Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD22 Exchange of health information			
R.C. 191.01 (repealed), 3798.01, 3798.07 Repeal: 191.02, 191.04, 3798.06, 3798.08, 3798.14-3798.16	**R.C. 191.01 (repealed), 3798.01, 3798.07 Repeal: 191.02, 191.04, 3798.06, 3798.08, 3798.14-3798.16**	**R.C. 191.01 (repealed), 3798.01, 3798.07 Repeal: 191.02, 191.04, 3798.06, 3798.08, 3798.14-3798.16**	**R.C. 191.01 (repealed), 3798.01, 3798.07 Repeal: 191.02, 191.04, 3798.06, 3798.08, 3798.14-3798.16**
Eliminates all provisions regarding approved health information exchanges in statutes governing protected health information, including provisions that require the Medicaid Director to adopt rules regarding such exchanges.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Repeals statutes regarding the exchange of protected health information between, and disclosure of personally identifiable information by, certain state agencies.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Fiscal effect: Potential decrease in rule promulgation costs.	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD30 Office of Health Transformation			
R.C. **191.01, 191.02, 191.04, 191.06, 191.08-191.10 (all repealed), 103.41, 3701.36, 3701.68, 3701.95, 3798.01, 3798.10, 3798.14-3798.16, 5101.061, 5162.12, 5164.01**	**R.C.** **191.01, 191.02, 191.04, 191.06, 191.08-191.10 (all repealed), 103.41, 3701.36, 3701.68, 3701.95, 3798.01, 3798.10, 3798.14-3798.16, 5101.061, 5162.12, 5164.01**	**R.C.** **191.01, 191.02, 191.04, 191.06, 191.08-191.10 (all repealed), 103.41, 3701.36, 3701.68, 3701.95, 3798.01, 3798.10, 3798.14-3798.16, 5101.061, 5162.12, 5164.01**	**R.C.** **191.01, 191.02, 191.04, 191.06, 191.08-191.10 (all repealed), 103.41, 3701.36, 3701.68, 3701.95, 3798.01, 3798.10, 3798.14-3798.16, 5101.061, 5162.12, 5164.01**
Repeals statutes that establish duties for the Office of Health Transformation. Removes all other references to the Office of Health Transformation from the Revised Code.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Fiscal effect: Reduces OBM expenditures by $0.5 million per year, of which approximately half are GRF savings. The remaining savings are attributed to Fund 3CM0, Medicaid Agency Transition, which the bill abolishes and transfers the remaining balance into Fund 3B10, Community Medicaid Expansion.	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD39 **VETOED Automatic designation of authorized representatives**			
	R.C. 5160.48, 5160.01		**R.C. 5160.48, 5160.01**
No provision.	[***VETOED: Specifies that, for an applicant for medical assistance who resides in a nursing facility or residential care facility that participates in the Assisted Living Program, the facility will be automatically designated as the individual's primary authorized representative at the time of the application for medical assistance, which permits the county department of job and family services to communicate with the facility regarding the application, as provided under existing law.***]	No provision.	Same as the House.
	Fiscal effect: None.		**Fiscal effect: Same as the House.**
MCDCD29 Fund abolishments			
R.C. 5162.01, Repealed: 5162.58, 5162.60, 5162.62	**R.C. 5162.01, Repealed: 5162.58, 5162.60, 5162.62**	**R.C. 5162.01, Repealed: 5162.58, 5162.60, 5162.62**	**R.C. 5162.01, Repealed: 5162.58, 5162.60, 5162.62**
Abolishes the following funds:	Same as the Executive.	Same as the Executive.	Same as the Executive.
(1) The Integrated Care Delivery Systems Fund;	(1) Same as the Executive.	(1) Same as the Executive.	(1) Same as the Executive.
(2) The Medicaid Administrative Reimbursement Fund; and	(2) Same as the Executive.	(2) Same as the Executive.	(2) Same as the Executive.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
(3) The Managed Care Performance Payment Fund.	(3) Same as the Executive.	(3) Same as the Executive.	(3) Same as the Executive.
MCDCD18 Health Care/Medicaid Support and Recoveries Fund and multi-system youth			
R.C. 5162.52, Section 333.95	**R.C. 5162.52, Section 333.95**	**R.C. 5162.52, Section 333.95**	**R.C. 5162.52, Section 333.95**
Requires that money credited to the Health Care/Medicaid Support and Recoveries Fund (Fund 5DL0) also be used for (1) programs that serve youth involved in multiple government agencies and (2) innovative programs that promote access to health care or help achieve long-term cost savings to the state.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Permits DPF Fund 5DL0 appropriation item 651690, Multi-system Youth Innovation and Support, to be used for the new purposes of the Health Care/Medicaid Support and Recoveries Fund.	Same as the Executive.	Replaces the Executive provision with a provision that requires line item 651690 to be used to prevent custody relinquishment of multi-system children and youth and to obtain services consistent with the multi-system youth action plan developed by the Ohio Family and Children First Council. Renames the line item as "Multi-System Youth Custody Relinquishment."	Same as the Senate.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD38 Social determinants of health			
	R.C. 5166.42	**R.C. 5162.72**	**R.C. 5162.72, 5162.01, 5162.1310**
No provision.	Requires the Medicaid Director to establish a Medicaid waiver component that addresses social determinants of health, including housing, transportation, food, interpersonal safety, and toxic stress.	Replaces the House provision with a provision that requires the Medicaid Director to implement strategies that address social determinants of health, including housing, transportation, food, interpersonal safety, and toxic stress.	Same as the Senate, but requires the strategies implemented to also address employment.
No provision.	No provision.	No provision.	Requires ODM to periodically evaluate the success that members of the expansion eligibility group (Group VIII) have with (1) obtaining employer-sponsored health insurance coverage, (2) improving health conditions that would otherwise prevent or inhibit stable employment, and (3) improving the conditions of employment, including duration and hours of employment. Requires ODM to complete a report for each evaluation.
	Fiscal effect: Increase in administrative costs associated with establishing and applying for the waiver.	**Fiscal effect: Potential increase in costs.**	**Fiscal effect: Same as the Senate.**
MCDCD59 Ohio Medicaid School Plan			
	R.C. 5162.364, 5162.01	**R.C. 5162.364, 5162.01**	**R.C. 5162.364, 5162.01**
No provision.	Permits educational service centers to participate in the school component of the Medicaid Program.	Same as the House.	Same as the House.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD19 Suspension of Medicaid provider agreements			
R.C. 5164.36, 5164.37 (repealed and new enact), 5164.38	**R.C. 5164.36, 5164.37 (repealed and new enact), 5164.38**	**R.C. 5164.36, 5164.37 (repealed and new enact), 5164.38**	**R.C. 5164.36, 5164.37 (repealed and new enact), 5164.38**
Generally conforms the terms and procedures for suspending a Medicaid provider agreement because of a disqualifying indictment to those for suspending a provider agreement because of a credible allegation of fraud.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Requires, with certain exceptions, that the provider agreement of a hospital, nursing facility, or ICF/IID be suspended when a disqualifying indictment is issued against the provider or the providers officer, authorized agent, associate, manager, or employee.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Requires, with certain exceptions, that the provider agreement of an independent provider be suspended when an indictment charges the provider with a felony or misdemeanor regarding furnishing or billing for Medicaid services or performing related management or administrative services.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Requires that all Medicaid payments for services rendered be suspended, regardless of the date of service, when the provider agreement is suspended because of a credible allegation of fraud or disqualifying indictment.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Permits ODM to suspend, without prior notice, a provider agreement and all Medicaid payments to the provider if there is evidence that the	Same as the Executive.	Same as the Executive.	Same as the Executive.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
provider presents a danger of immediate of serious harm to the health, safety, or welfare of Medicaid recipients.			
Fiscal effect: This change could result in reduced legal and administrative costs. ODM anticipates reductions of $5.0 million in ($1.5 million state share) in FY 2020 and $10.0 million ($3.0 million state share) in FY 2021.	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**
MCDCD55 **VETOED Health care price transparency**			
	R.C. 5164.65, 3962.01-3962.15, 751.30		**R.C. 5164.65, 3962.01-3962.15, 751.15**
No provision.	[***VETOED: Requires ODM to comply with the health care price transparency law (See INSCD9).***]	No provision.	Same as the House.
MCDCD70 Medicaid rates for aide and nursing services			
		R.C. 5164.77 (repealed)	**R.C. 5164.77 (repealed)**
No provision.	No provision.	Repeals a law that required the Department of Medicaid to (1) reduce the Medicaid rates for aide and nursing services on October 1, 2011 and (2) adjust the Medicaid rates for those services not sooner than July 1, 2012, in a manner that reflects certain factors.	Same as the Senate.
		Fiscal effect: Potential increase in Medicaid costs for future years.	**Fiscal effect: Same as the Senate.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD62 Post-hospital extended care agreements			
	R.C. 5164.302		
No provision.	Prohibits ODM from entering into a Medicaid provider agreement with, or revalidating the provider agreement of, a hospital unless requirements regarding post-hospital care agreements with nursing homes are met. **Fiscal effect: Potential administrative costs related to ensuring that hospitals receiving new or revalidated provider agreements comply with requirements.**	No provision.	No provision.
MCDCD44 Medicaid payment rates for emergency medical services			
	R.C. 5164.722, 5164.01, 5164.05, 5164.38, 5164.723, 5167.201		
No provision.	Specifies that the Medicaid payment rate for services provided to Medicaid recipients in hospital emergency departments cannot exceed payment rates for such services if provided in the most appropriate health care setting if the service is not needed to comply with the Emergency Medical Treatment and Labor Act.	No provision.	No provision.
No provision.	Requires ODM to conduct fiscal audits of hospital emergency departments to ensure that payment rates do not exceed the bill's limits.	No provision.	No provision.
No provision.	Permits ODM to reduce a hospital emergency department's Medicaid payments by up to half	No provision.	No provision.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
	and for five years if the hospital emergency department does not cooperate with a final fiscal audit.		
No provision.	Limits Medicaid payments to a federally-qualified health center that is located on the same campus as a hospital emergency department and that provides services to a Medicaid recipient referred to the emergency department.	No provision.	No provision.
No provision.	Provides exceptions to a requirement that a non-contracting hospital accept, under certain conditions, as payment in full from a Medicaid MCO the fee-for-service rate. **Fiscal effect: Potential decrease in Medicaid costs for emergency services. Potential loss of revenue for public hospitals. Administrative costs for both Medicaid and public hospitals.**	No provision.	No provision.
MCDCD65 **PARTIALLY VETOED MyCare Ohio and standardized claims forms**			
	R.C. 5164.91	**R.C. 5164.91**	**R.C. 5164.912**
No provision.	Requires the Medicaid Director to create a standardized claim form that allows a provider that renders a medically necessary health care service under MyCare Ohio to use the same claim form for that service, regardless of the payor.	Replaces the House provision with a provision that requires the Director to (1) select a standardized claim form for each provider type from among universally accepted claim forms used in the United States and (2) require that a provider that renders a medically necessary health care service under MyCare Ohio use the form.	Same as the Senate, except uses certain terminology that is more consistent with continuing state law governing the Medicaid program.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
No provision.	Requires the Medicaid Director to create standardized claim codes that allow a provider that renders a medically necessary health care service under MyCare Ohio to use the same code for that service, regardless of the payor.	Replaces the House provision with a provision that requires the Director to require that MyCare Ohio use the same medical codes used under the fee-for-service component of the Medicaid program except when other codes are used (1) to assist the collection of information reported to the Healthcare Effectiveness Data and Information Set (HEDIS), (2) for program integrity standards, or (3) pursuant to an agreement between ODM and a provider.	Same as the House, except uses certain terminology that is more consistent with continuing state law governing the Medicaid program.
No provision.	[***VETOED: Provides that any claim for a medically necessary service that is properly submitted using the standardized claim form and claim codes is to be considered a clean claim and must be paid not later than 30 days from the date the claim is submitted.***]	No provision.	Same as the House, except specifies that [***VETOED: (1) the 30 days are calendar days and (2) a claim must be for Medicaid services that, in addition to being medically necessary, are otherwise allowable.***]
No provision.	[***VETOED: Requires ODM, if it fails to pay such a claim within 35 calendar days, to pay interest on equal to 1% per month calculated from the expiration of the 35-day period.***]	No provision.	Same as the House.
No provision.	Provides that the interest is to accrue until the claim and interest are paid in full. **Fiscal effect: Potential costs, including administrative costs for developing the standardized form and claim codes and for paying any interest due.**	No provision. **Fiscal effect: Potential administrative costs.**	No provision. **Fiscal effect: Potential administrative costs.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD78 Medicaid prescribed drug spending			
			R.C. 5164.7515
No provision.	No provision.	No provision.	Requires the Medicaid Director, not later than July 1, 2020, to establish an annual benchmark for prescribed drug spending growth under the Medicaid Program.
No provision.	No provision.	No provision.	Requires the Director to identify specific prescribed drugs that significantly contribute to the spending in excess of the benchmark in years it is exceeded and to publish a list of those drugs.
No provision.	No provision.	No provision.	Requires the Director, for identified prescribed drugs, to determine if there is a current supplemental rebate agreement for those drugs with the drug manufacturer and to evaluate if a supplemental rebate agreement should be entered into or if an existing supplemental rebate agreement should be renegotiated. Requires the Director to establish a target rebate amount for a drug if the Director determines a supplemental rebate agreement should be renegotiated.
No provision.	No provision.	No provision.	Requires the Director to, in negotiating a new supplemental rebate agreement (1) seek to negotiate an amount equal to the target rebate amount and (2) not enter into an agreement that is less than 60% of the target rebate amount.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
No provision.	No provision.	No provision.	Provides that if no rebate agreement is established or renegotiated for an identified prescribed drug, the Director can consider removing the prescribed drug from the Medicaid Program's preferred drug list and imposing a prior authorization requirement on the drug. **Fiscal effect: There will be an increase in administrative costs to develop the benchmark. Any other impacts will depend on a number of factors.**

MCDCD21 **PARTIALLY VETOED Medicaid rates for nursing facility services**

R.C. 5165.01, 5165.15-5165.17, 5165.19, 5165.21, 5165.25, 5165.361 (repealed)	R.C. 5165.15, 5165.15, 5165.152, 5165.25, 5165.26, Section 333.270	R.C. 5165.15, 5165.152, 5165.21, 5165.25, 5165.26, Sections 333.270, 812.10, 812.12	R.C. 5165.15, 5165.152, 5165.21, 5165.25, 5165.26, Sections 333.270, 812.10, 812.12
Provides for the total per Medicaid day payment rate to be $115 for nursing facility services provided to low resource utilization residents regardless of whether the nursing facility cooperates with the Long-Term Care Ombudsman Program in efforts to help those residents receive the services that are most appropriate for their level of care needs.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Revises the law governing the quality payments that nursing facilities earn under the Medicaid Program for satisfying quality indicators.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Repeals a law that provides for adjustments in nursing facility Medicaid rates beginning in state FY 2020 in an amount that equals the difference	No provision.	Same as the Executive, except that (1) the adjustments are to continue to be made in determining nursing facilities' rates for ancillary	Same as the Senate.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
between the Medicare skilled nursing facility market basket index and a budget reduction adjustment factor.		and support costs and capital costs and costs per case-mix unit [***VETOED: and (2) delays the elimination of the adjustment for the remaining factors (total rates and rates for tax costs) until July 1, 2021.***]	
Repeals a law that states the General Assembly's intent to enact laws that specify the budget reduction adjustment factor for each state fiscal year.	Replaces the Executive provision with a provision that specifies that the budget reduction adjustment factor (1) is to be, for the second half of FY 2020, 2.4% and (2) is to be, for FY 2021, the Medicare skilled nursing facility market basket index for federal FY 2020.	Same as the House.	Same as the House.
Repeals a law that sets the budget reduction adjustment factor at zero for a state fiscal year if the General Assembly fails to enact a law specifying the budget reduction adjustment factor for that year.	No provision.	No provision.	No provision.
No provision.	Provides for nursing facilities to earn a quality incentive payment under the Medicaid program beginning with the second half of FY 2020.	Same as the House, but modifies the payment as follows:	Same as the Senate, but modifies as follows:
No provision.	Provides that the total amount to be spent on the payments for the second half of FY 2020 is to be determined as follows: (1) determine, for each nursing facility, the product of (a) the amount that is 2.4% of the nursing facility's base rate (its rate for the costs centers and, if applicable, critical access incentive payment) on January 1, 2020, and (b) the number of the nursing facility's Medicaid days for the second half of CY 2018; (2) determine the sum of the products determined under (1) for all nursing facilities.	Same as the House, except it includes a $16.44 add-on in the base rate.	Same as the Senate.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
No provision.	Provides that the total amount to be spent on the payments for FY 2021 and each fiscal year thereafter is to be determined as follows: (1) determine, for each nursing facility, the product of (a) the amount that is 2.4% of the nursing facility's base rate (its rate for the costs centers and, if applicable, critical access incentive payment) on the first day of the fiscal year and (b) the number of the nursing facility's Medicaid days for the applicable measurement period; (2) determine the sum of the products determined under (1) for all nursing facilities.	Same as the House, except provides for the total amount to be determined as follows: (1) for each nursing facility, determine (a) the amount that is 2.4% of the nursing facility's base rate (including a $16.44 add-on) on the first day of the fiscal year, (b) [***VETOED: the sum of the amount determined under (a) and its base rate for that day, (c)***] the product of [***VETOED: the sum determined under (b) and the Medicare skilled nursing facility market basket index for federal FY 2020, (d) the sum of the amounts determined under***] (a) [***VETOED: and (c), and (e) the product of the sum determined under (d)***] and the number of the nursing facility's Medicaid days for the applicable measurement period; (2) determine the sum of the products determined under (1) [***VETOED: (e)***] for all nursing facilities.	Same as the Senate.
No provision.	Requires a nursing facility's licensed occupancy percentage be at least 80% to earn the payment for the second half of FY 2020 and at least the statewide average to earn the payment for FY 2021 and future years.	Same as the House, but eliminates the requirement for the second half of FY 2020, changes the required percentage to 70% for FY 2021 and future years and provides that a nursing facility earns a payment despite not meeting the licensed occupancy percentage requirement if: (1) the facility has a quality score of at least 10 points or 2) the facility, [***VETOED: less than four years before the first day of the fiscal year,***] was initially certified for participation in the Medicaid program [***VETOED: or underwent a renovation in which the facility temporarily removed one or more of its licensed beds from service***].	Same as the Senate, but makes the following revisions: (1) requires the occupancy rate to be 80%, and (2) increases the number of points a nursing facility must earn to 15.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
Fiscal effect: Eliminating the Medicare market-basket index from the calculation of nursing facility per diem rates will decrease GRF spending by $74.8 million ($27.7 million state share) in FY 2020 and by $164.8 million ($61.0 million state share) in FY 2021.	**Fiscal effect: Increases appropriations by a total of approximately $74.8 million in FY 2020 and $77.0 million in FY 2021 across various line items, which breaks down as follows: GRF line item 651525, Medicaid Health Care Services, $62.7 million ($23.2 million state share) in FY 2020 and $64.5 million ($23.9 million state share) in FY 2021; DPF Fund 5R20 line item 651608, Medicaid Services - Long Term, by $4.5 million in FY 2020 and $4.6 million in FY 2021; and FED Fund 3F00 line item 651623, Medicaid Services - Federal, $7.6 million in FY 2020 and $7.9 million in FY 2021.**	**Fiscal effect: Same as the House, but makes the following appropriation changes to account for the Senate changes: decreases GRF line item 651525 by $37.4 million ($13.9 million state share) in FY 2020 and increases it by $73.6 million ($27.2 million state share) in FY 2021; and increases DPF Fund 5R20 line item 651508 by $5.3 million in FY 2021 and FED Fund 3F00 line item 651623 by $9.0 million in FY 2021. The provision that delays the elimination of the adjustment until July 1, 2021 could lower Medicaid expenditures in the future.**	**Fiscal effect: Same as the Senate.**
MCDCD56 **VETOED Home-delivered meals under Medicaid waivers**			
	R.C. 5166.04, Section 333.160	**R.C. 5166.04, Section 333.160**	**R.C. 5166.04, Section 333.160**
No provision.	[***VETOED: Establishes the payment rates for home-delivered meals provided under MyCare Ohio and Ohio Home Care waiver programs, during FY 2020 and FY 2021 as follows: $7.19 per meal delivered on a daily basis by a volunteer or employee of the provider, $6.99 per meal (chilled or frozen) delivered weekly by the provider or volunteer, and $6.50 per meal (chilled or frozen) delivered weekly be a common carrier. (This applies to PASSPORT as well, see AGECD13).***]	Same as the House.	Same as the House.
No provision.	[***VETOED: Requires each home and community-based services Medicaid waiver program that covers home-delivered meals to provide for the meals to be delivered in a format	Same as the House.	Same as the House.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
	and frequency consistent with individuals' needs and the individual who delivers the meals to meet face-to-face with the individual to whom the meals are delivered.***]		
	Fiscal effect: The current regular meal reimbursement is $6.50. The provision would result in an increase in meal reimbursement costs. The total cost will depend on the number of meals delivered at the higher rates. In addition, there could be an increase in costs to ensure formats and frequencies meet individual needs.	**Fiscal effect: Same as the House.**	**Fiscal effect: Same as the House.**
MCDCD71 **VETOED Medicaid rates for personal care services**			
		R.C. 5166.09	**R.C. 5166.09**
No provision.	No provision.	[***VETOED: Requires that the Medicaid rates for personal care services provided under a Medicaid waiver that is an alternative to nursing facility services be increased annually beginning with FY 2022 by the difference between the Medicare skilled nursing facility market basket index and the same budget reduction adjustment factor used to determined nursing facilities' Medicaid rates.***]	Same as the Senate.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD41 Restrictions on offering snacks with home-delivered meals			
	R.C. 5166.122, 5166.162		
No provision.	Prohibits entities that provide home-delivered meals under the Ohio Home Care and MyCare Ohio waiver programs from offering snacks unless the entities meet certain requirements regarding the snacks. (This applies to other programs, see AGECD12).	No provision.	No provision.
	Fiscal effect: None.		
MCDCD27 Clarification and simplification of Medicaid managed care statutes			
R.C. 5167.01, 3701.612,4729.80, 5166.01, 5167.03, 5167.04-5167.051, 5167.10-5167.11, 5167.13, 5167.14, 5167.17-5167.18, 5167.20, 5167.201, 5167.26, 5167.41, 5168.75	**R.C. 5167.01, 3701.612,4729.80, 5166.01, 5167.03, 5167.04-5167.051, 5167.10-5167.11, 5167.13, 5167.14, 5167.17-5167.18, 5167.20, 5167.201, 5167.26, 5167.41, 5168.75**	**R.C. 5167.01, 3701.612,4729.80, 5166.01, 5167.03, 5167.04-5167.051, 5167.10-5167.11, 5167.13, 5167.14, 5167.17-5167.18, 5167.20, 5167.201, 5167.22, 5167.26, 5167.41, 5168.75**	**R.C. 5167.01, 3701.612,4729.80, 5166.01, 5167.03, 5167.04-5167.051, 5167.10-5167.11, 5167.13, 5167.14, 5167.17-5167.18, 5167.20, 5167.201, 5167.22, 5167.26, 5167.41, 5168.75**
Clarifies and simplifies statutes governing the Medicaid managed care system.	Same as the Executive, except that the statutes are simplified further by using and defining the term "enrollee."	Same as the House, but applies the clarifications and simplifications to additional statutes.	Same as the Senate.
Fiscal effect: None.	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD25 Behavioral health services			
R.C. 5167.04	**R.C. 5167.04**		
Permits, instead of requires, ODM to include behavioral health services in the Medicaid managed care system.	Same as the Executive.	No provision.	No provision.
Fiscal effect: This change is being done to allow ODM flexibility to include or exclude various services and populations in the care management system in response to the managed care re-procurement.	**Fiscal effect: Same as the Executive.**		
MCDCD24 Prescribed drugs			
R.C. 5167.05, 4729.20	**R.C. 5167.05, 5167.12**	**R.C. 5167.05, 5167.12**	**R.C. 5167.05, 5167.12**
Permits, instead of requires, ODM to include prescribed drugs in the Medicaid managed care system.	Replaces the Executive provision with one that retains this requirement and simplifies the statute.	Same as the Executive.	Same as the Executive.
Eliminates the express authority of Medicaid MCOs, in covering the prescribed drug benefit, to use strategies for drug utilization management.	Replaces the Executive provision with one that retains this authority and simplifies the statute.	Same as the House.	Same as the House.
Eliminates a restriction against Medicaid MCOs requiring prior authorization for certain antidepressant and antipsychotic drugs.	Replaces the Executive provision with one that retains this restriction and simplifies the statute.	Same as the House.	Same as the House.
Eliminates a requirement that Medicaid MCOs comply with certain statutes governing coverage of prescribed drugs under the fee-for-service system, including prior authorization and	Replaces the Executive provision with one that retains this requirement and simplifies the statute.	Same as the House.	Same as the House.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
utilization review measures concerning opioids, medication synchronization, and step therapy protocols and exemptions.			
Eliminates a requirement that ODM authorize a Medicaid MCO to develop and implement a pharmacy utilization management program under which prior authorization is established as a condition of obtaining a controlled substance pursuant to a prescription.	Replaces the Executive provision with one that retains this requirement and simplifies the statute.	Same as the House.	Same as the House.
Fiscal effect: This change is being done to allow ODM flexibility to include or exclude various services and populations in the care management system in response to the managed care re-procurement.	**Fiscal effect: None.**	**Fiscal effect: The provision regarding the inclusion of prescribed drugs in the Medicaid managed care system is permissive.**	**Fiscal effect: Same as the Senate.**
MCDCD26 Help Me Grow and qualified community hubs			
R.C. 5167.15, 5167.173 (both repealed), 5167.173, with conforming changes: Section 603.10, 603.10	**R.C. 5167.16 (repealed), 5167.03**		
Eliminates a requirement that Medicaid MCOs cover certain home visits and cognitive behavioral therapy for Medicaid recipients who are enrolled in the Help Me Grow Program and either pregnant or the birth mother of a child under three years of age.	Same as the Executive.	No provision.	No provision.
Eliminates a requirement that Medicaid MCOs cover certain services provided by certified community health workers or public health nurses working for a qualified community hub.	No provision.	No provision.	No provision.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
Amends Section 4 of S.B. 322 of the 131st GA to make conforming changes. **Fiscal effect: This change is being done to allow ODM flexibility to include or exclude various services and populations in the care management system in response to the managed care re-procurement.**	No provision. **Fiscal effect: Same as the Executive.**	No provision.	No provision.
MCDCD37 Hospital value-based purchasing program			
No provision.	**R.C. 5167.19** Requires Medicaid managed care organizations to implement a hospital value-based purchasing program under which participating hospitals receive incentive payments based on their successes in meeting measures used for the Medicare Hospital Value-Based Purchasing Program. **Fiscal effect: The program is based on the Medicare program. The Medicare program is budget neutral since the hospital payment reductions are used for the incentive payments. There would be costs for administering the program.**	No provision.	No provision.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD31 Medicaid managed care recoupment requirements			
	R.C. 5167.22	**R.C. 5167.22**	**R.C. 5167.22, 5167.221, 5167.01**
No provision.	Prohibits a Medicaid managed care organization from initiating a recoupment of an overpayment made to a provider later than one year after the payment was made.	No provision.	No provision.
No provision.	Requires a Medicaid managed care organization to provide a provider all of the details of a recoupment including, the name, address, and Medicaid identification number of the recipient to whom the services were provided and the date or dates of the service.	Same as the House.	Same as the House.
No provision.	No provision.	No provision.	Requires ODM to assess the efforts of Medicaid MCOs to recoup overpayments made to providers and requires ODM to include in the contracts with Medicaid MCOs reasonable terms establishing limits on the recoupments
	Fiscal effect: Potential loss of recoupment revenue for overpayments and an increase in administrative costs to provide the required information.	**Fiscal effect: Potential administrative costs to provide the required information.**	**Fiscal effect: Potential administrative costs to provide the required information and to assess MCO efforts.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD20 Medicaid prompt payment requirements waiver			
R.C. 5167.25 (repealed), with conforming changes: 3901.3814	**R.C. 5167.25 (repealed), with conforming changes: 3901.3814**	**R.C. 5167.25 (repealed), with conforming changes: 3901.3814**	**R.C. 5167.25 (repealed), with conforming changes: 3901.3814**
Repeals the requirement that the Medicaid Director apply for a waiver from the federal Medicaid prompt payment requirements that would instead require health insuring corporations to submit claims in accordance with requirements established by the Department of Insurance.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Fiscal effect: None.	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**
MCDCD50 **VETOED Medicaid managed care - shared savings, quality incentive programs and other**			
	R.C. 5167.35, 4729.80, 4729.801, 5162.138, 5162.139, 5166.01, 5166.43, 5166.50, 5167.10, 5167.104, 5167.105, 5167.20, 5167.29, 5167.36, 5167.17, 5167.173, (conforming changes) 5167.01, 5167.101, 5167.102, 5167.11, 5167.13, 5167.171, 5167.172, 5167.12, Section 333.195	**R.C. 5167.15, 4729.80, 4729.801, Section 812.40**	**R.C. 5167.35, 4729.80, 4729.801, 5162.138, 5162.139, 5166.01, 5166.43, 5166.50, 5167.10, 5167.105, 5167.106, 5167.17, 5167.173, 5167.20, 5167.29, 5167.36, (conforming changes) 5167.01, 5167.101, 5167.102, 5167.11, 5167.13, 5176.171, 5167.172, 5167.12, Section 333.195**
No provision.	[***VETOED: Requires ODM to do all of the following if the U.S. Secretary of Health and Human Services agrees to enter into an enforceable agreement that safeguards the state's receipt of federal Medicaid funds:**]	No provision.	Same as the House.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
(1) No provision.	[***VETOED: (1) Establish the Shared Savings Bonus Program under which a Medicaid MCO earns a bonus if its three-year average per recipient capitated payment rate is less than the three-year average per recipient cost of certain other states' Medicaid programs.***]	(1) No provision.	(1) Same as the House.
(2) No provision.	[***VETOED: (2) Establish the Quality Incentive Program under which the Department randomly assigns certain Medicaid recipients to MCOs participating in the program based on the MCOs' points earned for meeting health and quality metrics.***]	(2) No provision.	(2) Same as the House.
(3) No provision.	[***VETOED: (3) Permit regional networks consisting of hospitals to become Medicaid MCOs if they accept a capitated payment that is not more than 90% of the lowest capitated payment made to a Medicaid MCO that is a health insuring corporation.***]	(3) No provision.	(3) Same as the House.
No provision.	[***VETOED: Requires each Medicaid MCO to establish a program that incentivizes enrollees to obtain covered health care from high quality and efficient providers.***]	No provision.	Same as the House.
No provision.	[***VETOED: Requires the Medicaid Director to establish a Medicaid waiver program under which Medicaid MCOs may cover any service or product that would have a beneficial effect on enrollees' health and is likely to reduce the costs under the plan within three years.***]	Replaces the House provision with a provision that authorizes a Medicaid MCO to include in its plans any service or product that would have a beneficial effect on the health of enrollees and that, because of the beneficial effect, is likely to reduce the per recipient per month costs under the plan by the end of the first three years that the service or product is covered.	Same as the House.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
No provision.	[***VETOED: Requires a Medicaid MCO, if it establishes a rate for a service that is greater than the fee-for-service rate for the service, to require providers of the service to enter into value-based contracts as a condition of joining the MCO's provider panel.***]	No provision.	Same as the House.
No provision.	[***VETOED: Prohibits a Medicaid MCO from permitting a provider to be part of the MCO's provider panel unless the provider assures the MCO that it will comply with a requirement regarding cost estimates.***]	No provision.	Same as the House.
No provision.	[***VETOED: Requires, with certain exceptions, a hospital to accept as payment in full from a Medicaid MCO an amount equal to 90% of the fee-for-service rate for a non-emergency service provided to a Medicaid recipient if the hospital does not have a contract with the MCO and the MCO refers the recipient to the hospital.***]	No provision.	Same as the House.
No provision.	[***VETOED: Allows a Medicaid MCO to submit a bulk request to the State Board of Pharmacy for information about all Medicaid recipients enrolled in the organization's Medicaid MCO plan and requires the Board to provide the requested information in a single electronic file or format.***]	Same as the House, but makes the following changes: requires the Board of Pharmacy to collaborate with the Office of InnovateOhio to provide the information; specifies that the information can also be provided by direct data transfer; and specifies that the provision does not take effect until March 1, 2020.	Same as the House.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
	Fiscal effect: Increase in administrative costs that include: developing the Shared Savings Bonus Program and Quality Incentive Program, as well as preparing and tracking MCO data to ensure compliance. Potential savings including the following: if any regional networks accept a lower capitated payment and hospital non-emergency services are reduced.	**Fiscal effect: The provision that authorizes Medicaid MCOs to include beneficial services or products in their plans is permissive; however, if any services or products are included, this could result in decreased costs. The Board of Pharmacy could realize an increase in costs for the bulk request provision.**	**Fiscal effect: Same as the House.**
MCDCD32 Medicaid managed care performance metrics			
	R.C. 5167.103	**R.C. 5167.103**	**R.C. 5167.103**
No provision.	Requires that ODM's website include the metrics ODM uses to determine a Medicaid managed care organization's contract performance.	Same as the House, but specifically requires ODM, in addition to the MCO performance payment program created in R.C. 5167.30, to establish performance metrics, which may include financial incentives and penalties, to evaluate and compare Medicaid MCO contract performance and then post the metrics to the website. Renumbers the ORC section.	Same as the Senate.
No provision.	Requires ODM to update its website quarterly to reflect any changes to the metrics used.	Same as the House.	Same as the House.
	Fiscal effect: Potential increase in ODM's administrative and IT costs.	**Fiscal effect: Same as the House.**	**Fiscal effect: Same as the House.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD74 Audits of Medicaid MCOs			
		R.C. 5167.104	
No provision.	No provision.	Requires ODM to periodically audit Medicaid MCOs to ensure their compliance with the MCO contracts and state and federal law and regulations. **Fiscal effect: Increase in administrative costs.**	No provision.
MCDCD77 **VETOED Adjustments in Medicaid managed care capitation rates**			
			R.C. 5167.107
No provision.	No provision.	No provision.	[***VETOED: Requires ODM to obtain JMOC's approval, and then the Controlling Board's approval for necessary appropriations, before adjusting any previously set capitation rates paid to Medicaid managed care organizations if the total cost to the Medicaid program would exceed $50.0 million.***]

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD52 **PARTIALLY VETOED Medicaid managed care organizations - PBM**			
	R.C. 5167.24, 3959.01, 5167.137, 5167.241, 5167.242, 5167.243, 5167.244, 5162.137	**R.C. 5167.124**	**R.C. 5167.122, 3959.01, 5162.137, 5167.01, 5167.24, 5167.241-5167.246**
No provision.	No provision.	No provision.	Requires the Medicaid Director, not later than July 1, 2020, to select a provisional single state pharmacy benefit manager (PBM) to administer pharmacy benefits for Medicaid managed care organizations (MCOs). Specifies that the entity will not be fully implemented as the state PBM until it demonstrates its ability to fulfill the duties of the state PBM through a readiness review process. [***VETOED: Specifies that the affiliated companies of the PBM selected may conduct PBM business in their own names with Medicaid MCOs.***]
No provision.	No provision.	No provision.	[***VETOED: Requires the state PBM to be responsible for processing all pharmacy claims under the care management system.***]
No provision.	No provision.	No provision.	Requires the contract to prohibit the PBM from requiring a Medicaid recipient to obtain a specialty drug from a specialty pharmacy owned or otherwise associated with the PBM and requires the Medicaid Director to define specialty drug and specialty pharmacy.
No provision.	No provision.	No provision.	Requires state PBM applicants to provide specified information, including the following: (1) conflicts of interest, (2) the state PBM's affiliations, (3) direct or indirect fees, charges, or

Executive	As Passed by the House	As Passed by the Senate	As Enacted
			any kind of assessments the state PBM imposes on pharmacies with which the state PBM or its affiliates shares common ownership, management, or control, (4) direct or indirect fees, charges, or any kind of assessments the state PBM imposes on pharmacies [***VETOED: that operate eleven or more, as well as eleven or fewer, locations in Ohio,***] and any financial terms and arrangements between the state PBM and prescription drug manufacturers or labelers, including formulary management, drug substitution programs, educational support claims processing, or data sales fees.
No provision.	No provision.	No provision.	[***VETOED: Requires the Medicaid Director to reprocure the state PBM contract every 4 years.***]
No provision.	Requires a Medicaid managed care organization to use the state PBM selected by and under contract with the Director of DAS pursuant to the terms of the master PBM contract developed by the Director (see DASCD37). Requires the state PBM to submit a quarterly report to ODM with specified information and the information required by the Medicaid Director. Requires the Medicaid Director to review the state PBM contract and recommend any changes to the DAS Director.	No provision.	Same as the House, but removes references to DAS [***VETOED: and requires the Medicaid Director to review the state PBM contract every six months and make any changes (as opposed to recommending changes to the DAS Director)***].
No provision.	[***VETOED: Requires ODM to develop findings based on the quarterly reports and submit those findings to the General Assembly. Requires ODM to keep as confidential any document or information marked confidential or proprietary	No provision.	Same as the House.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
	and to redact necessary information before it becomes public.***]		
No provision.	[***VETOED: Requires the state PBM, in consultation with the Medicaid Director, to establish a Medicaid prescribed drugs formulary for the Medicaid managed care prescribed drugs benefit. Specifies the Medicaid Director must approve the formulary before it becomes effective and requires the state PBM to notify the Medicaid Director of any changes. Allows the Medicaid Director to disapprove any change.***]	No provision.	Same as the House.
No provision.	Requires the Director to seek a waiver to price certain prescribed drugs based on the international pricing index model, if the Center for Medicare and Medicaid services adopts that model, and requires that model to be used instead.	No provision.	No provision.
No provision.	Prohibits violations of these provisions and tasks the Medicaid Director with adopting rules specifying civil penalties for violations.	No provision.	Same as the House.
No provision.	No provision.	No provision.	Imposes a civil penalty, in an amount to be determined by the Director, on a person for violating the terms of the master PBM contract.
No provision.	No provision.	No provision.	Requires the Director, as part of the data the state PBM must disclose to the Director, to collect from the state PBM clinical data as the Director sees fit.
No provision.	No provision.	No provision.	[***VETOED: Requires all contracts between the state PBM and a Medicaid MCO to specify that all pharmacy claims information shared

Executive	As Passed by the House	As Passed by the Senate	As Enacted
			between the parties is confidential and proprietary.***]
No provision.	No provision.	No provision.	[***VETOED: Requires the Medicaid Director to establish a dispensing fee to be paid to the pharmacy for dispensing prescribed drugs.***]
No provision.	No provision.	No provision.	[***VETOED: Requires the Medicaid Director to determine the rate the state PBM is paid for its services and specifies that all claims adjudication payments are to be made to the state PBM from a Medicaid MCO and payments relating to other administrative matters are to be made directly from ODM.***]
No provision.	No provision.	No provision.	Requires all payment arrangements between ODM, Medicaid MCOs, and the state PBM to comply with state and federal statutes and regulations, and any other agreement between ODM and CMS. Permits the Medicaid Director to change a payment arrangement in order to comply with state or federal statutes or regulations or other agreement between ODM and CMS.
No provision.	No provision.	No provision.	Requires each Medicaid MCO to disclose to ODM in the specified format the MCO's administrative costs associated with providing pharmacy services under the care management system.
No provision.	No provision.	Requires a PBM under contract with a Medicaid MCO to administer pharmacy services under the care management system to:	Same as the Senate, with the following changes:
No provision.	No provision.	(1) Upon the request of ODM, disclose all of its received payment streams, including drug	(1) Same as the Senate.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
		rebates, discounts, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other payments.	
No provision.	No provision.	(2) At least annually, contract with an independent third party to conduct a Service Organization Controls Report (SOC-1) audit and disclose that report to the Medicaid MCO, and upon request, to ODM.	(2) No provision.
No provision.	No provision.	Requires the Medicaid MCO and its PBM to cooperate with any other compliance audits of the PBM.	No provision.
No provision.	No provision.	Permits the Medicaid Director, if a PBM fails to comply with these provisions or an audit reveals a PBM has violated its contract with the Medicaid MCO or state and federal requirements, to (1) impose a financial penalty against the Medicaid MCO as permitted under the Medicaid MCO contract with ODM and (2) recommend to the Superintendent of Insurance that the Superintendent suspend the PBM's administrator license.	No provision.
No provision.	[***VETOED: Requires the Medicaid Director to adopt rules, including certain specific rules, as necessary to implement and enforce certain provisions.***]	No provision.	Same as the House, but [***VETOED: includes additional specific rules to be adopted.]

Executive	As Passed by the House	As Passed by the Senate	As Enacted
	Fiscal effect: Potential increase in administrative costs related to developing findings based on PBM quarterly reports and preparation of a report for submission to the General Assembly. Potential increase in administrative costs related to adopting rules. Any other impacts will depend on the terms in the new state master PBM contract.	**Fiscal effect: There would be administrative costs including contract costs for the SOC-1 audit. The provision would allow ODM to request data on a PBM's payment streams, reimbursements, etc.**	**Fiscal effect: Potential increase in administrative costs. Any other impacts will depend on the terms in the new state master PBM contract.**
MCDCD72 Care management single preferred drug list			
		R.C. 5167.122	
No provision.	No provision.	Requires ODM to establish a single preferred drug list for the care management system.	No provision.
No provision.	No provision.	Requires Medicaid MCOs and their contracted pharmacy benefit managers (PBMs) to follow the list.	No provision.
No provision.	No provision.	Requires the list to do certain things, including ease the administrative burden for prescribers, reduce confusion and the burden on Medicaid recipients, and ensure that prescribed drug rebates are sent directly to ODM instead of to a Medicaid MCO or PBM. **Fiscal effect: Any impact depends on the list established.**	No provision.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD73 Specialty pharmacies			
		R.C. 5167.123	
No provision.	No provision.	Requires, beginning on January 1, 2020, a Medicaid MCO to contract with a specialty pharmacy as a participating provider if the pharmacy (1) meets the Medicaid MCO's standards for participating providers (2) can provide pharmacy services at the same or lower cost than other participating provider specialty pharmacies and (3) seeks to be a participating provider.	No provision.
MCDCD60 Prior authorization requirements for home health services			
	R.C. 5167.221, 5167.01		
No provision.	Prohibits a Medicaid managed care organization from requiring a Medicaid recipient to obtain prior authorization for the first ten days of home health services if a physician, nursing facility, or hospital referred the recipient.	No provision.	No provision.
No provision.	Prohibits a Medicaid managed care organization from requiring a Medicaid recipient to obtain prior authorization for any home health services if the recipient is a hospice patient. **Fiscal effect: Potential increase in costs to managed care organizations. This cost may be passed to the state through increased capitation rates.**	No provision.	No provision.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD79 Appeals process for prescription drugs maximum allowable cost			
			R.C. 5167.245, 5167.246
No provision.	No provision.	No provision.	Requires the Medicaid Director to establish an appeals process that pharmacies can use to bring to the Department of Medicaid disputes about the maximum allowable cost set by the state PBM for a prescription drug.
No provision.	No provision.	No provision.	Requires pharmacies that participate in the care management system to use the appeals process to resolve maximum allowable cost disputes. **Fiscal effect: There will be an increase in costs to establish the appeals process. Any other impacts will depends on the disputes brought forward.**
MCDCD23 Updating references			
R.C. 5168.03, 3901.381, 5168.05-5168.08	**R.C. 5168.03, 3901.381, 5168.05-5168.08**	**R.C. 5168.03, 3901.381, 5168.05-5168.08**	**R.C. 5168.03, 3901.381, 5168.05-5168.08**
Replaces references to the former U.S. Health Care Financing Administration with references to the U.S. Centers for Medicare and Medicaid Services.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Fiscal effect: None.	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD4 OSU non-opiate, non-addictive pharmaceutical treatment			
Section: 333.55			
Requires $5.2 million in FY 2020 in GRF appropriation item 651525, Medicaid Health Care Services, to be distributed to OSU for development and clinical evaluation of a non-opiate, non-addictive pharmaceutical treatment intervention's efficacy to reduce a physician's reliance upon and limit a patient's initial exposure to opioids.	No provision. (The House budget includes a similar earmark under Facilities Establishment Fund (Fund 7037) line item 195615, Facilities Establishment, in the Development Services Agency budget, see DEVCD26) .	No provision. (The Senate budget includes this earmark under Fund 7009 appropriation item 195664, Innovation Ohio, see DEVCD24)	No provision. (This earmark is included under Fund 7009 appropriation item 195664, Innovation Ohio, see DEVCD24)
MCDCD1 Temporary authority regarding employees			
Section: 333.20	**Section: 333.20**	**Section: 333.20**	**Section: 333.20**
Extends through July 1, 2021, the authority of ODM to establish, change, and abolish positions and to assign, reassign, classify, reclassify, transfer, reduce, promote, or demote employees who are not subject to state law governing public employee's collective bargaining.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Permits a portion of various ODM appropriation items to be used to pay for costs associated with the administration of the Medicaid Program, including the personnel actions listed above.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Fiscal effect: None.	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD67 Positive Education Program Connections			
		Section: 333.30	**Section: 333.30**
No provision.	No provision.	Requires GRF appropriation item 651426, Positive Education Program Connections, to be used for the Positive Education Program Connections in Cuyahoga County.	Same as the Senate.
MCDCD2 Medicaid Health Care Services			
Section: 333.40	**Section: 333.40**	**Section: 333.40**	**Section: 333.40**
Requires that GRF appropriation item 651525, Medicaid Health Care Services, not be limited by R.C. 131.33, which requires that unexpended balances of appropriations revert to the funds from which they were made at the end of the appropriation period.	Same as the Executive.	Same as the Executive.	Same as the Executive.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD3 Lead abatement and related activities			
Section: 333.50	**Section: 333.50**	**Section: 333.50**	**Section: 333.50**
Allows the Director of OBM, upon the request of the Medicaid Director, to transfer state share appropriations from GRF appropriation item 651525, Medicaid Health Care Services, to appropriation items in other state agencies for the purposes of lead abatement and related activities. Permits the Director of OBM, if such a transfer occurs, to adjust the federal share of GRF appropriation item 651525, Medicaid Health Care Services, accordingly.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Allows the Medicaid Director to transfer federal funds for these transactions.	Same as the Executive.	Same as the Executive.	Same as the Executive.
MCDCD58 **VETOED PASSPORT enhanced community living services**			
	Section: 333.55	**Section: 333.55**	**Section: 333.55**
No provision.	[***VETOED: Earmarks $27,027 in each fiscal year from GRF appropriation item 651525, Medicaid Health Care Services, to increase the payment rates for enhanced community living services covered by the PASSPORT Program.***]	Same as the House.	Same as the House.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD66 Enhanced maternal care services			
		Section: 333.58	
No provision.	No provision.	Requires $2,500,000 in each fiscal year from the amounts allocated to home visiting services in GRF appropriation item 651525, Medicaid Health Care Services, to be used to fund practice transformation activities that increase safe spacing initiatives with high volume Medicaid providers serving women in high infant mortality regions.	No provision.
MCDCD5 Performance payments for Medicaid managed care			
Section: 333.60	**Section: 333.60**	**Section: 333.60**	**Section: 333.60**
Requires ODM, for FY 2020 and FY 2021, to provide performance payments to MCOs for participants in the Integrated Care Delivery System (ICDS), MyCare Ohio, separately from those under the Managed Care Performance Payment Program.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Requires ODM to (1) develop quality measures designed specifically to determine the effectiveness of services provided to ICDS participants and (2) determine an amount to be withheld from Medicaid premium payments paid to MCOs for ICDS participants.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Requires that the withheld amount be established as a percentage of each premium	Same as the Executive.	Same as the Executive.	Same as the Executive.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
payment. Requires MCOs to agree to the withholding. Requires ODM to certify the amount to the OBM Director.			
MCDCD43 **VETOED Medicaid managed care organization financial health**			
	Section: 333.65		**Section: 333.65**
No provision.	[***VETOED: Requires ODM, no later than January 1, 2020, to evaluate and benchmark the financial health of Medicaid managed care organizations and adopt rules addressing the organizations' financial health as evaluated.***]	No provision.	Same as the House, but [***VETOED: also requires ODM to submit its findings to the Joint Medicaid Oversight Committee***].
	Fiscal effect: Increase in administrative costs.		**Fiscal effect: Same as the House.**
MCDCD36 Performance indicators for children's hospitals			
	R.C. 5164.724		**Section: 333.67**
No provision.	Requires the Medicaid Director to adopt performance indicators to measure the quality of services provided by children's hospitals.	No provision.	Replaces the House provision with a provision that does the following: (1) requires ODM to establish a committee to study and develop performance indicators for children's hospitals; and (2) requires the committee to prepare and submit a report of its findings and recommendations to ODM.
	Fiscal effect: Increase in administrative costs for the development of performance indicators.		**Fiscal effect: Potential administrative costs.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD6 Hospital Franchise Fee Program			
Section: 333.70	**Section: 333.70**	**Section: 333.70**	**Section: 333.70**
Permits the Director of OBM to authorize additional expenditures from appropriation items 651623, Medicaid Services - Federal; 651525, Medicaid Health Care Services, and 651656, Medicaid Services - Hospital/UPL, to implement the hospital assessment fee. Appropriates any authorized amounts.	Same as the Executive.	Same as the Executive.	Same as the Executive.
MCDCD7 Medicare Part D			
Section: 333.80	**Section: 333.80**	**Section: 333.80**	**Section: 333.80**
Permits GRF appropriation item 651526, Medicare Part D, to be used by ODM for the implementation and operation of the Medicare Part D requirements contained in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Permits the Director of OBM, upon the request of ODM, to transfer the state share of appropriations between GRF appropriation items 651525, Medicaid Health Care Services, and 651526, Medicare Part D.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Requires the Director of OBM to adjust the federal share of item 651525, if the state share is adjusted.	Same as the Executive.	Same as the Executive.	Same as the Executive.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
Requires ODM to provide notification to the Controlling Board of any such transfers at their next scheduled meeting.	Same as the Executive.	Same as the Executive.	Same as the Executive.
MCDCD46 Brigid's Path Program			
	Section: 333.82	**Section: 333.82**	**Section: 333.82**
No provision.	Requires GRF appropriation item 651529, Brigid's Path Program, be distributed to the Brigid's Path Program in Montgomery County.	Same as the House.	Same as the House.
MCDCD61 Food Farmacy Pilot Project			
	Section: 333.83		**Section: 333.83**
No provision.	Requires GRF appropriation item 651533, Food Farmacy Pilot Project, to be distributed to a hospital system in a county with a charter form of government and with a total population between 500,000 and 1.0 million to provide comprehensive medical, nutrition, and lifestyle support for food-insecure patients with type 2 diabetes and their families.	No provision.	Same as the House.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD8 Health Care Services Support and Recoveries			
Section: 333.90	**Section: 333.90**	**Section: 333.90**	**Section: 333.90**
Requires the Medicaid Director to deposit into the Health Care Services Support and Recoveries Fund (Fund 5DL0), $350,000 in each fiscal year from the first installment of assessments and intergovernmental transfers made under the Hospital Care Assurance Program (HCAP) under R.C. 5168.06 and 5168.07.	Same as the Executive.	Same as the Executive.	Same as the Executive.
MCDCD9 Hospital Care Assurance match			
Section: 333.100	**Section: 333.100**	**Section: 333.100**	**Section: 333.100**
Permits the Director of OBM, at the request of the Medicaid Director, to authorize additional expenditures from the Health Care Federal Fund (Fund 3F00) if receipts credited to the fund exceed the amounts appropriated. Appropriates any authorized amounts.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Requires that DPF Fund 6510 appropriation item 651649, Medicaid Services – Hospital Care Assurance Program, be used by ODM for distributing the state share of all HCAP funds to hospitals. Permits the Director of OBM, at the request of the Medicaid Director, to authorize additional expenditures from the Hospital Care Assurance Program Fund (Fund 6510) if receipts credited to the fund exceed the amounts appropriated. Appropriates any authorized	Same as the Executive.	Same as the Executive.	Same as the Executive.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
amounts.			
MCDCD10 Refunds and Reconciliation Fund			
Section: 333.110 Permits the Director of OBM, at the request of the Medicaid Director, to authorize additional expenditures from the Refunds and Reconciliation Fund (Fund R055) if receipts credited to the fund exceed the amounts appropriated. Appropriates any authorized amounts.	**Section: 333.110** Same as the Executive.	**Section: 333.110** Same as the Executive.	**Section: 333.110** Same as the Executive.
MCDCD11 Medicaid Interagency Pass-Through			
Section: 333.120 Permits the Director of OBM to increase FED Fund 3G50 appropriation item 651655, Medicaid Interagency Pass-Through, at the request of the Medicaid Director. Appropriates the increase.	**Section: 333.120** Same as the Executive.	**Section: 333.120** Same as the Executive.	**Section: 333.120** Same as the Executive.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD12 Non-emergency medical transportation			
Section: 333.130 Permits the Director of OBM, at the request of the Medicaid Director to transfer the state share appropriations between GRF appropriation item 651525, Medicaid Health Care Services, in the ODM budget and 655523, Medicaid Program Support - Local Transportation, in the ODJFS budget to ensure access to a non-emergency medical transportation brokerage program. Requires that the Director of OBM adjust the federal share of item 651525 and federal fund 3F01 appropriation item 655624, Medicaid Program Support - Federal, in the ODJFS budget. Requires the ODM Director to transmit federal funds it receives for the transaction to Fund 3F01, used by ODJFS.	**Section: 333.130** Same as the Executive.	**Section: 333.130** Same as the Executive.	**Section: 333.130** Same as the Executive.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD13 Public assistance eligibility determination and local program support			
Section: 333.140	**Section: 333.140**	**Section: 333.140**	**Section: 333.140**
Permits the Director of OBM, at the request of the Medicaid Director to transfer up to $5.0 million in each fiscal year in state share appropriations between GRF appropriation item 651525, Medicaid Health Care Services, in the ODM budget and 655522, Medicaid Program Support - Local, in the ODJFS budget. Requires that the Director of OBM adjust the federal share of item 651525 and FED Fund 3F01 appropriation item 655624, Medicaid Program Support - Federal, in the ODJFS budget. Requires the Medicaid Director to transmit federal funds it receives for the transaction to Fund 3F01, used by ODJFS.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Prohibits these funds from being used for existing and ongoing operating expenses.	No provision.	No provision.	No provision.
Requires the Medicaid Director to establish criteria for distribution of funds and for CDJFS' to submit allowable expenses.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Requires CDJFSs to comply with new roles, processes, and responsibilities related to the new eligibility determination system and requires CDJFS to report to ODJFS and ODM how the funds were used.	Same as the Executive.	Same as the Executive.	Same as the Executive.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD75 **VETOED Medicaid payment rates for inpatient hospital services**			
		Section: 333.170	**Section: 333.170**
No provision.	No provision.	[***VETOED: Requires that an urban hospital's Medicaid base rate for inpatient services provided during FY 2020 be at least the average of the base rate for hospitals in the same peer group region if the urban hospital's FY 2019 base rate is less than $4,000.***]	Same as the Senate.
		Fiscal effect: Increases appropriation item 651525, Medicaid Health Care Services, by $6.0 million ($1.8 million state share) in FY 2020.	**Fiscal effect: Same as the Senate.**
MCDCD14 Medicaid payment rates for community behavioral health services			
Section: 333.180	**Section: 333.180**	**Section: 333.180**	**Section: 333.180**
Permits ODM to establish Medicaid payment rates for community behavioral health services provided during FY 2020 and FY 2021 that exceed authorized rates paid for the services under the Medicare Program.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Specifies that this provision does not apply to community behavioral health services provided by hospitals on an inpatient basis, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities.	Same as the Executive.	Same as the Executive.	Same as the Executive.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD33 **VETOED Medicaid rate for Vagus Nerve Stimulation**			
	Section: 333.185		**Section: 333.185**
No provision.	[***VETOED: Requires that the Medicaid rate for the Vagus Nerve Stimulation service provided under the outpatient hospital benefit equal 75% of the Medicare rate for the service during the period beginning July 1, 2019, and ending July 1, 2021.***]	No provision.	Same as the House.
No provision.	[***VETOED: Requires that the Medicaid rates for other services selected by the Medicaid Director be reduced to avoid an increase in Medicaid expenditures.***]	No provision.	Same as the House.
	Fiscal effect: None. The provision is designed to be fiscally neutral.		**Fiscal effect: Same as the House.**
MCDCD15 Area Agencies on Aging and Medicaid managed care			
Section: 333.190	**Section: 333.190**	**Section: 333.190**	**Section: 333.190**
Requires ODM, if it expands the inclusion of the aged, blind, and disabled (ABD) eligibility group or dual-eligibles in the care management system during the FY 2020-FY 2021 biennium, to do the following:	Same as the Executive.	Same as the Executive.	Same as the Executive.
(1) Require Area Agencies on Aging (AAA) to be the coordinators of home and community-based services available under Medicaid waiver components that those individuals and the group receive and permit Medicaid MCOs to	(1) Same as the Executive.	(1) Same as the Executive.	(1) Same as the Executive.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
delegate to the agencies full-care coordination functions for those services and other health-care services those individuals and that group receive; and			
(2) Give preference, when selecting MCOs to contract with, organizations that will enter into subcapitation arrangements with area agencies on aging under which the agencies are to perform, in addition to other functions, certain network management and payment functions.	(2) Same as the Executive.	(2) Same as the Executive.	(2) Same as the Executive.
MCDCD35 Employment connection incentive programs			
	R.C. 5167.28		**Section: 333.197**
No provision.	Requires each Medicaid managed care organization to establish an employment connection incentive program to assist Medicaid recipients in obtaining and maintaining employment.	No provision.	Replaces the House provision with a provision that requires ODM, as part of the reprocurement process for new Medicaid MCO contracts, to include in the measures used to determine which MCOs will be awarded contracts measures related to the abilities and commitment of MCOs to establish and operate employment programs for Medicaid recipients enrolled in their plans.
No provision.	Makes participation in a program voluntary for the recipients.	No provision.	No provision.
No provision.	Provides for Medicaid managed care organizations to earn incentive payments based on their successes with their programs.	No provision.	No provision.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
	Fiscal effect: Increase in administrative costs for managed care organizations to create programs, which could result in higher capitation payments. Increase in expenses for ODM due to incentive payments. There could be savings if the program results in individuals keeping and retaining employment and receiving medical insurance through this employment.		**Fiscal effect: Potential administrative costs.**

MCDCD16 Work requirement - OhioMeansJobs and county costs

Sections: 333.200, 333.210	**Sections: 333.200, 333.210**	**Sections: 333.200, 333.210**	**Sections: 333.200, 333.210**
Permits the Director of OBM, upon the request of the Medicaid Director, to transfer $500,000 of state share appropriations in each fiscal year between DPF Fund 5DL0 appropriation item 651685, Medicaid Recoveries - Program Support, in ODM's budget to GRF appropriation item 655425, Medicaid Program Support, in ODJFS' budget. Requires that the Director of OBM adjust the federal share of item 651624 and FED Fund 3F01 appropriation item 655624, Medicaid Program Support - Federal, in the ODJFS budget. Requires transferred funds to be used only for costs related to transitioning to a new work requirement.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Permits the Director of OBM, upon request of the Medicaid Director, to transfer $10.0 million of state share appropriations in each fiscal year between appropriation item 651525 and 655522, Medicaid Program Support - Local, used	Same as the Executive.	Same as the Executive.	Same as the Executive.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
by ODJFS. Requires federal shares to be adjusted if such a transfer occurs. Requires any increase to be provided to CDJFSs to be used only for costs related to transitioning to a new work requirement under the Medicaid program. Prohibits funds from being used for existing and ongoing operating expenses. Requires the Medicaid Director to establish criteria for distributing these funds and for CDJFSs to submit allowable expenses.			
MCDCD17 Care Innovation and Community Improvement Program			
Section: 333.220	**Section: 333.220**	**Section: 333.220**	**Section: 333.220**
Requires the Medicaid Director to continue the Care Innovation and Community Improvement Program (CICIP) for the FY 2020-FY 2021 biennium. Permits any nonprofit hospital agency affiliated with a state university or public hospital agency to volunteer to participate if the agency operates a hospital that has a Medicaid provider agreement.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Specifies that participating agencies are responsible for the state share of CICIP's costs and must make or request the appropriate government entity to make intergovernmental transfers to pay for those costs. Requires the Medicaid Director to establish a schedule for making the transfers.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Requires each participating agency to do at least one of certain tasks in accordance with	Same as the Executive.	Same as the Executive.	Same as the Executive.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
strategies, and for the purpose of meeting goals, that the Medicaid Director is required to establish for CICIP. Requires each participating agency to submit annual reports to JMOC summarizing the agency's work and progress in meeting goals.			
Requires each participating agency to receive supplemental payments under the Medicaid Program for physician and other professional services that are covered by the Medicaid program and provided to recipients. Requires payments to equal the difference between the Medicaid payment rates for the services and the average commercial payment rates for the services. Permits the Medicaid Director to terminate or adjust the amount of supplemental payments if the amount of funds available for CICIP is inadequate.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Requires the Medicaid Director, no later than January 1, 2020, to establish a process to evaluate the work done by participating agencies and the agencies' progress in meeting CICIP goals. Permits the Medicaid Director to terminate an agency's participation if the Director determines the agency is not doing at least one of the specified tasks.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Requires all intergovernmental transfers be deposited into the Care Innovation and Community Improvement Program Fund (Fund 5AN0). Requires money in Fund 5AN0 and the corresponding federal participation in the Health Care - Federal Fund (Fund 3F00) be used	Same as the Executive.	Same as the Executive.	Same as the Executive.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
to make supplemental payments.			
Permits the Medicaid Director to request the Director of OBM to authorize additional expenditures from Fund 5AN0 and Fund 3F00 if the amounts appropriated and the corresponding federal share are inadequate to make supplement payments. Appropriates any authorized amounts.	Same as the Executive.	Same as the Executive.	Same as the Executive.
MCDCD68 Managed Care Claims Fund			
		Section: 333.225	**Section: 333.225**
No provision.	No provision.	Creates the Managed Care Claims Fund in the state treasury, which will consist of money that Medicaid MCOs pay to ODM in order for ODM to make payments to providers under the care management system that the organizations are unable to make due to systems issues. Requires moneys in the fund to be used to make such payments.	Same as the Senate.
No provision.	No provision.	Allows the Medicaid Director to request the Director of OBM to authorize expenditures from the Managed Care Claims Fund and the corresponding federal share from the Health Care Federal Fund (Fund 3F00). Appropriates any requested amounts upon the approval of the Director of OBM.	Same as the Senate.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD69 **VETOED Rural Healthcare Workforce Training and Retention Program**			
		Section: 333.227	**Section: 333.227**
No provision.	No provision.	[***VETOED: Requires the Medicaid Director to create the Rural Healthcare Workforce Training and Retention Program for FY 2020 and FY 2021 under which nonprofit hospital agencies and public hospital agencies may earn supplemental Medicaid payments for graduate medical education costs.***]	Same as the Senate.
No provision.	No provision.	[***VETOED: Requires participating agencies to be responsible for the state share of the program's costs and to make or request the appropriate government entity to make intergovernmental transfers to pay for these costs. Creates the Rural Healthcare Workforce Training and Retention Program Fund in the state treasury, which will consist of these intergovernmental transfers. Requires moneys in the fund and the corresponding federal financial participation in the Health Care - Federal Fund (Fund 3F00) to be used to make supplemental payments.***]	Same as the Senate.
No provision.	No provision.	[***VETOED: Allows the Medicaid Director to request the Director of OBM to authorize additional expenditures from the fund and the corresponding federal financial participation as needed to make supplemental payments. Appropriates any additional amounts upon the Director of OBM's approval.***]	Same as the Senate.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
		Fiscal effect: The Senate budget appropriates $15.0 million in FY 2020 and $30.0 million in FY 2021 in new DPF Fund 5VW0 appropriation item 651691, Rural Health Care Workforce Training and Retention Program. Increases FED Fund 3F00 appropriation item 651623, Medicaid Services - Federal, by $35.1 million in FY 2020 and $70.0 million in FY 2021.	**Fiscal effect: Same as the Senate.**
MCDCD57 **VETOED Re-procurement of Medicaid managed care organizations**			
	R.C. 5167.10, Section 333.230		**Section: 333.230**
No provision.	[***VETOED: Requires the Medicaid Director to re-procure its contracts with Medicaid managed care organizations by July 1, 2020.***]	No provision.	Same as the House.
No provision.	Requires the Medicaid Director to establish eligibility criteria for Medicaid managed care organizations and accept applications from entities seeking to become a Medicaid managed care organization as part of this process.	No provision.	No provision.
No provision.	Specifies that there is no limit on the number of Medicaid managed care organization contracts ODM can have at any one time.	No provision.	No provision.
MCDCD53 Review prescribed drug reforms savings			
	Section: 333.240		**Section: 333.240**
No provision.	Requires ODM to review all of the savings to the state from the bill's prescribed drug reforms and issue a report.	No provision.	Same as the House.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
	Fiscal effect: Potential increase in administrative costs related to research and preparing report.		**Fiscal effect: Same as the House.**
MCDCD64 340B Drug Pricing			
	Section: 333.260	**Section: 333.260**	
No provision.	Creates a 340B Study Committee and requires the committee to collect data from 340B covered entities that are hospital Medicaid providers. Requires the Study Committee to make recommendations based on the collected data and submit a report to the General Assembly by January 1, 2021, outlining its findings. Terminates the Study Committee on submission of the report.	Replaces the House provision with one that requires, no later than January 1, 2021, the Medicaid Director to submit a report to the General Assembly detailing the processes and methods employed by ODM to ensure that: (1) utilization data used to invoice prescribed drug manufacturers does not include data on claims representing drugs purchased under the 340B Drug Pricing Program; and (2) identify a Medicaid provider that is a 340B covered entity and any pharmacy that has a contract to dispense on that provider's behalf drugs purchased under the 340B Drug Pricing Program	No provision.
	Fiscal effect: Potential administrative costs, as well as member reimbursement costs.	**Fiscal effect: Potential administrative costs.**	
MCDCD76 **PARTIALLY VETOED Retail pharmacy supplemental dispensing fee**			
		Section: 333.280	**Section: 333.280**
No provision.	No provision.	Requires [***VETOED: , by January 1, 2020,***] ODM to adopt rules to provide to pharmacies a supplemental dispensing fee under the care management system.	Same as the Senate.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
No provision.	No provision.	Provides that the dispensing fee must include at least three different payment levels based on the number of Medicaid prescriptions a pharmacy location fills each month.	Replaces the Senate provision with a provision that requires the supplemental dispensing fee to have at least three payment levels [***VETOED: and to be based on (1) the ratio of Medicaid prescriptions compared to total prescriptions a pharmacy location fills and (2) the number of pharmacy locations participating in the care management system in that geographic area, as determined by ODM.***]
No provision.	No provision.	No provision.	Requires the Medicaid Director to adjust the supplemental dispensing fees if federal Medicaid statutes or regulations reduce the amount of federal funds ODM receives for the supplemental dispensing fee. Specifies that ODM expend $10.0 million state share in FY 2020 and $20.3 million state share in FY 2021, along with any corresponding federal shares, for the supplemental dispensing fees.
		Fiscal effect: Increases GRF appropriation item 651525, Medicaid Health Care Services, by $33.8 million ($10.0 million state share) in FY 2020 and $66.3 million ($20.3 million state share) in FY 2021.	**Fiscal effect: Same as the Senate.**
MCDCD80 Prescribed drug claims processing pilot program			
			Section: 333.290
No provision.	No provision.	No provision.	Requires ODM to establish a pilot program for pre-audit processing of Medicaid MCOs and pharmacy benefit manager prescribed drug claims.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
No provision.	No provision.	No provision.	Provides that in order for a claim to be processed under the program, the prescription must be filled in a county in southeastern Ohio and the dispensing pharmacy must serve a significant share of Medicaid patients in the county.
No provision.	No provision.	No provision.	Requires ODM under the program to approve claims processors and ensure that claims are adjudicated by approved claims processors that submit claims information to ODM for review.
No provision.	No provision.	No provision.	Requires the pilot program to be fully operational by January 1, 2020, and conclude on December 31, 2020. Requires ODM, at the program's conclusion, to evaluate and review certain data relating to each prescribed drug claim.
No provision.	No provision.	No provision.	Requires ODM, not later than September 1, 2021, to submit a report to the Governor, Speaker of the House, Senate President, and Chairperson of JMOC.
No provision.	No provision.	No provision.	Specifies that the report must include any cost savings trends and utilization rates under the program and any policy recommendations, including whether to reinstate the program. **Fiscal effect: Increases GRF appropriation item 651525, Medicaid Health Care Services, by $500,000 state share in FY 2020 and requires funds to be used to support the program.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
MCDCD28 Hospital Care Assurance Program and franchise permit fee			
Sections: 601.22, 601.23 Amends Sections 125.10 and 125.11 of H.B. 59 of the 130th G.A. to delay the repeal of the Hospital Care Assurance Program, which compensates hospitals that provide a disproportionate share of care to indigent patients, and a separate hospital franchise permit fee, from October 16, 2019, to October 16, 2021.	**Sections: 601.22, 601.23** Same as the Executive.	**Sections: 601.22, 601.23** Same as the Executive.	**Sections: 601.22, 601.23** Same as the Executive.
Fiscal effect: The bill appropriates $249.2 million in FY 2020 and $168.3 million in FY 2021 in DPF Fund 6510 appropriation item 651649, Medicaid Services - Hospital Care Assurance Program, for the program. The cash used for the program is from an assessment imposed on hospitals.	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
DASCD37 Single Medicaid managed care pharmacy benefit manager procurement process			
	R.C. 125.93, 125.931, 3959.01		
(1) No provision.	(1) Not later than July 1, 2020, requires the Director of DAS, in consultation with the Director of Medicaid, to select and contract with a single state pharmacy benefit manager (PBM) to administer pharmacy benefits for Medicaid managed care organizations (MCOs). Specifies that the Department of Medicaid is a party to the contract and is responsible for enforcing the contract.	(1) No provision.	(1) No provision. (See MCDCD52)
(2) No provision.	(2) Requires the PBM to be responsible for processing all pharmacy claims under the care management system.	(2) No provision.	(2) No provision. (See MCDCD52)
(3) No provision.	(3) Requires the contract to prohibit a PBM from requiring a Medicaid recipient to obtain a specialty drug from a specialty pharmacy owned or otherwise associated with the PBM.	(3) No provision.	(3) No provision. (See MCDCD52)
(4) No provision.	(4) Requires state PBM applicants to provide specified information, including the following: (A) conflicts of interest, (B) the state PBM's affiliations, (C) direct or indirect fees, charges, or any kind of assessments the state PBM imposes on pharmacies with which the state PBM or its affiliates shares common ownership, management, or control, (D) direct or indirect fees, charges, or any kind of assessments the state PBM imposes on pharmacies that operate eleven or more, as well as eleven or fewer,	(4) No provision.	(4) No provision. (See MCDCD52)

Executive	As Passed by the House	As Passed by the Senate	As Enacted
	locations in Ohio, and (E) any financial terms and arrangements between the state PBM and prescription drug manufacturers or labelers, including formulary management, drug substitution programs, educational support claims processing, or data sales fees.		
(5) No provision.	(5) Specifies that the state PBM's affiliated companies can also engage in PBM business for Medicaid MCOs.	(5) No provision.	(5) No provision. (See MCDCD52)
(6) No provision.	(6) Specifies that the state PBM has a fiduciary responsibility to DAS and Department of Medicaid, including negotiating the lowest prices for prescription drugs, pricing drugs at the lowest prices on the prescription drug formulary, and cooperating with audits conducted by a state entity.	(6) No provision.	(6) No provision. (See MCDCD52)
(7) No provision.	(7) Clarifies that the state PBM is an "administrator" subject to licensure by the Department of Insurance.	(7) No provision.	(7) No provision. (See MCDCD52)
(8) No provision.	(8) Requires the DAS Director to reprocure the state PBM contract every 4 years.	(8) No provision.	(8) No provision. (See MCDCD52)
	Fiscal effect: DAS would incur some additional cost for overseeing the master state PBM contract procurement process. The effect on Medicaid prescription drug costs will depend on terms in the new state master PBM contract.		

Executive	As Passed by the House	As Passed by the Senate	As Enacted
AGECD12 Restrictions on offering snacks with home-delivered meals			
	R.C. 173.30, 173.525		
No provision.	Prohibits ODA from awarding a grant under Title III of the Older Americans Act of 1965 to a provider of home-delivered meals if the provider offers snacks in addition to the regular meals unless certain requirements regarding the snacks are met.	No provision.	No provision.
No provision.	Prohibits entities that provide home-delivered meals under the PASSPORT waiver program from offering snacks unless the entities meet certain requirements regarding the snacks. (This provision applies to certain other Medicaid waivers, see MCDCD41).	No provision.	No provision.
	Fiscal effect: None.		
AGECD16 **VETOED Assisted Living and PASSPORT Program Payment Rates**			
	Sections: 209.40, 209.60	**Sections: 209.40, 209.60**	**Sections: 209.40, 209.60**
No provision.	[***VETOED: Requires that the rates for each tier of assisted living services provided under the Assisted Living Program during FY 2020 and FY 2021 be at least 2.7% higher than the rates in effect on June 30, 2019.***]	Same as the House, but [*** VETOED: requires the rates to be increased by at least 5.1% instead.***]	Same as the Senate.
No provision.	[***VETOED: Requires that the base and unit rates for home care attendant, personal care, and waiver nursing services provided under the PASSPORT program during FY 2020 and FY 2021	Same as the House, but [***VETOED: requires the rates to be increased by at least 5.1% instead.***]	Same as the Senate.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
	be at least 2.7% higher than the rates in effect on June 30, 2019.***]		
No provision.	No provision.	[***VETOED: Makes conforming changes related to the repeal of a law concerning Medicaid rates for aide and nursing services (see MCDCD71).***]	Same as the Senate.
	Fiscal effect: Appropriations have been adjusted to Medicaid GRF line item 651525, Medicaid Health Care Services by approximately $10.8 million ($4.0 million state share) in each fiscal year. Individuals enrolled in the MyCare Ohio Waiver may also receive PASSPORT and Assisted Living services. Payments for MyCare Ohio services are provided under managed care. As a result of this provision, it is possible that MyCare Ohio costs may increase.	**Fiscal effect: Same as the House, but increases GRF line item 651525 by an additional $8.7 million ($3.2 million state share) in FY 2020 and $9.2 million ($3.4 million state share) in FY 2021 to account for the Senate changes.**	**Fiscal effect: Same as the Senate.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
AGECD13 **VETOED Home-delivered meals under PASSPORT**			
	Section: 209.50	**Section: 209.50**	**Section: 209.50**
No provision.	[***VETOED: Establishes the payment rates for home-delivered meals provided under the PASSPORT waiver program, during FY 2020 and FY 2021 as follows: $7.19 per meal delivered daily by the provider or volunteer, $6.99 per meal (chilled or frozen) delivered weekly by the provider or volunteer, and $6.50 per meal (chilled or frozen) delivered weekly by a common carrier. (This provision is applied to certain other Medicaid waivers, see MCDCD56).***]	Same as the House.	Same as the House.
	Fiscal effect: The current regular meal reimbursement is $6.50. The provision would result in an increase in PASSPORT costs for meal reimbursements. The total cost will depend on the number of meals delivered at the higher rates.	**Fiscal effect: Same as the House.**	**Fiscal effect: Same as the House.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
AUDCD13 **VETOED Medicaid auditing for FY 2020-FY 2023**			
		Section: 701.55	**Section: 701.55**
No provision.	No provision.	[***VETOED: Specifies that, through June 30, 2023, for any audit that the Auditor of State is authorized to conduct, the Auditor of State may charge a state agency, local public office, or private entity for the cost of the audit in the manner provided for under current law.***]	Same as the Senate.
No provision.	No provision.	In addition to allowing the Auditor to audit the accounts of Medicaid providers as under current Ohio law, through June 30, 2023, allows the Auditor to conduct audits of Medicaid providers and Medicaid comprehensive risk contracts, as defined by federal guidelines under 42 CFR 438.2.	[***VETOED: Replaces the Senate provision with one that: (1) requires the Auditor to audit Medicaid managed care organizations as defined in R.C. 5167.01 instead of allowing the Auditor to conduct audits of Medicaid comprehensive risk contracts, as defined by federal guidelines under 42 CFR 438.2, and (2) requires the Auditor to provide a copy of the each audit of a MCO performed under this section to the Governor, Medicaid Director, and Joint Medicaid Oversight Committee.***] (The Auditor is also authorized to conduct audits of Medicaid providers under continuing current law.)
No provision.	No provision.	[***VETOED: Through June 30, 2023, notwithstands a provision of law requiring the Auditor to pay for any costs the Auditor incurs auditing a medical assistance recipient or examining records regarding medical assistance programs to specify that the Auditor is not responsible for those costs.***]	Same as the Senate.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
		Fiscal effect: Generally maintains current audit funding mechanisms, but also relieves the Auditor of State from the cost of auditing medical assistance recipients or medical assistance programs, which would instead be responsible for those costs over the FY 2020-FY 2023 time period.	Fiscal effect: Same as the Senate.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
OBMCD82 Transfer to the GRF from the Health Care Services Support and Recoveries Fund			
		Section: 509.47	**Section: 509.47**
No provision.	No provision.	Requires the Director of OBM to transfer $6,000,000 in FY 2020 and $4,000,000 in FY 2021 from the Health Care Services Support and Recoveries Fund (Fund 5DL0), which is used by the Department of Medicaid, to the GRF.	Same as the Senate.

Executive	As Passed by the House	As Passed by the Senate	As Enacted

Other Education Provisions

EDUCD36 Medicaid School Program Administrative Fund

Executive	As Passed by the House	As Passed by the Senate	As Enacted
R.C. 5162.64 (repealed)	**R.C. 5162.64 (repealed)**	**R.C. 5162.64 (repealed)**	**R.C. 5162.64 (repealed)**
Abolishes the Medicaid School Program Administrative Fund in the state treasury.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Fiscal effect: None. According to OBM, this fund was never created in the state accounting system.	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
DOHCD63 Breast and Cervical Cancer Project eligibility			
		R.C. 3701.144	**R.C. 3701.144**
No provision.	No provision.	Makes the following changes to the eligibility requirements for screening and diagnostic services provided through the Ohio Breast and Cervical Cancer Project:	Same as the Senate.
(1) No provision.	(1) No provision.	(1) Specifies that a woman seeking breast and cervical cancer screening and diagnostic services must have a countable family income not exceeding 300% of the federal poverty line, rather than 250% as under current law;	(1) Same as the Senate.
(2) No provision.	(2) No provision.	(2) In the case of women seeking breast cancer screening and diagnostic services generally, eliminates the requirement that women be less than 65 years of age; and	(2) Same as the Senate.
(3) No provision.	(3) No provision.	(3) In the case of women seeking breast cancer screening and diagnostic services because of family history, clinical examination results, or other factors, lowers to 21 (from 25) the age at which women become eligible for such services.	(3) Same as the Senate.
		Fiscal effect: ODH may experience additional expenses related to the Breast and Cervical Cancer Project if additional women are screened. Any additional women screened who are diagnosed with breast or cervical cancer could receive treatment under Medicaid.	**Fiscal effect: Same as the Senate.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
DOHCD37 Standard pregnancy risk assessment form			
R.C. 3701.953			
Requires the Director of the Governor's Children's Initiative to convene a workgroup by January 1, 2020, to develop a standard, electronic pregnancy risk assessment form and to identify the processes and technology systems necessary for obstetric care providers, other persons, and government entities to comply with the required use of the form.	No provision.	No provision.	No provision.
Specifies the workgroup's membership.	No provision.	No provision.	No provision.
Requires an obstetric care provider, beginning January 1, 2021, to complete a pregnancy risk assessment form for each obstetric patient at the patient's first visit designated for prenatal care and to submit the form through the designated state interface.	No provision.	No provision.	No provision.
Requires a person or government entity that has or has had a relationship with a patient to accept a completed pregnancy risk assessment form as valid authorization for the disclosure of that patient's protected health information.	No provision.	No provision.	No provision.
Prohibits information in the form from being used for discriminatory or unauthorized purposes and from being further disclosed by the authorized recipients.	No provision.	No provision.	No provision.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
Fiscal effect: Increase in administrative costs for the development of the form and for other workgroup duties. Potential increase in administrative costs for practitioners to fill out and submit the form. Potential increase in costs for case management services and a subsequent decrease in costs if women are referred to services that support healthy birth outcomes.			
DOHCD36 ODM access to social security numbers accompanying vital statistics records			
R.C. 3705.07, 3705.09, 3705.10	**R.C. 3705.07, 3705.09, 3705.10**	**R.C. 3705.07, 3705.09, 3705.10**	**R.C. 3705.07, 3705.09, 3705.10**
Requires ODH's Office of Vital Statistics to make available to ODM, for the purpose of medical assistance eligibility determinations, social security numbers that accompany birth certificates or death certificates.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Fiscal effect: Potential minimal increase in administrative costs.	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
REPCD4 Health and Human Services Efficiencies and Alignment Study Committee			
	Section: 751.20		
No provision.	Establishes the Health and Human Services Efficiencies and Alignment Study Committee to examine the alignment and administrative efficiencies within the state's health and human services agencies.	No provision.	No provision.
No provision.	Specifies that the Committee's membership include four legislative members (the chairs of the House Finance Subcommittee on Health and Human Services, the House Aging and Long Term Care Committee, the Senate Finance Subcommittee on Health and Medicaid, and Senate Health, Human Services and Medicaid Committee). Includes among the Committee membership directors or their designees from the following agencies: MCD, DOH, JFS, DDD, MHA, AGE, and offices within GOV (Recovery Ohio, Governor's Office of Children's Initiatives, and Innovate Ohio).	No provision.	No provision.
No provision.	Requires the Committee to produce a report of its recommendations regarding costs, benefits, and policies by December 31, 2020. Specifies that the Committee ceases to exist after submitting its report. **Fiscal effect: Participating agencies might incur some small cost for conducting the review and preparing the report.**	No provision.	No provision.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
INSCD9 **VETOED Health care price transparency**			
	R.C. 3962.01, 3962.011 through 3962.15, 5164.65, and Section 751.30	**R.C. 3727.46, 3727.461, 3727.462, 3902.60, 3962.01, 5162.80 (repealed), and Section 751.30**	**R.C. 3962.01, 3962.011 to 3962.15, 5164.65, and Section 751.15**
No provision.	[***VETOED: Adds to current health care price transparency requirements that apply to products, services, and procedures.***]	Replaces the House provision with one that repeals existing health care price transparency provisions which were permanently enjoined from enforcement in February 2019, and replaces them with the following provisions:	Same as the House.
No provision.	[***VETOED: Requires that certain health care providers and health plan issuers provide to patients or their representatives a cost estimate for nonemergency health care products, services, or procedures before each is provided. Enumerates certain information that must be included in a cost estimate. Clarifies what is to occur with the provision of a cost estimate when specific information (such as the provider who will be providing the health care product, service, or procedure) is not readily available at the time the appointment for the product, service, or procedure is made. Specifies that the requirement applies to a health care provider that is a hospital or hospital system or is owned by a hospital or hospital system on the effective date of this bill. Specifies that on and after March 1, 2020, the requirement applies to all other health care providers.***]	Replaces the House provision with a provision that requires a hospital, beginning January 1, 2020, and on the request of a patient or the patient's representative, to provide a patient with a verbal or written cost estimate for scheduled services. Specifies that the requirement does not apply if the patient is insured and the patient's health plan issuer fails to supply the necessary information to the hospital within 48 hours of the hospital's request. Enumerates certain information that must be included in a cost estimate. Requires a health plan issuer to provide to its covered persons estimates of the costs of health care services and procedures to at least the same extent it is required to do so by federal law, and prohibits the Superintendent of Insurance from enforcing this requirement.	Same as the House.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
No provision.	[***VETOED: Requires the cost estimates to be provided within certain time limits and in accordance with all applicable laws pertaining to the privacy of patient-identifying information.***]	Same as the House, but does not require the cost estimates to be provided in accordance with applicable privacy laws.	Same as the House.
No provision.	[***VETOED: Requires the Department of Insurance to create or procure a connector portal that health care providers may use to transmit information to health plan issuers for their use in generating cost estimates.***]	No provision.	Same as the House.
No provision.	[***VETOED: Grants qualified immunity from civil liability to a health care provider or health plan issuer that provides cost estimates in accordance with the bill's provisions.***]	No provision.	Same as the House.
No provision.	[***VETOED: Authorizes the Superintendent of Insurance, the Department of Health, Department of Medicaid, or the relevant regulatory board to impose administrative remedies on a health plan issuer or health care provider who fails to comply with the bill's health care price transparency provisions.***]	No provision.	Same as the House.
No provision.	[***VETOED: Specifies that a contract clause prohibiting a health care provider or health plan issuer from providing patients with quality or cost information is invalid and unenforceable.***]	No provision.	Same as the House.
No provision.	[***VETOED: Authorizes any member of the General Assembly to intervene in litigation that challenges the bill's health care price transparency provisions or the existing law pertaining to price transparency.***]	No provision.	Same as the House.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
No provision.	[***VETOED: Specifies that it is the General Assembly's intent in enacting the bill's health care price transparency provisions to provide patients with the information they need to make informed choices regarding their health care, to maximize health care cost savings for all residents of Ohio, and to reduce the burden of health care expenditures on government entities, including Medicaid.***]	No provision.	Same as the House.
No provision.	[***VETOED: Specifies that the provision requiring the provision of a cost estimate to the patient or the patient's representative does not prohibit the provider or the patient's health plan issuer from collecting payment from the patient.***]	Replaces the House provision with a provision that specifies that the patient or the party responsible for paying for a patient's care is responsible for paying for hospital services provided even if a hospital fails to comply with the requirement to provide a cost estimate to the patient or the patient's representative.	Same as the House.
No provision.	No provision.	Requires a hospital to publish on its website the standard list of health care items and services it must annually prepare and make public under federal law.	No provision.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
	Fiscal effect: The requirement that the Department of Insurance create or procure a connector portal would increase the Department's costs by an uncertain amount. Any increase in such costs would be paid from Fund 5540. Administrative costs for the departments of Insurance, Health, and Medicaid, and other regulatory boards may increase due to regulatory need to monitor compliance by health plan issuers and health care providers. Potential reduction in costs to state and local public employee benefit plans and the Medicaid program due to potential increase in consumers shopping for lower prices for medical services; if there are any such reductions, the magnitude is uncertain.	Fiscal effect: Uncertain.	Fiscal effect: Same as the House.

Executive	As Passed by the House	As Passed by the Senate	As Enacted
JCRCD4 Agency rule review for regulatory restrictions			
		Section: 121.95	**Section: 121.95**
No provision.	No provision.	Requires certain agencies to identify which of their rules contain regulatory restrictions and to produce an inventory of regulatory restrictions before December 31, 2019.	Same as the Senate.
No provision.	No provision.	Requires these agencies to post the inventory on their websites and transmit copies to JCARR. Requires JCARR to review the inventory and transmit it to the House Speaker and Senate President.	Same as the Senate.
No provision.	No provision.	Prohibits these agencies, during FYs 2020, 2021, 2022, and 2023, from adopting a new regulatory restriction unless they simultaneously remove two or more existing regulatory restrictions.	Same as the Senate.
		Fiscal effect: Affected state agencies will incur administrative costs to develop and post the inventory and potentially to revise rules to comply with the limitations on regulatory restrictions. JCARR will incur administrative costs to review the inventories.	**Fiscal effect: Same as the Senate.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
JMOCD2 Monitoring of behavioral health in managed care			
R.C. 103.416 (repealed)	**R.C. 103.416 (repealed)**	**R.C. 103.416 (repealed)**	**R.C. 103.416 (repealed)**
Repeals, effective June 30, 2020, a requirement that JMOC periodically monitor ODM's inclusion of alcohol, drug addiction, and mental health services in the Medicaid managed care system.	Same as the Executive.	Same as the Executive.	Same as the Executive.
Fiscal effect: Potential decrease in administrative costs.	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**	**Fiscal effect: Same as the Executive.**

Executive	As Passed by the House	As Passed by the Senate	As Enacted
PRXCD2 State pharmacy benefit manager			
	R.C. 4729.261		
(1) No provision.	(1) Requires the State Board of Pharmacy, by July 1, 2020, to adopt rules: (a) defining "specialty drug" and "specialty pharmacy," and (b) prohibiting the state pharmacy benefit manager (PBM) from requiring Medicaid recipients to use a specialty pharmacy owned or otherwise affiliated with the state PBM to obtain specialty drugs.	(1) No provision.	(1) No provision.
(2) No provision.	(2) Permits the Board to consult with the Department of Medicaid in adopting the rules described in provision (1) above.	(2) No provision.	(2) No provision.
	Fiscal effect: None.		