiscal year 2013, per member per month spending for PASSPORT Administrative Agency case management functions will be maintained at fiscal year 2011 levels;

(3) For fiscal year 2012, spending for PASSPORT Administrative Agency site operation functions will be ninety-five per cent of the level provided in fiscal year 2011. For fiscal year 2013, spending for PASSPORT Administrative Agency site operation functions will be ninety-five per cent of the level provided in fiscal year 2012.

(C) The Department of Job and Family Services and the Department of Aging shall identify any significant variance in expenditures from the overall funding levels provided under divisions (A) and (B) of this section, and shall take corrective action where variances may adversely affect the delivery of Medicaid waiver-funded PASSPORT Home Care, Choices, Assisted Living, and PACE services.

SECTION 309.30.23. HATTIE LARLHAM COMMUNITY LIVING

Of the foregoing appropriation item 600525, Health Care/Medicaid, $62,500 in each fiscal year shall be awarded to Hattie Larlham Community Living.

SECTION 309.30.30. REDUCTION IN MEDICAID PAYMENT RATES

(A) As used in this section, "charge high trim point" means a measure, excluding the measure established by paragraph (A)(6) of rule 5101:3-2-07.9 of the Administrative Code, used to determine whether a claim for a hospital inpatient service qualifies for a cost outlier payment under the Medicaid program.

(B) For fiscal year 2012 and fiscal year 2013, the Director of Job and Family Services shall implement purchasing strategies and rate reductions for hospital and other Medicaid-covered services, as determined by the Director, that result in payment rates for those services being at least two per cent less than the respective payment rates for fiscal year 2011. In implementing the purchasing strategies and rate reductions, the Director shall do the following:

(1) Notwithstanding the section of this act titled "CONTINUATION OF MEDICAID RATES FOR HOSPITAL INPATIENT AND OUTPATIENT SERVICES," modernize hospital inpatient and outpatient reimbursement methodologies by doing the following:

(a) Modifying the inpatient hospital capital reimbursement

methodology;

(b) Establishing new diagnosis-related groups in a cost-neutral manner;

(c) For hospital discharges that occur during the period beginning October 1, 2011, and ending January 1, 2012, modifying charge high trim points, as in effect on January 1, 2011, by a factor of 13.6%;

(d) For hospital discharges that occur during the period beginning January 1, 2012, and ending on the effective date of the first of the new diagnosis-related groups established under division (B)(1)(b) of this section, modifying charge high trim points, as in effect on October 1, 2011, by a factor of 9.72%;

(e) Implementing other changes the Director considers appropriate.

(2) Establish selective contracting and prior authorization requirements for types of medical assistance the Director identifies.

(C) The Director shall adopt rules under section 5111.02 and 5111.85 of the Revised Code as necessary to implement this section.

(D) This section does not apply to nursing facility and intermediate care facility for the mentally retarded services provided under the Medicaid program.

SECTION 309.30.31. FISCAL YEAR 2012 MEDICARE COPAYMENT FOR DIALYSIS SERVICES PROVIDED TO MEDICAID RECIPIENTS

(A) As used in this section, "dual eligible individual" has the same meaning as in section 1915(h)(2)(B) of the "Social Security Act," 124 Stat. 315 (2010), 42 U.S.C. 1396n(h)(2)(B).

(B) Notwithstanding any conflicting provision of section 5111.021 of the Revised Code or any other conflicting provision of the Revised Code or this act, in fiscal year 2012, for dialysis services provided to a dual eligible individual, the Department of Job and Family Services shall pay under the Medicaid program an amount equal to the Medicare copayment amount that applies to the service, as that amount was paid by the Department immediately prior to the effective date of this section.

SECTION 309.30.32. FISCAL YEAR 2013 MEDICAID RATE FOR DIALYSIS SERVICES

In fiscal year 2013, the Department of Job and Family Services may adjust the Medicaid rates that are paid for dialysis services by an amount sufficient to achieve aggregate savings of not more than $9 million in state share expenditures under the Medicaid program. The aggregate savings shall include any savings that may be achieved through measures taken with

regard to dialysis services under the section of this act titled "REDUCTION IN MEDICAID PAYMENT RATES.

SECTION 309.30.33. HOSPITAL INPATIENT AND OUTPATIENT SUPPLEMENTAL UPPER PAYMENT LIMIT PROGRAM; MEDICAID MANAGED CARE HOSPITAL INCENTIVE PAYMENT PROGRAM

(A) As used in this section:

(1) "Hospital" has the same meaning as in section 5112.40 of the Revised Code.

(2) "Hospital Assessment Fund" means the fund created under section 5112.45 of the Revised Code.

(3) "Medicaid managed care organization" means an entity under contract pursuant to section 5111.17 of the Revised Code to provide or arrange services for Medicaid recipients who are required or permitted to participate in the Medicaid care management system.

(B) The Department of Job and Family Services shall submit to the United States Secretary of Health and Human Services a Medicaid state plan amendment to do both of the following:

(1) Continue the Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program that was established pursuant to Section 309.30.17 of Am. Sub. H.B. 1 of the 128th General Assembly, with any modifications necessary to implement the program as described under division (D) of this section;

(2) Create the Medicaid Managed Care Hospital Incentive Payment Program, as described under division (E) of this section.

(C) Of the amounts deposited into the Hospital Assessment Fund in fiscal year 2012 and fiscal year 2013:

(1) Up to $432,432,725 (state and federal) in fiscal year 2012 and up to $415,162,388 (state and federal) in fiscal year 2013 shall be used for the Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program;

(2) Up to $162,000,000 (state and federal) in each fiscal year shall be used for the Medicaid Managed Care Hospital Incentive Payment Program;

(3) Up to $176,021,111 (state and federal) in fiscal year 2012 and up to $195,158,394 (state and federal) in fiscal year 2013 shall be used for the program authorized by the section of this act titled "CONTINUATION OF MEDICAID RATES FOR HOSPITAL INPATIENT AND OUTPATIENT SERVICES."

(D)(1) If the Medicaid state plan amendment submitted under division (B)(1) of this section is approved, the Department shall implement the

Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program during fiscal year 2012 and fiscal year 2013. Under the Program, subject to division (D)(2) of this section, supplemental Medicaid payments shall be made to hospitals for Medicaid-covered inpatient and outpatient services. The Department shall make the payments through amounts that are made available for the Program under division (C) of this section and any federal financial participation available for the Program.

(2) The Department shall take all actions necessary to cease implementation of the Program if the United States Secretary determines that the assessment imposed under section 5112.41 of the Revised Code is an impermissible healthcare-related tax under section 1903(w) of the "Social Security Act," 105 Stat. 1793 (1991), 42 U.S.C. 1396b(w), as amended.

(E)(1) If the Medicaid state plan amendment submitted under division (B)(2) of this section is approved, the Department shall implement the Medicaid Managed Care Hospital Incentive Payment Program. The purpose of the Program is to increase access to hospital services for Medicaid recipients who are enrolled in Medicaid managed care organizations.

Under the Program, subject to division (E)(3) of this section, funds shall be provided to Medicaid managed care organizations, which shall use the funds to increase payments to hospitals for providing services to Medicaid recipients who are enrolled in the organizations. The Department shall provide the funds through amounts that are made available for the Program under division (C) of this section and any federal financial participation available for the Program.

(2) Not later than July 1, 2012, the Department shall select an actuary to conduct a study of the contracted reimbursement rates between Medicaid managed care organizations and hospitals. The actuary shall determine if a reduction in the capitation rates paid to Medicaid managed care organizations in fiscal year 2013 is appropriate as a result of the contracted reimbursement rates between the organizations and hospitals. The actuary shall notify the Department of its determination.

If the actuary determines that a reduction in the capitation rates paid to Medicaid managed care organizations in fiscal year 2013 will not achieve $22 million in state savings in fiscal year 2013, the state shall receive the difference between what the actuary determines the state will save and $22 million. The Department, in consultation with the Ohio Association of Health Plans and the Ohio Hospital Association, shall establish a methodology under which the difference is paid equally by Medicaid managed care organizations and hospitals in this state.

Notwithstanding anything to the contrary specified in division (E)(3)(b)

or (c) of this section, the Medicaid managed care organizations and hospitals shall pay the amounts determined under the methodology, unless the Department waives the requirement to make the payments. The requirement may be waived if spending for the Medicaid program in fiscal year 2013 is less than the amount that is budgeted for that fiscal year. If payments are made, the amount received by the Department shall be deposited into the state treasury to the credit of the Health Care Compliance Fund created under section 5111.171 of the Revised Code.

(3)(a) The Department shall not provide funds to Medicaid managed care organizations under the Program unless an actuary selected by the Department certifies that the Program would not violate the actuarial soundness of the capitation rates paid to Medicaid managed care organizations.

(b) The Department shall not implement the Program in a manner that causes a hospital to receive less money from the Hospital Assessment Fund than the hospital would have received if the Program were not implemented.

(c) The Department shall not implement the Program in a manner that causes a Medicaid managed care organization to receive a lower capitation payment rate solely because funds are made available to the organization under the Program.

(d) The Department shall take all necessary actions to cease implementation of the Program if the United States Secretary determines that the assessment imposed under section 5112.41 of the Revised Code is an impermissible healthcare-related tax under section 1903(w) of the "Social Security Act," 105 Stat. 1793 (1991), 42 U.S.C. 1396b(w), as amended.

(F) The Director of Budget and Management may authorize additional expenditures from appropriation item 600623, Health Care Federal, appropriation item 600525, Health Care/Medicaid, and appropriation item 600656, Medicaid-Hospital, in order to implement the programs authorized by this section and to implement the section of this act titled "CONTINUATION OF MEDICAID RATES FOR HOSPITAL INPATIENT AND OUTPATIENT SERVICES." Any amounts authorized are hereby appropriated.

(G) Nothing in this section reduces payments to children's hospitals authorized under the section of this act titled "CHILDREN'S HOSPITALS SUPPLEMENTAL FUNDING."

SECTION 309.30.35. CONTINUATION OF MEDICAID RATES FOR HOSPITAL INPATIENT AND OUTPATIENT SERVICES

The Director of Job and Family Services shall amend rules adopted

under section 5111.02 of the Revised Code as necessary to continue, for fiscal year 2012 and fiscal year 2013, the Medicaid reimbursement rates in effect on June 30, 2011, for Medicaid-covered hospital inpatient services and hospital outpatient services that are paid under the prospective payment system established in those rules.

SECTION 309.30.38. CHILDREN'S HOSPITALS SUPPLEMENTAL FUNDING

(A) As used in this section, "children's hospital" means a children's hospital, as defined in section 3702.51 of the Revised Code, that is located in this state, primarily serves patients eighteen years of age and younger, is subject to the Medicaid prospective payment system for hospitals established in rules adopted under section 5111.02 of the Revised Code, and is excluded from Medicare prospective payment in accordance with 42 C.F.R. 412.23(d).

(B) For fiscal year 2012 and fiscal year 2013, the Director of Job and Family Services shall make additional Medicaid payments to children's hospitals for inpatient services to compensate children's hospitals for the high percentage of Medicaid recipients they serve. The additional payments shall be made under a program modeled after the program the Department of Job and Family Services was required to create for fiscal year 2006 and fiscal year 2007 in Section 206.66.79 of Am. Sub. H.B. 66 of the 126th General Assembly. The program may be the same as the program the Director used for making the payments to children's hospitals for fiscal year 2010 and fiscal year 2011 under Section 309.30.15 of Am. Sub. H.B. 1 of the 128th General Assembly.

(C) All of the following shall be used to make additional Medicaid payments to children's hospitals under division (B) of this section:

(1) Of the foregoing appropriation item 600537, Children's Hospital, up to $6 million in each fiscal year plus the corresponding federal match;

(2) Of the amounts deposited into the Hospital Assessment Fund created under section 5112.45 of the Revised Code, $4.4 million in fiscal year 2012, plus the corresponding federal match, and $4 million in fiscal year 2013, plus the corresponding federal match.

SECTION 309.30.40. MANAGED CARE PERFORMANCE PAYMENT PROGRAM

At the beginning of each quarter, or as soon as possible thereafter, the Director of Job and Family Services shall certify to the Director of Budget

and Management the amount withheld in accordance with section 5111.1711 of the Revised Code for purposes of the Managed Care Performance Payment Program. Upon receiving certification, the Director of Budget and Management shall transfer cash in the amount certified from the General Revenue Fund to the Managed Care Performance Payment Fund. The transferred cash is hereby appropriated. Appropriation item 600525, Health Care/Medicaid, is hereby reduced by the amount of the transfer.

SECTION 309.30.50. COORDINATION OF CARE FOR COVERED FAMILIES AND CHILDREN PENDING MEDICAID MANAGED CARE ENROLLMENT

(A) As used in this section, "Medicaid managed care" means the care management system established under section 5111.16 of the Revised Code.

(B) The departments of Job and Family Services and Health shall work together on the issue of achieving efficiencies in the delivery of medical assistance provided under Medicaid to families and children.

(C) As part of their work under division (B) of this section, the departments shall develop a proposal for coordinating medical assistance provided to families and children under Medicaid while they wait to be enrolled in Medicaid managed care. In developing the proposal, the departments may do the following:

(1) Conduct research on the status of families and children waiting to be enrolled in Medicaid managed care, including research on the reasons for the wait and the utilization of medical assistance during the waiting period;

(2) Conduct a review of ways to help families and children receive medical assistance in the most appropriate setting while they wait to be enrolled in Medicaid managed care;

(3) Develop recommendations for a coordinated, cost-effective system of helping families and children waiting to be enrolled in Medicaid managed care find the medical assistance they need during the waiting period;

(4) For the purpose of reducing the waiting period for enrollment in Medicaid managed care, develop recommendations for improving the enrollment processes.

(D) As part of the work that is done under division (B) of this section, the Department of Job and Family Services may submit to the United States Secretary of Health and Human Services a request for a Medicaid state plan amendment to authorize payment for Medicaid-reimbursable targeted case management services that are provided in connection with the Help Me Grow Program and for services provided under the Program. Each quarter during fiscal year 2012 and fiscal year 2013 following approval of the

Medicaid state plan amendment, the Department of Job and Family Services shall certify to the Director of Budget and Management the state and federal share of the amount the Department of Job and Family Services has expended that quarter for services under this section. On receipt of each quarterly certification to the Director of Budget and Management shall decrease appropriation from appropriation item 440459, Help Me Grow, an amount equal to the state share of the certified expenditures and increase appropriation item 600525, Health Care/Medicaid by an equal amount and adjust the Federal share accordingly. This transfer is not intended to reduce General Revenue Funds appropriated for the Help Me Grow Program, but is done solely for the purpose of drawing down the federal share of Medicaid reimbursement.

SECTION 309.30.53. MEDICAID MANAGED CARE EXEMPTIONS

Notwithstanding section 5111.16 of the Revised Code, as amended by this act, the Department of Job and Family Services shall not include in the care management system established under that section in either fiscal year 2012 or fiscal year 2013 any individual receiving services through the program for medically handicapped children established under section 3701.023 of the Revised Code who has one or more of the following conditions and who was not receiving services through the care management system immediately before the effective date of this section:

(1) Cystic fibrosis;

(2) Hemophilia;

(3) Cancer.

SECTION 309.30.55. PRIOR AUTHORIZATION FOR COMMUNITY MENTAL HEALTH SERVICES

(A) As used in this section, "community mental health services" means mental health services included in the state Medicaid plan pursuant to section 5111.023 of the Revised Code.

(B) For fiscal year 2012 and fiscal year 2013, a Medicaid recipient who is under twenty-one years of age automatically satisfies all requirements for any prior authorization process for community mental health services provided under a component of the Medicaid program administered by the Department of Mental Health pursuant to an interagency agreement authorized by section 5111.91 of the Revised Code if any of the following apply to the recipient:

(1) The recipient is in the temporary custody or permanent custody of a

public children services agency or private child placing agency or is in a planned permanent living arrangement.

(2) The recipient has been placed in protective supervision by a juvenile court.

(3) The recipient has been committed to the Department of Youth Services.

(4) The recipient is an alleged or adjudicated delinquent or unruly child receiving services under the Felony Delinquent Care and Custody Program operated under section 5139.43 of the Revised Code.

SECTION 309.30.60. FISCAL YEAR 2012 MEDICAID REIMBURSEMENT SYSTEM FOR NURSING FACILITIES

(A) As used in this section:

"Franchise permit fee," "Medicaid days," "nursing facility," and "provider" have the same meanings as in section 5111.20 of the Revised Code.

"Nursing facility services" means nursing facility services covered by the Medicaid program that a nursing facility provides to a resident of the nursing facility who is a Medicaid recipient eligible for Medicaid-covered nursing facility services.

(B) Except as otherwise provided by this section, the provider of a nursing facility that has a valid Medicaid provider agreement on June 30, 2011, and a valid Medicaid provider agreement during fiscal year 2012 shall be paid, for nursing facility services the nursing facility provides during fiscal year 2012, the rate calculated for the nursing facility under sections 5111.20 to 5111.331 of the Revised Code with the following adjustments:

(1) For the purpose of determining the nursing facility's rate for direct care costs under section 5111.231 of the Revised Code, the nursing facility's semiannual case-mix score for the period beginning July 1, 2011, and ending January 1, 2012, shall be the same as the semiannual case-mix score, as determined under section 5111.232 of the Revised Code, used in calculating the nursing facility's June 30, 2011, rate for direct care costs.

(2) The cost per case mix-unit calculated under section 5111.231 of the Revised Code, the rate for ancillary and support costs calculated under section 5111.24 of the Revised Code, the rate for tax costs calculated under section 5111.242 of the Revised Code, and the rate for capital costs calculated under section 5111.25 of the Revised Code shall each be increased by 5.08 per cent.

(3) The per resident per day rate paid under section 5111.243 of the Revised Code for the franchise permit fee shall be $11.47.

(4) The mean payment used in the calculation of the quality incentive payment made under section 5111.244 of the Revised Code shall be, weighted by Medicaid days, $3.03 per Medicaid day.

(C) If the rate determined for a nursing facility under division (B) of this section for nursing facility services provided during fiscal year 2012 is less than 90 per cent of the rate the provider is paid for nursing facility services the nursing facility provides on June 30, 2011, the Department of Job and Family Services, except as provided in division (D) of this section, shall provide for the nursing facility's rate for fiscal year 2012 to be the percentage determined as follows less than its June 30, 2011, rate:

(1) Determine the percentage difference between the nursing facility's June 30, 2011, rate and the rate determined for the nursing facility under division (B) of this section;

(2) Reduce the percentage determined under division (C)(1) of this section by ten percentage points;

(3) Divide the percentage determined under division (C)(2) of this section by two;

(4) Increase the percentage determined under division (C)(3) of this section by ten percentage points.

(D) If the franchise permit fee must be reduced or eliminated to comply with federal law, the Department of Job and Family Services shall reduce the amount it pays providers of nursing facility services under this section as necessary to reflect the loss to the state of the revenue and federal financial participation generated from the franchise permit fee.

(E) The Department of Job and Family Services shall follow this section in determining the rate to be paid to the provider of a nursing facility that has a valid Medicaid provider agreement on June 30, 2011, and a valid Medicaid provider agreement during fiscal year 2012 notwithstanding anything to the contrary in sections 5111.20 to 5111.331 of the Revised Code.

SECTION 309.30.70. FISCAL YEAR 2013 MEDICAID REIMBURSEMENT SYSTEM FOR NURSING FACILITIES

(A) As used in this section:

"Franchise permit fee," "Medicaid days," "nursing facility," and "provider" have the same meanings as in section 5111.20 of the Revised Code.

"Low resource utilization resident" means a Medicaid recipient residing in a nursing facility who, for purposes of calculating the nursing facility's Medicaid reimbursement rate for direct care costs, is placed in either of the

two lowest resource utilization groups, excluding any resource utilization group that is a default group used for residents with incomplete assessment data.

"Nursing facility services" means nursing facility services covered by the Medicaid program that a nursing facility provides to a resident of the nursing facility who is a Medicaid recipient eligible for Medicaid-covered nursing facility services.

(B) Except as otherwise provided by this section, the provider of a nursing facility that has a valid Medicaid provider agreement on June 30, 2012, and a valid Medicaid provider agreement during fiscal year 2013 shall be paid, for nursing facility services the nursing facility provides during fiscal year 2013, the rate calculated for the nursing facility under sections 5111.20 to 5111.331 of the Revised Code with the following adjustments:

(1) The cost per case mix-unit calculated under section 5111.231 of the Revised Code, the rate for ancillary and support costs calculated under section 5111.24 of the Revised Code, the rate for tax costs calculated under section 5111.242 of the Revised Code, and the rate for capital costs calculated under section 5111.25 of the Revised Code shall each be increased by 5.08 per cent;

(2) The maximum quality incentive payment made under section 5111.244 of the Revised Code shall be $16.44 per Medicaid day.

(C) The rate determined under division (B) of this section shall not be paid for nursing facility services provided to low resource utilization residents. Except as provided in division (D) of this section, the provider of a nursing facility that has a valid Medicaid provider agreement on June 30, 2012, and a valid Medicaid provider agreement during fiscal year 2013 shall be paid, for nursing facility services the nursing facility provides during fiscal year 2013 to low resource utilization residents, $130.00 per Medicaid day.

(D) If the franchise permit fee must be reduced or eliminated to comply with federal law, the Department of Job and Family Services shall reduce the amount it pays providers of nursing facility services under this section as necessary to reflect the loss to the state of the revenue and federal financial participation generated from the franchise permit fee.

(E) The Department of Job and Family Services shall follow this section in determining the rate to be paid to the provider of a nursing facility that has a valid Medicaid provider agreement on June 30, 2012, and a valid Medicaid provider agreement during fiscal year 2013 notwithstanding anything to the contrary in sections 5111.20 to 5111.331 of the Revised Code.

SECTION 309.30.73. JOINT LEGISLATIVE COMMITTEE FOR UNIFIED LONG-TERM SERVICES AND SUPPORTS

(A) There is hereby created the Joint Legislative Committee for Unified Long-Term Services and Supports. 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 Committee may examine the following issues:

(1) The implementation of the dual eligible integrated care demonstration project authorized by section 5111.981 of the Revised Code;

(2) The implementation of a unified long-term services and support Medicaid waiver component under section 5111.864 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 3721.50 to 3721.58 of the Revised Code;

(6) Other issues of interest to the committee.

(D) The co-chairpersons of the Committee shall provide for the Director of the Office of Ohio Health Plans in the Department of Job and Family Services to testify before the Committee not later than September 30, 2011, and at least quarterly thereafter regarding the issues that the Committee

examines.

SECTION 309.30.80. STUDY OF ICF/MR ISSUES

(A) As used in this section:

"Home and community-based services" has the same meaning as in section 5123.01 of the Revised Code.

"ICF/MR" means an intermediate care facility for the mentally retarded as defined in section 5111.20 of the Revised Code.

"ICF/MR services" means services covered by the Medicaid program that an ICF/MR provides to a Medicaid recipient eligible for the services.

(B) The Departments of Job and Family Services and Developmental Disabilities shall study issues regarding Medicaid reimbursement for ICF/MR services. In conducting the study, the Departments shall examine the following:

(1) Revising the Individual Assessment Form Answer Sheet in a manner that provides a more accurate assessment of the acuity and care needs of individuals who need ICF/MR services, especially the acuity and care needs of such individuals who have intensive behavioral or medical needs;

(2) Revising the Medicaid reimbursement formula for ICF/MR services to accomplish the following:

(a) Ensure that reimbursement for capital costs is adequate for maintaining the capital assets of ICFs/MR in a manner that promotes the well-being of the residents;

(b) Provide capital incentives for reducing the capacity of ICFs/MR as necessary to achieve goals regarding the optimal capacity of ICFs/MR;

(c) Ensure that wages paid individuals who provide direct care services to ICF/MR residents are sufficient for ICFs/MR to meet staffing and quality requirements;

(d) Provide incentives for high quality services;

(e) Achieve other goals developed for the purpose of improving the appropriateness and sufficiency of Medicaid reimbursements for ICF/MR services.

(C) The Departments shall examine the issue of revising the Individual Assessment Form Answer Sheet before examining the issue of revising the Medicaid reimbursement formula for ICF/MR services. The Departments shall prepare a report of the study conducted under this section and submit the report to the Governor and, in accordance with section 101.68 of the Revised Code, the General Assembly.

(D) At the same time that the Departments conduct the study under this section, they shall work with the Governor's Office of Health

Transformation and persons interested in the issue of ICF/MR services to develop recommendations regarding the following:

(1) Goals regarding the ratio of home and community-based services and ICF/MR services provided under the Medicaid program that take into account goals regarding the optimal capacity of ICFs/MR;

(2) The roles and responsibilities of both of the following:

(a) ICFs/MR owned and operated by the Department of Developmental Disabilities;

(b) Providers of home and community-based services.

(3) Simplifying and eliminating duplicate regulations regarding ICFs/MR in a manner that lowers the cost of ICF/MR services.

SECTION 309.30.90. FISCAL YEAR 2012 MEDICAID REIMBURSEMENT SYSTEM FOR ICFs/MR

(A) As used in this section:

"Capped per diem rate" means the per diem rate calculated for an ICF/MR under division (D) of this section.

"Change of operator," "entering operator," and "exiting operator" have the same meanings as in section 5111.65 of the Revised Code.

"Franchise permit fee" and "provider" have the same meanings as in section 5111.20 of the Revised Code.

"ICF/MR" means an intermediate care facility for the mentally retarded as defined in section 5111.20 of the Revised Code.

"ICF/MR services" means services covered by the Medicaid program that an ICF/MR provides to a Medicaid recipient eligible for the services.

"Medicaid days" means all days during which a resident who is a Medicaid recipient occupies a bed in an ICF/MR that is included in the ICF/MR's Medicaid-certified capacity. Therapeutic or hospital leave days for which payment is made under section 5111.33 of the Revised Code are considered Medicaid days proportionate to the percentage of the ICF/MR's per resident per day rate paid for those days.

"Modified per diem rate" means the per diem rate calculated for an ICF/MR under division (C) of this section.

"Unmodified per diem rate" means the per diem rate calculated for an ICF/MR under sections 5111.20 to 5111.331 of the Revised Code.

(B) This section applies to each provider of an ICF/MR to which either of the following applies:

(1) The provider has a valid Medicaid provider agreement for the ICF/MR on June 30, 2011, and a valid Medicaid provider agreement for the ICF/MR during fiscal year 2012.

(2) The ICF/MR undergoes a change of operator that takes effect during fiscal year 2012, the exiting operator has a valid Medicaid provider agreement for the ICF/MR on the day immediately preceding the effective date of the change of operator, and the entering operator has a valid Medicaid provider agreement for the ICF/MR during fiscal year 2012.

(C) An ICF/MR's total modified per diem rate for fiscal year 2012 shall be the ICF/MR's total unmodified per diem rate for that fiscal year with the following modifications:

(1) In place of the inflation adjustment otherwise made under section 5111.235 of the Revised Code, the ICF/MR's desk-reviewed, actual, allowable, per diem other protected costs, excluding the franchise permit fee, from calendar year 2010 shall be multiplied by 1.0123.

(2) In place of the maximum cost per case-mix unit established for the ICF/MR's peer group under division (B)(2) of section 5111.23 of the Revised Code, the ICF/MR's maximum costs per case-mix unit shall be the following:

(a) In the case of an ICF/MR with more than eight beds, $108.21;

(b) In the case of an ICF/MR with eight or fewer beds, $102.21.

(3) In place of the inflation adjustment otherwise calculated under division (B)(3) of section 5111.23 of the Revised Code for the purpose of division (C)(2) of that section, an inflation adjustment of 1.0123 shall be used.

(4) In place of the maximum rate for indirect care costs established for the ICF/MR's peer group under division (B) of section 5111.241 of the Revised Code, the maximum rate for indirect care costs for the ICF/MR's peer group shall be the following:

(a) In the case of an ICF/MR with more than eight beds, $68.98;

(b) In the case of an ICF/MR with eight or fewer beds, $59.60.

(5) In place of the inflation adjustment otherwise calculated under division (C)(1) of section 5111.241 of the Revised Code for the purpose of division (A)(1) of that section only, an inflation adjustment of 1.0123 shall be used.

(6) In place of the efficiency incentive otherwise calculated under division (A)(2) of section 5111.241 of the Revised Code, the ICF/MR's efficiency incentive for indirect care costs shall be the following:

(a) In the case of an ICF/MR with more than eight beds, $3.69;

(b) In the case of an ICF/MR with eight or fewer beds, $3.19.

(7) The ICF/MR's efficiency incentive for capital costs, as determined under division (B) of section 5111.251 of the Revised Code, shall be reduced by 50 per cent.

(D) An ICF/MR's total capped per diem rate for fiscal year 2012 shall be the ICF/MR's total unmodified per diem rate for that fiscal year reduced by the percentage by which the mean total unmodified per diem rates for all ICFs/MR in this state for fiscal year 2012, weighted by May 2011 Medicaid days and calculated as of July 1, 2011, exceeds $282.59.

(E) Except as otherwise provided by this section, the provider of an ICF/MR to which this section applies shall be paid, for ICF/MR services the ICF/MR provides during fiscal year 2012, a total per diem rate determined as follows:

(1) Add the ICF/MR's total modified per diem rate to the ICF/MR's total capped per diem rate;

(2) Divide the amount determined under division (E)(1) of this section by two.

(F) If the mean total per diem rate for all ICFs/MR to which this section applies, weighted by May 2011 Medicaid days and determined under division (E) of this section as of July 1, 2011, is other than $282.59, the Department of Job and Family Services shall adjust, for fiscal year 2012, the total per diem rate for each ICF/MR to which this section applies by a percentage that is equal to the percentage by which the mean total per diem rate is greater or less than $282.59.

(G) If the United States Centers for Medicare and Medicaid Services requires that the franchise permit fee be reduced or eliminated, the Department of Job and Family Services shall reduce the amount it pays providers of ICF/MR services under this section as necessary to reflect the loss to the state of the revenue and federal financial participation generated from the franchise permit fee.

(H) The Department of Job and Family Services shall follow this section in determining the rate to be paid providers of ICF/MR services subject to this section notwithstanding anything to the contrary in sections 5111.20 to 5111.331 of the Revised Code.

SECTION 309.33.10. FISCAL YEAR 2013 MEDICAID REIMBURSEMENT SYSTEM FOR ICFs/MR

(A) As used in this section:

"Capped per diem rate" means the per diem rate calculated for an ICF/MR under division (D) of this section.

"Change of operator," "entering operator," and "exiting operator" have the same meanings as in section 5111.65 of the Revised Code.

"Franchise permit fee" and "provider" have the same meanings as in section 5111.20 of the Revised Code.

"ICF/MR" means an intermediate care facility for the mentally retarded as defined in section 5111.20 of the Revised Code.

"ICF/MR services" means services covered by the Medicaid program that an ICF/MR provides to a Medicaid recipient eligible for the services.

"Medicaid days" means all days during which a resident who is a Medicaid recipient occupies a bed in an ICF/MR that is included in the ICF/MR's Medicaid-certified capacity. Therapeutic or hospital leave days for which payment is made under section 5111.33 of the Revised Code are considered Medicaid days proportionate to the percentage of the ICF/MR's per resident per day rate paid for those days.

"Modified per diem rate" means the per diem rate calculated for an ICF/MR under division (C) of this section.

"Unmodified per diem rate" means the per diem rate calculated for an ICF/MR under sections 5111.20 to 5111.331 of the Revised Code.

(B) This section applies to each provider of an ICF/MR to which either of the following applies:

(1) The provider has a valid Medicaid provider agreement for the ICF/MR on June 30, 2012, and a valid Medicaid provider agreement for the ICF/MR during fiscal year 2013.

(2) The ICF/MR undergoes a change of operator that takes effect during fiscal year 2013, the exiting operator has a valid Medicaid provider agreement for the ICF/MR on the day immediately preceding the effective date of the change of operator, and the entering operator has a valid Medicaid provider agreement for the ICF/MR during fiscal year 2013.

(C) An ICF/MR's total modified per diem rate for fiscal year 2013 shall be the ICF/MR's total unmodified per diem rate for that fiscal year with the following modifications:

(1) In place of the inflation adjustment otherwise made under section 5111.235 of the Revised Code, the ICF/MR's desk-reviewed, actual, allowable, per diem other protected costs, excluding the franchise permit fee, from calendar year 2011 shall be multiplied by 1.0123.

(2) In place of the maximum cost per case-mix unit established for the ICF/MR's peer group under division (B)(2) of section 5111.23 of the Revised Code, the ICF/MR's maximum costs per case-mix unit shall be the following:

(a) In the case of an ICF/MR with more than eight beds, $108.21;

(b) In the case of an ICF/MR with eight or fewer beds, $102.21.

(3) In place of the inflation adjustment otherwise calculated under division (B)(3) of section 5111.23 of the Revised Code for the purpose of division (C)(2) of that section, an inflation adjustment of 1.0123 shall be

used.

(4) In place of the maximum rate for indirect care costs established for the ICF/MR's peer group under division (B) of section 5111.241 of the Revised Code, the maximum rate for indirect care costs for the ICF/MR's peer group shall be the following:

(a) In the case of an ICF/MR with more than eight beds, $68.98;

(b) In the case of an ICF/MR with eight or fewer beds, $59.60.

(5) In place of the inflation adjustment otherwise calculated under divisions (C)(1) and (2) of section 5111.241 of the Revised Code for the purpose of division (A)(1) of that section only, an inflation adjustment of 1.0123 shall be used.

(6) In place of the efficiency incentive otherwise calculated under division (A)(2) of section 5111.241 of the Revised Code, the ICF/MR's efficiency incentive for indirect care costs shall be the following:

(a) In the case of an ICF/MR with more than eight beds, $3.69;

(b) In the case of an ICF/MR with eight or fewer beds, $3.19.

(7) The ICF/MR's efficiency incentive for capital costs, as determined under division (B) of section 5111.251 of the Revised Code, shall be reduced by 50 per cent.

(D) An ICF/MR's total capped per diem rate for fiscal year 2013 shall be the ICF/MR's total unmodified per diem rate for that fiscal year reduced by the percentage by which the mean total unmodified per diem rates for all ICFs/MR in this state for fiscal year 2013, weighted by May 2012 Medicaid days and calculated as of July 1, 2012, exceeds $282.92.

(E) Except as otherwise provided by this section, the provider of an ICF/MR to which this section applies shall be paid, for ICF/MR services the ICF/MR provides during fiscal year 2013, a total per diem rate determined as follows:

(1) Add the ICF/MR's total modified per diem rate to the ICF/MR's total capped per diem rate;

(2) Divide the amount determined under division (E)(1) of this section by two.

(F) If the mean total per diem rate for all ICFs/MR to which this section applies, weighted by May 2012 Medicaid days and determined under division (E) of this section as of July 1, 2012, is other than $282.92, the Department of Job and Family Services shall adjust, for fiscal year 2013, the total per diem rate for each ICF/MR to which this section applies by a percentage that is equal to the percentage by which the mean total per diem rate is greater or less than $282.92.

(G) If the United States Centers for Medicare and Medicaid Services

requires that the franchise permit fee be reduced or eliminated, the Department of Job and Family Services shall reduce the amount it pays providers of ICF/MR services under this section as necessary to reflect the loss to the state of the revenue and federal financial participation generated from the franchise permit fee.

(H) The Department of Job and Family Services shall follow this section in determining the rate to be paid providers of ICF/MR services subject to this section notwithstanding anything to the contrary in sections 5111.20 to 5111.331 of the Revised Code.

SECTION 309.33.20. ICF/MR AND WAIVER SERVICES TRANSFERRED TO DEPARTMENT OF DEVELOPMENTAL DISABILITIES

The Director of Budget and Management shall establish line items for use by the Department of Developmental Disabilities for purposes regarding the Department's assumption of powers and duties under section 5111.226 of the Revised Code regarding the Medicaid program's coverage of ICF/MR services and, under section 5111.871 of the Revised Code, the Medicaid waiver component known as the Transitions Developmental Disabilities Waiver. The Department of Developmental Disabilities shall certify to the Director of Budget and Management and the Director of Job and Family Services the appropriation amounts, in fiscal year 2012 and fiscal year 2013, necessary for the Department of Developmental Disabilities to fulfill its obligations regarding the new powers and duties without duplicating administration or services that remain with the Department of Job and Family Services.

Once the certification required under this section has been submitted and approved by the Directors of Budget and Management and Job and Family Services, the appropriation items established under this section are hereby appropriated in the amounts approved by the Director of Budget and Management. The Director of Budget and Management may reduce the amount of one or more of the Department of Job and Family Services' appropriation items if the Director determines that the reduction is necessary and appropriate because of the appropriation items established under this section for the Department of Developmental Disabilities. The appropriations are hereby reduced by the amount as determined by the Director of Budget and Management.

SECTION 309.33.30. ADMINISTRATIVE ISSUES RELATED TO

TERMINATION OF MEDICAID WAIVER PROGRAMS

(A) As used in this section, "ODJFS or ODA Medicaid waiver component" means the following:

(1) The Medicaid waiver component of the PASSPORT program created under section 173.40 of the Revised Code;

(2) The Choices program created under section 173.403 of the Revised Code;

(3) The Ohio Home Care program created under section 5111.861 of the Revised Code;

(4) The Ohio Transitions II Aging Carve-Out program created under section 5111.863 of the Revised Code;

(5) The Medicaid waiver component of the Assisted Living program created under section 5111.89 of the Revised Code.

(B) If an ODJFS or ODA Medicaid waiver component is terminated under section 173.40, 173.403, 5111.861, 5111.863, or 5111.89 of the Revised Code, all of the following apply:

(1) All applicable statutes, and all applicable rules, standards, guidelines, or orders issued by the Director or Department of Job and Family Services or Director or Department of Aging before the component is terminated, shall remain in full force and effect on and after that date, but solely for purposes of concluding the component's operations, including fulfilling the Departments' legal obligations for claims arising from the component relating to eligibility determinations, covered medical assistance provided to eligible persons, and recovering erroneous overpayments.

(2) Notwithstanding the termination of the component, the right of subrogation for the cost of medical assistance given under section 5101.58 of the Revised Code to the Department of Job and Family Services and an assignment of the right to medical assistance given under section 5101.59 of the Revised Code to the Department continue to apply with respect to the component and remain in force to the full extent provided under those sections.

(3) The Departments of Job and Family Services and Aging may use appropriated funds to satisfy any claims or contingent claims for medical assistance provided under the component before the component's termination.

(4) Neither department has liability under the component to reimburse any provider or other person for claims for medical assistance rendered under the component after it is terminated.

(C) The Directors of Job and Family Services and Aging may adopt rules in accordance with Chapter 119. of the Revised Code to implement

this section.

SECTION 309.33.40. BEACON QUALITY IMPROVEMENT INITIATIVES

Building on the quality improvement work of the Best Evidence for Advancing Child Health in Ohio Now (BEACON) Council, the Departments of Health, Mental Health, and Job and Family Services, in conjunction with the Governor's Office of Health Transformation, may seek assistance from, and work with, the BEACON Council and hospitals and other provider groups to identify specific targets and initiatives to reduce the cost, and improve the quality, of medical assistance provided under the Medicaid program to children**.** At a minimum, the targets and initiatives shall focus on reducing all of the following:

(A) Avoidable hospitalizations;

(B) Inappropriate emergency room utilization;

(C) Use of multiple medications when not medically indicated;

(D) The state's rate of premature births;

(E) The state's rate of elective, preterm births.

If the Departments of Health, Mental Health, and Job and Family Services identify initiatives under this section, they shall make the initiatives available on their internet web sites. The Departments shall also make a list of hospitals and other provider groups involved in the initiatives available on their internet web sites.

SECTION 309.33.50. EXPANSION AND EVALUATION OF PACE PROGRAM

(A) In order to effectively administer and manage growth within the PACE Program, the Director of Aging, in consultation with the Director of Job and Family Services, may expand the PACE Program to regions of the state beyond those currently served by the PACE Program if all of the following apply:

(1) Funding is available for the expansion.

(2) The Directors of Aging and Job and Family Services mutually determine, taking into consideration the results of the evaluation conducted under division (B) of this section, that the PACE Program is a cost effective alternative to nursing home care.

(3) The United States Centers for Medicare and Medicaid Services agrees to share with the state any savings to the Medicare program resulting from an expansion of the PACE Program.

(B) The Director of Aging shall contract with Miami University's Scripps Gerontology Center for an evaluation of the PACE program.

(C) If the PACE Program is expanded, the Director of Aging may not decrease the number of individuals in Cuyahoga and Hamilton counties and parts of Butler, Clermont, and Warren counties who are participants in the PACE Program below the number of individuals in those counties and parts of counties who were participants in the PACE Program on July 1, 2011.

SECTION 309.33.60. REPEAL OF THE CHILDREN'S BUY-IN PROGRAM

(A) Notwithstanding sections 5101.5211 to 5101.5216 of the Revised Code and all references in the Revised Code to those sections or the Children's Buy-In Program, no person may enroll in the Program on or after the effective date of this section.

Notwithstanding this act's repeal on October 1, 2011, of the statutes under which the Program is operated, persons enrolled in the Program immediately prior to that date may continue to receive services under the Program, as if those statutes were not repealed. Such persons may receive the services through December 31, 2011, as long as they remain eligible for the Program.

(B) Commencing on the effective date of this section, the Director of Job and Family Services shall take steps as necessary to transition persons enrolled in the Program to other health coverage options and otherwise conclude Program operations.

All Program-related rules, standards, guidelines, or orders issued by the Director or Department of Job and Family Services prior to October 1, 2011, shall remain in full force and effect on and after that date, but solely for purposes of concluding the Program's operations. Such purposes include permitting eligible persons to receive services under the Program through December 31, 2011, as authorized by this section, and fulfilling the Department's legal obligations for claims arising from the Program relating to eligibility determinations, covered medical services rendered to eligible persons, and recovering erroneous overpayments.

(C) Notwithstanding this act's repeal of the statutes authorizing the Program, the right of subrogation for the cost of medical services and care given under section 5101.58 of the Revised Code to the Department and an assignment of the right to medical support given under section 5101.59 of the Revised Code to the Department continue to apply with respect to the Program and remain in force to the full extent provided under those sections.

(D) The Department may use appropriated funds to satisfy any claims or

contingent claims for services rendered to Program participants prior to October 1, 2011, and to eligible persons who receive services under the Program through December 31, 2011, as authorized by this section. The Department has no liability under the Program to reimburse any provider or other person for claims for services rendered on or after January 1, 2012.

(E) The Department may adopt rules in accordance with section 111.15 of the Revised Code to implement this section.

SECTION 309.33.70. CONTINUATION OF DISPENSING FEE FOR NONCOMPOUNDED DRUGS

The Medicaid dispensing fee for each noncompounded drug covered by the Medicaid program shall be $1.80 for the period beginning July 1, 2011, and ending on the effective date of a rule, or an amendment to a rule, changing the amount of the fee that the Director of Job and Family Services adopts or amends under section 5111.02 of the Revised Code.

SECTION 309.33.80. MONEY FOLLOWS THE PERSON ENHANCED REIMBURSEMENT FUND

The Money Follows the Person Enhanced Reimbursement Fund, created by Section 751.20 of Am. Sub. H.B. 562 of the 127th General Assembly, shall continue to exist in the state treasury for fiscal year 2012 and fiscal year 2013. The federal payments made to the state under subsection (e) of section 6071 of the "Deficit Reduction Act of 2005," Pub. L. No. 109-171, as amended, shall be deposited into the fund. The Department of Job and Family Services shall continue to use money deposited into the fund for system reform activities related to the Money Follows the Person demonstration project.

SECTION 309.33.90. MEDICARE PART D

The foregoing appropriation item 600526, Medicare Part D, may be used by the Department of Job and Family Services for the implementation and operation of the Medicare Part D requirements contained in the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003," Pub. L. No. 108-173, as amended. Upon the request of the Department of Job and Family Services, the Director of Budget and Management may transfer the state share of appropriations between appropriation item 600525, Health Care/Medicaid, or appropriation item 600526, Medicare Part D. If the state share of appropriation item 600525,

Health Care/Medicaid, is adjusted, the Director of Budget and Management shall adjust the federal share accordingly. The Department of Job and Family Services shall provide notification to the Controlling Board of any transfers at the next scheduled Controlling Board meeting.

SECTION 309.35.10. REBALANCING LONG-TERM CARE

(A) As used in this section:

"Balancing Incentive Payments Program" means the program established under section 10202 of the Patient Protection and Affordable Care Act.

"Long-term services and supports" has the same meaning as in section 10202(f)(1) of the Patient Protection and Affordable Care Act.

"Non-institutionally-based long-term services and supports" has the same meaning as in section 10202(f)(1)(B) of the Patient Protection and Affordable Care Act.

"Patient Protection and Affordable Care Act" means Public Law 111-148.

(B) The Departments of Job and Family Services, Aging, and Developmental Disabilities shall continue efforts to achieve a sustainable and balanced delivery system for long-term services and supports. In so doing, the Departments shall strive to realize the following goals by June 30, 2013:

(1) Having at least fifty per cent of Medicaid recipients who are sixty years of age or older and need long-term services and supports utilize non-institutionally-based long-term services and supports;

(2) Having at least sixty per cent of Medicaid recipients who are less than sixty years of age and have cognitive or physical disabilities for which long-term services and supports are needed utilize non-institutionally-based long-term services and supports.

(C) If the Department of Job and Family Services determines that participating in the Balancing Incentive Payments Program will assist in achieving the goals specified in division (B) of this section, the Department may apply to the United States Secretary of Health and Human Services to participate in the program. Any funds the state receives as the result of the enhanced federal financial participation provided to states participating in the Balancing Incentive Payments Program shall be deposited into the Balancing Incentive Payments Program Fund, which is hereby created in the state treasury. The Department of Job and Family Services shall use the money in the fund in accordance with section 10202(c)(4) of the Patient Protection and Affordable Care Act.

SECTION 309.35.20. BALANCING INCENTIVE PAYMENTS PROGRAM FUND

The Director of Job and Family Services may seek Controlling Board approval to make expenditures from the Balancing Incentive Payments Program Fund.

SECTION 309.35.30. DUAL ELIGIBLE INTEGRATED CARE DEMONSTRATION PROJECT

The Director of Job and Family Services may seek Controlling Board approval to make expenditures from the Integrated Care Delivery Systems Fund.

SECTION 309.35.40. OHIO ACCESS SUCCESS PROJECT AND IDENTIFICATION OF OVERPAYMENTS

(A) Notwithstanding any limitations in sections 3721.51 and 3721.56 of the Revised Code, in each fiscal year, cash from the Nursing Home Franchise Permit Fee Fund (Fund 5R20) may be used by the Department of Job and Family Services for the following purposes:

(1) Up to $3,000,000 in each fiscal year to fund the state share of audits or limited reviews of Medicaid providers;

(2) Up to $450,000 in each fiscal year to provide one-time transitional benefits under the Ohio Access Success Project that the Director of Job and Family Services may establish under section 5111.97 of the Revised Code.

(B) On July 1, 2011, or as soon as possible thereafter, the Director of Budget and Management shall transfer the cash balance in the Home and Community-Based Services for the Aged Fund (Fund 4J50) to the Nursing Home Franchise Permit Fee Fund (Fund 5R20). The transferred cash is hereby appropriated. Upon completion of the transfer, Fund 4J50 is abolished. The Director shall cancel any existing encumbrances against appropriation item 600613, Nursing Facility Bed Assessments, and appropriation item 600618, Residential State Supplement Payments, and reestablish them against appropriation item 600608, Medicaid - Nursing Facilities.

SECTION 309.35.50. PROVIDER FRANCHISE FEE OFFSETS

(A) At least quarterly, the Director of Job and Family Services shall certify to the Director of Budget and Management both of the following:

(1) The amount of offsets withheld under section 3721.541 of the Revised Code from payments made from the General Revenue Fund.

(2) The amount of offsets withheld under section 5112.341 of the Revised Code from payments made from the General Revenue Fund.

(B) The Director of Budget and Management may transfer cash from the General Revenue Fund to all of the following:

(1) The Nursing Home Franchise Permit Fee Fund (Fund 5R20), in accordance with section 3721.56 of the Revised Code;

(2) The ICF/MR Bed Assessments Fund (Fund 4K10).

(C) Amounts transferred pursuant to this section are hereby appropriated.

SECTION 309.35.60. TRANSFER OF FUNDS TO THE DEPARTMENT OF DEVELOPMENTAL DISABILITIES

The Department of Job and Family Services may transfer cash in each fiscal year from the ICF/MR Bed Assessments Fund (Fund 4K10) to the Home and Community-Based Services Fund (Fund 4K80), used by the Department of Developmental Disabilities. The amount to be transferred shall be agreed to by both departments. The transfer may occur on a quarterly basis or on a schedule developed and agreed to by both departments. The transfer may be made using an intrastate transfer voucher.

SECTION 309.35.70. HOSPITAL CARE ASSURANCE MATCH

The foregoing appropriation item 600650, Hospital Care Assurance Match, shall be used by the Department of Job and Family Services solely for distributing funds to hospitals under section 5112.08 of the Revised Code.

SECTION 309.35.73. HEALTHCARE COMPLIANCE APPROPRIATION

Notwithstanding the provisions of section 5111.171 of the Revised Code specifying the uses of the HealthCare Compliance Fund, appropriations in appropriation item 600625, HealthCare Compliance, may be used for expenses incurred in implementation or operation of Health Home programs and for the creation, modification, or replacement of any federally funded Medicaid healthcare systems in fiscal year 2012 and fiscal year 2013.

SECTION 309.35.80. HEALTH CARE SERVICES ADMINISTRATION FUND

Of the amount received by the Department of Job and Family Services during fiscal year 2012 and fiscal year 2013 from the first installment of assessments paid under section 5112.06 of the Revised Code and intergovernmental transfers made under section 5112.07 of the Revised Code, the Director of Job and Family Services shall deposit $350,000 in each fiscal year into the state treasury to the credit of the Health Care Services Administration Fund (Fund 5U30).

SECTION 309.35.90. TRANSFERS OF OFFSETS TO THE HEALTH CARE SERVICES ADMINISTRATION FUND

(A) As used in this section:

"Hospital offset" means an offset from a hospital's Medicaid payment authorized by section 5112.991 of the Revised Code.

"Vendor offset" means a reduction of a Medicaid payment to a Medicaid provider to correct a previous, incorrect Medicaid payment.

(B) At least quarterly during fiscal year 2012 and fiscal year 2013, the Director of Job and Family Services shall certify to the Director of Budget and Management the amount of hospital offsets and vendor offsets for the period covered by the certification and the particular funds that would have been used to make the extra payments to providers if not for the offsets. The certification shall specify how much extra would have been taken from each of the funds if not for the hospital offsets and vendor offsets.

(C) On receipt of a certification under division (B) of this section, the Director of Budget and Management shall transfer cash from the funds identified in the certification to the Health Care Services Administration Fund (Fund 5U30). The amount transferred from a fund shall equal the amount that would have been taken from the fund if not for the hospital offsets and vendor offsets as specified in the certification. The transferred cash is hereby appropriated.

SECTION 309.37.10. PROVIDER APPLICATION FEES

If receipts credited to the Health Care Services Administration Fund (Fund 5U30) exceed the amounts appropriated from the fund, the Director of Job and Family Services may seek Controlling Board approval to increase the appropriations in appropriation item 600654, Health Care Services

Administration.

SECTION 309.37.20. INTERAGENCY REIMBURSEMENT

The Director of Job and Family Services may request the Director of Budget and Management to increase appropriation item 600655, Interagency Reimbursement. Upon the approval of the Director of Budget and Management, the additional amounts are hereby appropriated.

SECTION 309.37.30. MEDICAID PROGRAM SUPPORT FUND - STATE

The foregoing appropriation item 600671, Medicaid Program Support, shall be used by the Department of Job and Family Services to pay for Medicaid services and contracts. The Department may also deposit to the Medicaid Program Support Fund (Fund 5C90) revenues received from other state agencies for Medicaid services under the terms of interagency agreements between the Department and other state agencies.

SECTION 309.37.40. TRANSFERS OF IMD/DSH CASH TO THE DEPARTMENT OF MENTAL HEALTH

The Department of Job and Family Services shall transfer cash from the Medicaid Program Support Fund (Fund 5C90), to the Behavioral Health Medicaid Services Fund (Fund 4X50), used by the Department of Mental Health, in accordance with an interagency agreement that delegates authority from the Department of Job and Family Services to the Department of Mental Health to administer specified Medicaid services. The transfer shall be made using an intrastate transfer voucher.

SECTION 309.37.50. PRESCRIPTION DRUG COVERAGE UNDER MEDICAID MANAGED CARE

(A) As used in this section:

(1) "Controlled substance" has the same meaning as in section 3719.01 of the Revised Code.

(2) "Licensed health professional authorized to prescribe drugs" has the same meaning as in section 4729.01 of the Revised Code.

(B) Not later than October 1, 2011, the Department of Job and Family Services shall enter into new contracts or amend existing contracts with health insuring corporations, pursuant to section 5111.17 of the Revised Code, as the Department considers necessary to require, in accordance with

section 5111.172 of the Revised Code, as amended by this act, that each health insuring corporation participating in the Medicaid care management system include coverage of prescription drugs for the Medicaid recipients who are enrolled in the health insuring corporation.

(C) For a period of thirty days immediately following the effective date of the inclusion of prescription drug coverage under a new or amended contract with a health insuring corporation pursuant to division (B) of this section, if, immediately prior to the effective date of the coverage, a Medicaid recipient enrolled in the health insuring corporation was being treated with a controlled substance prescribed by a licensed health professional authorized to prescribe drugs, and the drug is not an antidepressant or antipsychotic described in division (B)(2) of section 5111.172 of the Revised Code, as amended by this act, the health insuring corporation shall provide coverage of the controlled substance without using drug utilization or management techniques, including any prior authorization requirements, that are more stringent than the utilization or management techniques, if any, that the Medicaid recipient was subject to immediately prior to the effective date of the coverage.

(D) For a period of ninety days immediately following the effective date of the inclusion of prescription drug coverage under a new or amended contract with a health insuring corporation pursuant to division (B) of this section, if, immediately prior to the effective date of the coverage, a Medicaid recipient enrolled in the health insuring corporation was being treated with a drug prescribed by a licensed health professional authorized to prescribe drugs, and the drug is not a controlled substance and the drug is not an antidepressant or antipsychotic described in division (B)(2) of section 5111.172 of the Revised Code, as amended by this act, the health insuring corporation shall provide coverage of the drug without using drug utilization or management techniques, including any prior authorization requirements, that are more stringent than the utilization or management techniques, if any, that the Medicaid recipient was subject to immediately prior to the effective date of the coverage.

(E) For a period of one hundred twenty days immediately following the effective date of the inclusion of prescription drug coverage under a new or amended contract with a health insuring corporation pursuant to division (B) of this section, both of the following apply:

(1) If, immediately prior to the effective date of the coverage, a Medicaid recipient enrolled in the health insuring corporation was being treated with an antidepressant or antipsychotic described in division (B)(2) of section 5111.172 of the Revised Code, as amended by this act, the health

insuring corporation shall provide coverage of the drug without imposing a prior authorization requirement.

(2) Notwithstanding division (B)(3) of section 5111.172 of the Revised Code, as amended by this act, the health insuring corporation shall permit the health professional who was prescribing the drug to continue prescribing the drug for the Medicaid recipient, regardless of whether the prescriber is a psychiatrist as described in division (B)(3)(a) or (b) of that section.

SECTION 309.37.53. PHYSICIAN ASSISTANT MEDICAID PROVIDER AGREEMENTS, CLAIMS SUBMISSIONS, AND FISCAL YEAR 2013 REIMBURSEMENT RATES

(A) With respect to section 5111.053 of the Revised Code, as enacted by this act, regarding Medicaid provider agreements for physician assistants and submission of Medicaid claims for physician assistant services, the Department of Job and Family Services shall implement the provisions of that section when the Department determines that the computer system improvements necessary to implement those provisions are in place. The Department shall ensure that the necessary improvements are in place not later than July 1, 2012.

(B) The Medicaid reimbursement rates for services provided by physician assistants during fiscal year 2013 shall not be greater than the Medicaid reimbursement rates for such services provided on June 30, 2012.

SECTION 309.40. FAMILY STABILITY

SECTION 309.40.10. FOOD STAMPS TRANSFER

On July 1, 2011, or as soon as possible thereafter, the Director of Budget and Management may transfer up to $1,000,000 cash from the Food Stamp Program Fund (Fund 3840), to the Food Assistance Fund (Fund 5ES0).

SECTION 309.40.20. NAME OF FOOD STAMP PROGRAM

The Director of Job and Family Services is not required to amend rules regarding the Food Stamp Program to change the name of the program to the Supplemental Nutrition Assistance Program. The Director may refer to the program as the Food Stamp Program or the Food Assistance Program in rules and documents of the Department of Job and Family Services.

SECTION 309.40.30. OHIO ASSOCIATION OF SECOND HARVEST FOOD BANKS

The foregoing appropriation item 600540, Second Harvest Food Banks, shall be used to provide funds to the Ohio Association of Second Harvest Food Banks to purchase and distribute food products.

Notwithstanding section 5101.46 of the Revised Code and any other provision in this bill, in addition to funds designated for the Ohio Association of Second Harvest Food Banks in this section, in fiscal year 2012 and fiscal year 2013, the Director of Job and Family Services shall provide assistance from eligible funds to the Ohio Association of Second Harvest Food Banks in an amount up to or equal to the assistance provided in state fiscal year 2011 from all funds used by the Department, except the General Revenue Fund.

Eligible nonfederal expenditures made by member food banks of the Association shall be counted by the Department of Job and Family Services toward the TANF maintenance of effort requirements of 42 U.S.C. 609(a)(7). The Director of Job and Family Services shall enter into an agreement with the Ohio Association of Second Harvest Food Banks, in accordance with sections 5101.80 and 5101.801 of the Revised Code, to carry out the requirements under this section.

SECTION 309.40.40. PUBLIC ASSISTANCE ACTIVITIES/TANF MOE

The foregoing appropriation item 600658, Public Assistance Activities, shall be used by the Department of Job and Family Services to meet the TANF maintenance of effort requirements of 42 U.S.C. 609(a)(7). When the state is assured that it will meet the maintenance of effort requirement, the Department of Job and Family Services may use funds from appropriation item 600658, Public Assistance Activities, to support public assistance activities.

SECTION 309.40.50. INDEPENDENT LIVING INITIATIVE

Of the foregoing appropriation item 600689, TANF Block Grant, up to $2,000,000 in each fiscal year shall be used, in accordance with sections 5101.80 and 5101.801 of the Revised Code, to support the Independent Living Initiative, including life skills training and work supports for older children in foster care and those who have recently aged out of foster care.

SECTION 309.40.60. KINSHIP PERMANENCY INCENTIVE PROGRAM

Of the foregoing appropriation item 600689, TANF Block Grant, $1,200,000 in each fiscal year shall be used to support the activities of the Kinship Permanency Incentive Program established in section 5101.802 of the Revised Code.

SECTION 309.40.63. OHIO COMMISSION ON FATHERHOOD

Of the foregoing appropriation item 600689, TANF Block Grant, $1,000,000 in each fiscal year shall be provided to the Ohio Commission on Fatherhood.

SECTION 309.40.70. SWIPE CARD PILOT PROGRAM

During fiscal year 2012 and fiscal year 2013, if the Department of Job and Family Services implements a program that utilizes a swipe card system and point of service device to track attendance and submit invoices for payment for publicly funded child care, both of the following apply:

(A) Misuse of the system by a child care provider participating in the program constitutes a reason for which the provider's license or certification may be revoked.

(B) Misuse of the system by a caretaker parent participating in the program constitutes a reason for which the caretaker parent may lose eligibility for publicly funded child care.

SECTION 309.50. CHILD WELFARE

SECTION 309.50.10. DIFFERENTIAL RESPONSE

In accordance with an independent evaluation of the Ohio Alternative Response Pilot Program that recommended statewide implementation, the Department of Job and Family Services shall plan the statewide expansion of the Ohio Alternative Response Pilot Program on a county by county basis, through a schedule determined by the Department. The program shall be known as the "differential response" approach as defined in section 2151.011 of the Revised Code. Notwithstanding provisions of Chapter 2151. of the Revised Code that refer to "differential response," "traditional response," and "alternative response," those provisions shall become

effective on the scheduled date of expansion of the differential response approach to that county. Prior to statewide implementation, the Department may adopt rules in accordance with Chapter 119. of the Revised Code as necessary to carry out the purposes of this section.

SECTION 309.50.20. FLEXIBLE FUNDING FOR FAMILIES AND CHILDREN

In collaboration with the county family and children first council, a county department of job and family services or public children services agency that receives an allocation from the Department of Job and Family Services from the foregoing appropriation item 600523, Children and Families Services, or 600533, Child, Family, and Adult Community & Protective Services, may transfer a portion of either or both allocations to a flexible funding pool as authorized by the section of this act titled "FAMILY AND CHILDREN FIRST FLEXIBLE FUNDING POOL."

SECTION 309.50.30. CHILD, FAMILY, AND ADULT COMMUNITY AND PROTECTIVE SERVICES

(A) The foregoing appropriation item 600533, Child, Family, and Adult Community & Protective Services, shall be distributed to each county department of job and family services using the formula the Department of Job and Family Services uses when distributing Title XX funds to county departments of job and family services under section 5101.46 of the Revised Code. County departments shall use the funds distributed to them under this section as follows, in accordance with the written plan of cooperation entered into under section 307.983 of the Revised Code:

(1) To assist individuals achieve or maintain self-sufficiency, including by reducing or preventing dependency among individuals with family income not exceeding two hundred per cent of the federal poverty guidelines;

(2) Subject to division (B) of this section, to respond to reports of abuse, neglect, or exploitation of children and adults, including through the differential response approach program developed under Section 309.50.10 of this act;

(3) To provide outreach and referral services regarding home and community-based services to individuals at risk of placement in a group home or institution, regardless of the individuals' family income and without need for a written application;

(4) To provide outreach, referral, application assistance, and other

services to assist individuals receive assistance, benefits, or services under Medicaid; Title IV-A programs, as defined in section 5101.80 of the Revised Code; the Supplemental Nutrition Assistance Program; and other public assistance programs.

(B) Protective services may be provided to a child or adult as part of a response, under division (A)(2) of this section, to a report of abuse, neglect, or exploitation without regard to a child or adult's family income and without need for a written application. The protective services may be provided if the case record documents circumstances of actual or potential abuse, neglect, or exploitation.

SECTION 309.50.33. CHILDREN AND FAMILY SERVICES ACTIVITIES

The foregoing appropriation item 600609, Children and Family Services Activities, shall be used to expend miscellaneous foundation funds and grants to support children and family services activities.

SECTION 309.50.40. ADOPTION ASSISTANCE LOAN

Of the foregoing appropriation item 600634, Adoption Assistance Loan, the Department of Job and Family Services may use up to ten per cent for administration of adoption assistance loans pursuant to section 3107.018 of the Revised Code.

SECTION 309.60. UNEMPLOYMENT COMPENSATION

SECTION 309.60.10. FEDERAL UNEMPLOYMENT PROGRAMS

All unexpended funds remaining at the end of fiscal year 2011 that were appropriated and made available to the state under section 903(d) of the Social Security Act, as amended, in the foregoing appropriation item 600678, Federal Unemployment Programs (Fund 3V40), are hereby appropriated to the Department of Job and Family Services. Upon the request of the Director of Job and Family Services, the Director of Budget and Management may increase the appropriation for fiscal year 2012 by the amount remaining unspent from the fiscal year 2011 appropriation and may increase the appropriation for fiscal year 2013 by the amount remaining unspent from the fiscal year 2012 appropriation. The appropriation shall be used under the direction of the Department of Job and Family Services to pay for administrative activities for the Unemployment Insurance Program,

employment services, and other allowable expenditures under section 903(d) of the Social Security Act, as amended.

The amounts obligated pursuant to this section shall not exceed at any time the amount by which the aggregate of the amounts transferred to the account of the state under section 903(d) of the Social Security Act, as amended, exceeds the aggregate of the amounts obligated for administration and paid out for benefits and required by law to be charged against the amounts transferred to the account of the state.

SECTION 309.60.20. UNEMPLOYMENT COMPENSATION INTEREST CONTINGENCY FUND

The General Health and Human Service Pass-Through Fund (Fund 5HC0) is hereby renamed the Unemployment Compensation Interest Contingency Fund. On July 1, 2011, or as soon as possible thereafter, the Director of Budget and Management shall transfer $23,000,000 cash from the Child and Adult Protective Services Fund (Fund 5GV0), used by the Department of Job and Family Services, to the Unemployment Compensation Interest Contingency Fund. The Director of Budget and Management may seek Controlling Board approval to establish appropriations for payment of interest costs paid to the United States Secretary of the Treasury for the repayment of accrued interest related to federal unemployment account borrowing.

SECTION 311.10. JCR JOINT COMMITTEE ON AGENCY RULE REVIEW

General Revenue Fund

GRF 029321 Operating Expenses	$ 435,168	$ 435,168
TOTAL GRF General Revenue Fund	$ 435,168	$ 435,168
TOTAL ALL BUDGET FUND GROUPS	$ 435,168	$ 435,168

OPERATING GUIDANCE

The Chief Administrative Officer of the House of Representatives and the Clerk of the Senate shall determine, by mutual agreement, which of them shall act as fiscal agent for the Joint Committee on Agency Rule Review. Members of the Committee shall be paid in accordance with section 101.35 of the Revised Code.

OPERATING EXPENSES

On July 1, 2011, or as soon as possible thereafter, the Executive Director of the Joint Committee on Agency Rule Review may certify to the Director of Budget and Management the amount of the unexpended, unencumbered balance of the foregoing appropriation item 029321,