Sub. H. B. No. 96
As Passed by the Senate

_____ moved to amend as follows:

In line 345 of the title, after "103.24," insert "103.41, 103.411, 103.413, 103.415"

Delete lines 3062 through 3195 (remove R.C. 103.41, and 103.416) and insert:

"Sec. 103.13. The Ohio legislative service commission shall:

(A) Conduct research, make investigations, and secure information or data on any subject and make reports thereon to the general assembly;

(B) Ascertain facts and make reports concerning the state budget, the revenues and expenditures of the state, and of the organization and functions of the state, its departments, subdivisions, and agencies;

(C) Make surveys, investigations, and studies, and compile data, information, and records on any question which may be referred to it by either house of the general assembly or any standing committee of the general assembly;

(D) Assist and cooperate with any interim legislative

committee or other agency created by the general assembly;

(E) Prepare or advise in the preparation of any bill or resolution, when requested by any member of the general assembly;

(F) Collect, classify, and index the documents of the state which shall include executive and legislative documents and departmental reports and keep on file all bills, resolutions, and official journals printed by order of either house of the general assembly;

(G) Provide members of the general assembly with impartial and accurate information and reports concerning legislative problems in accordance with rules prescribed by the commission;

(H) Annually collect the reports required by section 4743.01 of the Revised Code and prepare a report evaluating the extent to which state boards and commissions which regulate occupations are financially self-supporting. The report shall be presented to the speaker and the minority leader of the house of representatives, the president and the minority leader of the senate, and the chairperson and ranking minority member of the finance committees of both houses, on or before the thirty-first day of December each year.

(I) Codify the rules of administrative agencies of the state in accordance with the provisions of section 103.05 of the Revised Code;

(J) Publish the register of Ohio under section 103.051 of the Revised Code;

(K) Operate the electronic rule-filing system under section 103.0511 of the Revised Code;

(L) Assist the standing committees of the house of representatives and the senate that primarily consider legislation governing the medicaid program, to carry out continuing oversight and other duties regarding the state's medicaid program enumerated under sections 103.41 to 103.412 of the Revised Code.

Sec. 103.41. The standing committees of the house of representatives and the senate that primarily consider legislation governing the medicaid program shall meet jointly during each session of the general assembly to oversee the medicaid program on a continuing basis.

In odd numbered years, the standing committees shall meet jointly at the call of the chairperson of the senate committee that considers the medicaid program. In even numbered years, the standing committees shall meet jointly at the call of the chairperson of the house of representatives committee that considers the medicaid program.

Sec. ~~103.412~~ 103.411. ~~(A) JMOC shall oversee the medicaid program on a continuing basis. As part of its oversight, JMOC~~ To assist the standing committees overseeing the medicaid program as provided in section 103.41 of the Revised Code, the legislative service commission shall ~~do all of the~~ research, review, and summarize the following to the joint standing committees on request of the chairperson who calls the meeting:

~~(1) Review how~~ (A) 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~~(B) Reports issued by all agencies that participate in the medicaid program that are submitted to the commission;

~~(3) Recommend policies~~ (C) Policies and strategies related to ~~encourage~~ both of the following:

~~(a)~~ (1) Medicaid recipients being physically and mentally able to join and stay in the workforce and ultimately becoming self-sufficient;

~~(b)~~ (2) Less use of the medicaid program.

~~(4) Recommend, to the extent JMOC determines appropriate, improvements in statutes and~~ (D) Newly-adopted rules concerning the medicaid program;

~~(5) Develop a plan of action for the future of the medicaid program~~(E) Pending Ohio medicaid legislation;

~~(6) Receive and consider reports submitted by local~~ (F) Medicaid legislation and innovations in other states;

(G) Local healthier buckeye councils reports submitted 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. ~~103.414~~ 103.412. (A) Before the beginning of each fiscal biennium, ~~JMOC~~ the legislative service commission 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~~ the commission 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.

(B) On receipt of the actuary's report, ~~JMOC~~ the commission shall share the report with the standing committees overseeing the medicaid program under section 103.41 of the Revised Code. The standing committees, acting jointly, shall determine whether ~~it agrees~~ they agree with the actuary's projected medical inflation rate. If ~~JMOC disagrees~~ they disagree with the actuary's projected medical inflation rate, ~~JMOC shall~~ the standing committees shall work with the commission to determine a different projected medical inflation rate for the upcoming fiscal biennium.

The actuary, the commission, and~~, if JMOC determines a different projected medical inflation rate, JMOC~~ standing committees 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.~~

(C) 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, the commission shall submit a report to the governor, medicaid director, and the standing committees that includes the following information:

(1) The projected medical inflation rate, whether the standing committees recommend the actuary's rate or the alternate rate recommended by the standing committees;

(2) If the standing committees recommend an alternate rate, an explanation for rejecting the actuary's rate;

(3) A copy of the actuary's report.

Sec. 103.65. (A) There is hereby created the Ohio health oversight and advisory committee. The committee shall consist of the following members:

(1) Three members of the senate appointed by the president of the senate, two of whom are members of the majority party and one of whom is a member of the minority party;

(2) Three members of the house of representatives appointed by the speaker of the house of representatives, two of whom are members of the majority party and one of whom is a member of the minority party.

(B) The president and speaker shall make the initial appointments to the committee not later than fifteen calendar days after June 23, 2021. The president and speaker shall make subsequent appointments not later than forty-five calendar days after the commencement of the first regular session of each general assembly. Members of the committee shall serve on the committee until appointments are made in the first regular session of the following general assembly, until a member no longer serves as a member of the chamber from which the member was initially appointed, or until a member is removed by the speaker or president. No committee member shall be removed during the member's term during a state of emergency as defined in section 107.42 of the Revised Code, unless an extraordinary circumstance exists that prevents a member from serving on the committee. A vacancy on the committee shall be filled in the same manner as the original appointment.

(C) In odd-numbered years, the president shall designate one committee member from the senate who is a member of the majority party as the committee chairperson, and the speaker shall designate one committee member from the house who is a member of the majority party as the committee vice-chairperson and one committee member from the house who is a member of the minority party as the committee ranking minority member. In

even-numbered years, the speaker shall designate one committee member from the house who is a member of the majority party as the committee chairperson, and the president shall designate one committee member from the senate who is a member of the majority party as the committee vice-chairperson and one committee member from the senate who is a member of the minority party as the committee ranking minority member.

(D) In appointing members from the minority party, and in designating ranking minority members, the president and speaker shall consult with the minority leader of their respective houses.

(E) The Ohio health oversight and advisory committee shall meet at the call of the chairperson.

(F) The ~~executive director and other employees of the joint medicaid oversight committee~~ legislative service commission shall ~~serve~~ provide staff services to the Ohio health oversight and advisory committee to enable the committee to successfully and efficiently perform its duties."

Strike through line 7194

In line 7195, strike through "(3)" and insert "(2)"

In line 7196, strike through "(4)" and insert "(3)"

In line 7197, strike through "(5)" and insert "(4)"

In line 7198, strike through "(6)" and insert "(5)"

After line 12045, insert:

"Sec. 125.95. (A) There is hereby created within the department of administrative services the prescription drug transparency and affordability advisory council. The department

shall provide administrative support to the advisory council as necessary for the advisory council to carry out its duties under this section.

(1) Members of the advisory council shall include the following:

(a) The director of administrative services;

(b) The director of health;

(c) The medicaid director;

(d) The director of ~~mental~~ behavioral health ~~and addiction services~~;

(e) The administrator of workers' compensation.

(2) Members of the advisory council shall also include individuals who are working to address prescription drug availability and affordability in any of the following areas:

(a) Insurance;

(b) Local, state, and federal government service;

(c) Private industry;

(d) Organizations of faith;

(e) Health care providers;

(f) Consumer organizations;

(g) Prescription drug manufacturers;

(h) Prescription drug wholesale distributors;

(i) Pharmacists;

(j) Business organizations;

(k) Individuals concerned about mental health or substance abuse matters;

(l) Advocates for individuals struggling to afford prescription drugs.

The governor, the senate president, and the speaker of the house of representatives shall each appoint three members, each of whom represents at least one of the categories listed in divisions (A)(2)(a) to (l) of this section.

(B) Members shall serve without compensation. Initial appointments shall be made not later than sixty days after ~~the effective date of this section~~ October 17, 2019. Vacancies shall be filled in the manner provided for original appointments.

(C) Not later than six months after the date of initial appointments under division (B) of this section, the advisory council shall submit a report to the governor~~,~~ and the general assembly~~, and the chairperson of the joint medicaid oversight committee~~ in accordance with section 101.68 of the Revised Code. The report shall include recommendations on all of the following:

(1) How this state can best achieve prescription drug price transparency;

(2) New payment models or other avenues to create the most affordable environment for purchasing prescription drugs;

(3) Leveraging this state's purchasing power across all state agencies, boards, commissions, and similar entities;

(4) Creating efficiencies across different health care systems, such as hospitals, the criminal justice system, treatment and recovery support programs, and employer-sponsored

health insurance, to reduce duplicative service delivery across these systems, ensure that patients receive high quality and affordable prescription drugs, and support quality care and outcomes;

(5) Which critical outcomes can be measured and used to improve this state's system of purchasing affordable prescribed drugs;

(6) How federal, state, and local resources are being used to optimize these outcomes and identify where the resources can be better coordinated or redirected to meet the needs of consumers in this state.

(D) State agencies, boards, commissions, and similar entities shall cooperate with and provide assistance to the advisory council as necessary for the advisory council to carry out its duties under this section.

(E) On ~~the effective date of this amendment~~ September 30, 2021, the advisory council shall cease to exist. Thereafter, the ~~joint medicaid oversight committee~~ legislative service commission may examine any of the topics described in the report prepared by the former advisory council under division (C) of this section upon the request of a member of the ~~committee~~the standing committees with oversight of the medicaid program as provided in section 103.41 of the Revised Code. "

After line 26402, insert:

"Sec. 355.04. A local healthier buckeye council shall report the following information to the ~~joint medicaid oversight committee created in section 103.41 of the Revised Code~~legislative service commission:

(A) Notification that the local council has been established and information regarding the council's organization, plan, and activities;

(B) Information regarding enrollment or outcome data collected under division (E) 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."

After line 83664, insert:

"Sec. 3901.90. The superintendent of insurance, in consultation with the director of ~~mental~~ behavioral health ~~and addiction services~~, shall develop consumer and payer education on mental health and addiction services insurance parity and establish and promote a consumer hotline to collect information and help consumers understand and access their insurance benefits.

The department of insurance and the department of ~~mental~~ behavioral health ~~and addiction services~~ shall jointly report annually on the department's efforts, which shall include information on consumer and payer outreach activities and identification of trends and barriers to access and coverage in this state. The departments shall submit the report to the general assembly, the ~~joint medicaid oversight committee~~legislative service commission, and the governor, not later than the thirtieth day of January of each year."

In line 115442, strike through "joint medicaid oversight committee" and insert "legislative service commission"

In line 119405, delete "joint medicaid oversight committee" and insert "legislative service commission"

After line 119413, insert:

"Sec. 5162.13. (A) On or before the first day of January of each year, the department of medicaid shall 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 all of the following, delineated by race and ethnic group:

(1) The estimated number of pregnant women, infants, and children eligible for the program;

(2) The actual number of eligible persons enrolled in the program;

(3) The actual number of enrolled pregnant women categorized by estimated gestational age at time of enrollment;

(4) The average number of days between the following events:

(a) A pregnant woman's application for medicaid and enrollment in the fee-for-service component of medicaid;

(b) A pregnant woman's application for enrollment in a medicaid managed care organization and enrollment in the managed care organization.

The information described in divisions (A)(4)(a) and (b) of this section shall also be delineated by county and the urban and rural communities specified in rules adopted under section

3701.142 of the Revised Code.

(5) The number of prenatal, postpartum, and child health visits;

(6) The estimated number of enrolled women of child-bearing age who use a tobacco product;

(7) The estimated number of enrolled women of child-bearing age who participate in a tobacco cessation program or who use a tobacco cessation product;

(8) The rates at which enrolled pregnant women receive addiction or mental health services, progesterone therapy, and any other service specified by the department;

(9) 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;

(10) A comparison of the prenatal, delivery, and child health costs of the program with such costs of similar programs in other states, where available;

(11) A report on performance data generated by the component of the state innovation model (SIM) grant pertaining to episode-based payments for perinatal care that was awarded to this state by the center for medicare and medicaid innovation in the United States centers for medicare and medicaid services;

(12) A report on funds allocated for infant mortality reduction initiatives in the urban and rural communities specified in rules adopted under section 3701.142 of the Revised Code;

(13) A report on the results of client responses to

questions related to pregnancy services and healthcheck that are asked by the personnel of county departments of job and family services;

(14) A comparison of the performance of the fee-for-service component of medicaid with the performance of each medicaid managed care organization on perinatal health metrics;

(15) A report demonstrating cost savings resulting from program investments;

(16) Beginning two years after ~~the effective date of this amendment~~ April 30, 2024, a report on the medicaid coverage of doula services required by section 5164.071 of the Revised Code, including:

(a) Outcomes related to maternal health and maternal morbidity;

(b) Infant health outcomes;

(c) The average costs of providing doula services to mothers and infants;

(d) Estimated cost increases or savings as a result of providing doula coverage.

(B) 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.

(C) The department shall provide to the ~~joint medicaid oversight committee~~ legislative service commission a copy of the data used to calculate the information required in the report under division (A)(16) of this section."

In line 119435, strike through "joint"

In line 119436, strike through "medicaid oversight committee"; delete "and the"

In line 119438, after "medicaid" insert "and the legislative service commission"

In line 119444, strike through the comma and insert "and the"

In line 119445, strike through ", and joint medicaid oversight committee"

After line 119459, insert:

"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. 5162.136. (A) The department of medicaid shall conduct periodic reviews to determine the barriers that medicaid recipients face in gaining full access to interventions intended to reduce tobacco use, prevent prematurity, and promote optimal birth spacing. The first review shall occur not later than sixty days after ~~the effective date of this section~~ April 6, 2017. Thereafter, reviews shall be conducted every six months. The department shall prepare a report that summarizes the results of each review, which must contain the information specified in division (C)(1) or (2) of this section, as applicable. Each report shall be submitted to the commission on infant mortality~~,~~

~~the joint medicaid oversight committee,~~ and the general assembly. Submissions to the general assembly shall be made in accordance with section 101.68 of the Revised Code.

(B) The department shall make a presentation on each report at the first meeting of the commission on infant mortality that follows the report's submission to the commission.

(C)(1) All of the following shall be in the first report submitted in accordance with division (A) of this section:

(a) Identification of the access barriers described in division (A) of this section, the individuals affected by the barriers, and whether the barriers result from policies implemented by the department, medicaid managed care organizations, providers, or others;

(b) Recommendations for the expedient removal of the access barriers;

(c) An analysis of the performance of the fee-for-service component of medicaid and the performance of each medicaid managed care organization on health metrics pertaining to tobacco cessation, prematurity prevention, and birth spacing;

(d) Any other information the department considers pertinent to the report's topic.

(2) All of the following shall be in each subsequent report submitted in accordance with division (A) of this section:

(a) The progress that has been made on removing the access barriers described in division (A) of this section and the impact such progress has had on reducing the infant mortality

rate in this state;

(b) A performance analysis of the fee-for-service component of medicaid and each medicaid managed care organization on health metrics pertaining to tobacco cessation, prematurity prevention, and birth spacing;

(c) Any other information the department considers pertinent.

Sec. 5162.1310. (A) The department of medicaid shall periodically evaluate the success that members of the expansion eligibility group have with the following:

(1) Obtaining employer-sponsored health insurance coverage;

(2) Improving health conditions that would otherwise prevent or inhibit stable employment;

(3) Improving the conditions of their employment, including duration and hours of employment.

(B) For the purpose of aiding the department's evaluations under this section, medicaid managed care organizations shall collect and submit to the department relevant data about members of the expansion eligibility group who are enrolled in the organizations' medicaid MCO plans. The department may request that a medicaid managed care organization collect and submit to the department additional data the department needs for the evaluation.

(C) The department shall complete a report for each evaluation conducted under this section. 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."

After line 119561, insert:

"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 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, as determined under section 103.412 of the Revised Code.

(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~~ legislative service commission 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.

Sec. 5162.82. Before making any payment rate increases greater than ten per cent under the medicaid program, the medicaid director shall notify the ~~joint medicaid oversight committee~~ standing committees with oversight of the medicaid program as provided in section 103.41 of the Revised Code of the increase ~~and be available to testify before the joint medicaid oversight committee regarding the increase~~. "

In line 119590, delete "joint medicaid oversight"

In line 119591, delete "committee" and insert "legislative service commission"

After line 120542, insert:

"Sec. 5167.24. (A) If the department of medicaid includes prescribed drugs in the care management system as authorized under section 5167.05 of the Revised Code, the medicaid director, through a procurement process, shall select a third-party administrator to serve as the single pharmacy benefit manager used by medicaid managed care organizations under the care management system. The state pharmacy benefit manager shall be responsible for processing all pharmacy claims under the care management system. The department of medicaid is responsible for enforcing the contract after the procurement process.

(B) As part of the procurement process, the director shall do all of the following:

(1) Accept applications from entities seeking to become the state pharmacy benefit manager;

(2) Establish eligibility criteria an entity must meet in order to become the state pharmacy benefit manager;

(3) Select and contract with a single state pharmacy

benefit manager;

(4) Develop a master contract to be used by the director when contracting with the state pharmacy benefit manager, which shall prohibit the state pharmacy benefit manager from requiring a medicaid recipient to obtain a specialty drug from a specialty pharmacy owned or otherwise associated with the state pharmacy benefit manager.

(C) A prospective state pharmacy benefit manager shall disclose to the director all of the following during the procurement process:

(1) Any activity, policy, practice, contract, or arrangement of the state pharmacy benefit manager that may directly or indirectly present any conflict of interest with the pharmacy benefit manager's relationship with or obligation to the department or a medicaid managed care organization;

(2) All common ownership, members of a board of directors, managers, or other control of the pharmacy benefit manager (or any of the pharmacy benefit manager's affiliated companies) with any of the following:

(a) A medicaid managed care organization and its affiliated companies;

(b) An entity that contracts on behalf of a pharmacy or any pharmacy services administration organization and its affiliated companies;

(c) A drug wholesaler or distributor and its affiliated companies;

(d) A third-party payer and its affiliated companies;

(e) A pharmacy and its affiliated companies.

(3) Any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in this state with which the pharmacy benefit manager shares common ownership, management, or control; or that are owned, managed, or controlled by any of the pharmacy benefit manager's affiliated companies;

(4) Any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in this state;

~~(6)~~ (5) Any financial terms and arrangements between the pharmacy benefit manager and a prescription drug manufacturer or labeler, including formulary management, drug substitution programs, educational support claims processing, or data sales fees.

~~(D) The director shall select a provisional state pharmacy benefit manager not later than July 1, 2020.~~

~~(1) Once a provisional state pharmacy benefit manager has been selected, full implementation of the entity as the state pharmacy benefit manager shall be subject to that entity's demonstrated ability to fulfill the duties and obligations of the state pharmacy benefit manager as illustrated through a readiness review process established by the director. Any entity failing to complete the readiness review process shall be deemed as having not met the criteria of the review process. The selected entity shall not enter into contracts with the department or medicaid managed care organizations as the state pharmacy benefit manager before the date on which the entity has satisfactorily completed the readiness review process.~~

~~(2) If the director determines that, for reasons beyond~~

~~the director's control, selection of a provisional state pharmacy benefit manager cannot occur before July 1, 2020, the director shall notify the joint medicaid oversight committee of the reasons for the delay and identify the steps the director is taking to complete the selection as expeditiously as possible.~~ "

After line 120721, insert:

"Sec. 5168.90. (A) At least quarterly, the medicaid director shall report to the ~~members of the joint medicaid oversight committee and the executive director of the joint medicaid oversight committee~~ legislative service commission both of the following:

(1) The fee rates and the aggregate total of the fees assessed for each of the following:

(a) The hospital assessment established under section 5168.21 of the Revised Code;

(b) The nursing home and hospital long-term care unit franchise permit fee under section 5168.41 of the Revised Code;

(c) The ICF/IID franchise permit fee under section 5168.61 of the Revised Code;

(d) The health insuring corporation franchise fee under section 5168.76 of the Revised Code.

(2) If there is a rate increase for any of the fee rates listed under division (A)(1) of this section pending before the centers for medicare and medicaid services.

(B) The director may adopt rules under section 5162.02 of the Revised Code to compile and submit the reports required under this section, including rules, as authorized under section 5162.021 of the Revised Code, that specify the information that

must be submitted to the director by the department of developmental disabilities regarding the ICF/IID franchise permit fee. "

After line 120866, insert:

"Sec. 5180.17. (A) As used in this section:

(1) "Contractor" means a person who provides personal services pursuant to a contract.

(2) "Critical access hospital" means a facility designated as a critical access hospital by the director of health under section 3701.073 of the Revised Code.

(3) "Crib" includes a portable play yard or other suitable sleeping place.

(B) Each hospital and freestanding birthing center shall implement an infant safe sleep screening procedure. The purpose of the procedure is to determine whether there will be a safe crib for an infant to sleep in once the infant is discharged from the facility to the infant's residence following birth. The procedure shall consist of questions that facility staff or volunteers must ask the infant's parent, guardian, or other person responsible for the infant regarding the infant's intended sleeping place and environment.

The director of children and youth shall develop questions that facilities may use when implementing the infant safe sleep screening procedure required by this division. The director may consult with persons and government entities that have expertise in infant safe sleep practices when developing the questions.

(C) If, prior to an infant's discharge from a facility to the infant's residence following birth, a facility other than a

critical access hospital or a facility identified under division (D) of this section determines through the procedure implemented under division (B) of this section that the infant is unlikely to have a safe crib at the infant's residence, the facility shall make a good faith effort to arrange for the parent, guardian, or other person responsible for the infant to obtain a safe crib at no charge to that individual. In meeting this requirement, the facility may do any of the following:

(1) Obtain a safe crib with its own resources;

(2) Collaborate with or obtain assistance from persons or government entities that are able to procure a safe crib or provide money to purchase a safe crib;

(3) Refer the parent, guardian, or other person responsible for the infant to a person or government entity described in division (C)(2) of this section to obtain a safe crib free of charge from that source;

(4) If funds are available for the cribs for kids program or a successor program administered by the department of children and youth, refer the parent, guardian, or other person responsible for the infant to a site, designated by the department for purposes of the program, at which a safe crib may be obtained at no charge.

If a safe crib is procured as described in division (C)(1), (2), or (3) of this section, the facility shall ensure that the crib recipient receives safe sleep education and crib assembly instructions from the facility or another source. If a safe crib is procured as described in division (C)(4) of this section, the department of children and youth shall ensure that the cribs for kids program or a successor program administered

by the department provides safe sleep education and crib assembly instructions to the recipient.

(D) The director of children and youth shall identify the facilities in this state that are not critical access hospitals and are not served by a site described in division (C)(4) of this section. The director shall identify not less than annually the facilities that meet both criteria and notify those that do so.

(E) When a facility that is a hospital registers with the department of health under section 3701.07 of the Revised Code or a facility that is a freestanding birthing center renews its license in accordance with rules adopted under section 3702.30 of the Revised Code, the facility shall report the following information to the department of children and youth in a manner the department prescribes:

(1) The number of safe cribs that the facility obtained and distributed by using its own resources as described in division (C)(1) of this section since the last time the facility reported this information to the department;

(2) The number of safe cribs that the facility obtained and distributed by collaborating with or obtaining assistance from another person or government entity as described in division (C)(2) of this section since the last time the facility reported this information to the department;

(3) The number of referrals that the facility made to a person or government entity as described in division (C)(3) of this section since the last time the facility reported this information to the department;

(4) The number of referrals that the facility made to a

site designated by the department as described in division (C)(4) of this section since the last time the facility reported this information to the department;

(5) Demographic information specified by the director of children and youth regarding the individuals to whom safe cribs were distributed as described in division (E)(1) or (2) of this section or for whom a referral described in division (E)(3) or (4) of this section was made;

(6) In the case of a critical access hospital or a facility identified under division (D) of this section, demographic information specified by the director of children and youth regarding each parent, guardian, or other person responsible for the infant determined to be unlikely to have a safe crib at the infant's residence pursuant to the procedure implemented under division (B) of this section;

(7) Any other information collected by the facility regarding infant sleep environments and intended infant sleep environments that the director determines to be appropriate.

(F) The director of children and youth shall prepare a written report that summarizes the information collected under division (E) of this section for the preceding twelve months, assesses whether at-risk families are sufficiently being served by the crib distribution and referral system established by this section, makes suggestions for system improvements, and provides any other information the director considers appropriate for inclusion in the report. On completion, the report shall be submitted to the general assembly with, and in the same manner as, the report that the department of medicaid submits to the general assembly ~~and joint medicaid oversight committee~~ pursuant to section 5162.13 of the Revised Code. A copy of the report

also shall be submitted to the governor.

(G) A facility, and any employee, contractor, or volunteer of a facility, that implements an infant safe sleep procedure in accordance with division (B) of this section is not liable for damages in a civil action for injury, death, or loss to person or property that allegedly arises from an act or omission associated with implementation of the procedure, unless the act or omission constitutes willful or wanton misconduct.

A facility, and any employee, contractor, or volunteer of a facility, that implements an infant safe sleep screening procedure in accordance with division (B) of this section is not subject to criminal prosecution or, to the extent that a person is regulated under Title XLVII of the Revised Code, professional disciplinary action under that title, for an act or omission associated with implementation of the procedure.

This division does not eliminate, limit, or reduce any other immunity or defense that a facility, or an employee, contractor, or volunteer of a facility, may be entitled to under Chapter 2744. of the Revised Code, or any other provision of the Revised Code, or the common law of this state.

(H) A facility, and any employee, contractor, or volunteer of a facility, is neither liable for damages in a civil action, nor subject to criminal prosecution, for injury, death, or loss to person or property that allegedly arises from a crib obtained by a parent, guardian, or other person responsible for the infant as a result of any action the facility, employee, contractor, or volunteer takes to comply with division (C) of this section.

The immunity provided by this division does not require

compliance with division (D) of section 2305.37 of the Revised Code.

Sec. 5180.20. (A) The director of children and youth shall identify each government program providing benefits, other than the help me grow program established by the department of children and youth pursuant to section 5180.21 of the Revised Code, that has the goal of reducing infant mortality and negative birth outcomes or the goal of reducing disparities among women who are pregnant or capable of becoming pregnant and who belong to a racial or ethnic minority. A program shall be identified only if it provides education, training, and support services related to those goals to program participants in their homes. The director may consult with the Ohio partnership to build stronger families for assistance with identifying the programs.

(B) An administrator of a program identified under division (A) of this section shall report to the director data on program performance indicators that are used to assess progress toward achieving program goals. The administrator shall report the data in the format and within the time frames specified in rules adopted under division (C) of this section. Using the data reported under this division, the director shall prepare an annual report assessing the performance of each government program identified pursuant to division (A) of this section during the immediately preceding twelve-month period. In addition, the report shall summarize and provide an analysis of the information contained in the "information for medical and health use only" section of the birth records for individuals born during the prior twelve-month period.

The director shall provide a copy of the report to the

general assembly ~~and the joint medicaid oversight committee. The copy to the general assembly shall be provided~~ in accordance with section 101.68 of the Revised Code.

(C) The director shall adopt rules specifying program performance indicators on which data must be reported by the administrators described in division (B) of this section as well as the format and time frames in which the data must be reported. To the extent possible, the program performance indicators specified in the rules shall be consistent with federal reporting requirements for federally funded home visiting services. The rules shall be adopted in accordance with Chapter 119. of the Revised Code."

In line 145058, after "103.24," insert "103.41, 103.411, 103.413, 103.415,"

In line 145596, delete "Joint Medicaid Oversight Committee" and insert "Legislative Service Commission"

In the table on line 149676, in row C, delete "$530,532 $654,606" and insert "$133,000 $0"

In the table on line 149676, in rows D and E, subtract $397,532 from fiscal year 2026 and $654,606 from fiscal year 2027

Delete lines 149682 through 149697

In line 150198, delete "authorized by the"

In line 150199, delete "Joint Medicaid Oversight Committee"

After line 155812, insert:

"**Section 525.00.01.** (A) Effective on the ninety-first day after this section takes effect, the Joint Medicaid Oversight Committee is abolished. All records of the Committee shall be

transferred to the Legislative Service Commission, and all of its other assets and liabilities shall be transferred to the Commission. The Commission is successor to, and assumes the obligations of, the Committee.

(B) Any business commenced, but not completed by the Committee on the effective date of this section shall be completed by the Commission in the same manner, and with the same effect, as if completed by the Committee. No validation, cure, right, privilege, remedy, obligation, or liability is lost or impaired by reason of the transfer required by this section.

(C) Wherever the Committee Executive Director or the Committee is referred to in any law, contract, or other document, the reference shall be deemed to refer to the Commission Director or the Commission, whichever is appropriate.

(D) No action or proceeding pending on the effective date of this section is affected by the transfer, and any such action or proceeding shall be prosecuted or defended in the name of the Commission. In all such actions and proceedings, the Commission, on application to the court, shall be substituted as a party."

In line 156913, delete "Executive Director of the Joint Medicaid Oversight Committee" and insert "the standing committees of the House of Representatives and the Senate that primarily consider legislation governing the Medicaid program and the Legislative Service Commission"

In line 157026, delete "Joint Medicaid Oversight Committee" and insert "the standing committees of the House of Representatives and the Senate that primarily consider legislation governing the Medicaid program and the Legislative Service Commission"

In line 157113, delete "Joint Medicaid"

In line 157114, delete "Oversight Committee and the"

Update the title, amend, enact, or repeal clauses accordingly

The motion was _____ agreed to.

SYNOPSIS

JMOC duties - transfer to standing Medicaid committees and LSC

R.C. 103.13 and 103.41 through 103.412 and Section 525.00.01; conforming changes in R.C. 103.65, 121.93, 125.95, 355.04, 3901.90, 5119.89, 5162.08, 5162.13, 5162.132, 5162.133, 5162.134, 5162.136, 5162.1310, 5162.70, 5162.82, 5163.04, 5167.24, 5168.90, 5180.17, and 5180.20; Sections 209.20, 313.10, 313.20, 333.85, 751.70, 751.111, and 751.130

Transfers legislative oversight of the state's Medicaid program from JMOC to the standing committees in the House and Senate that primarily consider Medicaid legislation (meeting jointly) and support for that work from JMOC staff to LSC, respectively.

Requires LSC to research and review Medicaid reports and legislation, including reviewing other states' legislation, and present this material to the standing committees at joint meetings of the standing committees.

Requires LSC, instead of JMOC, to contract biennially with an actuary to calculate the projected medical inflation rate, and for the standing committees, rather than JMOC, to approve or reject the actuary's calculated rate.

Removes from the Senate-passed bill a House-added provision that would have required, by the beginning of October 2025, ODM, ODJFS, and CDJFSs to provide the JMOC Executive Director and staff of JMOC access to view information and systems used for determining eligibility for public assistance benefits, as well for billing, payments, and tracking for providers.

Decreases GRF ALI 048321, Operating Expenses, by $397,532 in FY 2026 and by $654,606 (to $0) in FY 2027 to provide for funding to conclude the agency's operations and zero out funding thereafter. Removes reappropriations clauses pertaining to the ongoing operation of the agency.