
DEPARTMENT OF MEDICAID

Suspension of provider agreements and payments

- 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.
- Requires, with certain exceptions, that the provider agreement of a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID) be suspended when a disqualifying indictment is issued against the provider or the provider's officer, authorized agent, associate, manager, or employee.
- 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.
- 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.
- Permits the Department of Medicaid to suspend, without prior notice, a provider agreement and all Medicaid payments to the provider if there is evidence that the provider presents a danger of immediate and serious harm to the health, safety, or welfare of Medicaid recipients.

Medicaid payment rates for nursing facility services

- Provides for a nursing facility's Medicaid payment rate to be \$115 per day for 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.
- Revises the law governing the quality payments that nursing facilities earn under the Medicaid program for satisfying quality indicators.

Market basket index and budget reduction adjustment factor

- Repeals a provision that would have adjusted nursing facilities' rates, beginning in FY 2020, by an amount equal to the difference between the Medicare skilled nursing facility market basket index and a budget reduction adjustment factor.
- Repeals a statement of the General Assembly's intent to enact laws that specify the budget reduction adjustment factor for each state fiscal year.
- Repeals a provision setting the budget reduction adjustment factor at zero for a state fiscal year if the General Assembly fails to enact a law for that year.

Medicaid prompt payment requirements waiver

- 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.

Medicaid rates for community behavioral health services

- Permits the Department of Medicaid to establish Medicaid rates for community behavioral health services provided during FYs 2020 and 2021 that exceed the Medicare rates paid for the services.

Medicaid managed care

Behavioral health services

- Permits, instead of requiring, the Department of Medicaid to include behavioral health services in the Medicaid managed care system.
- Provides that the Joint Medicaid Oversight Committee is required to periodically monitor the Department's inclusion of behavioral health services in the Medicaid managed care system only if the Department includes the services in the system and eliminates the monitoring requirement altogether on July 1, 2020.

Prescribed drugs

- Permits, instead of requiring, the Department of Medicaid to include prescribed drugs in the Medicaid managed care system.
- Eliminates the express authority of Medicaid managed care organizations (MCOs), in covering the prescribed drug benefit, to use strategies for drug utilization management.
- Eliminates a restriction against Medicaid MCOs requiring prior authorization for certain antidepressant and antipsychotic drugs.
- 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 utilization review measures concerning opioids, medication synchronization, and step therapy protocols and exemptions.

Help Me Grow and qualified community hubs

- 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.
- 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.

Duties of area agencies on aging

- Requires the Department, if it adds to the Medicaid managed care system during FYs 2020 and 2021 more Medicaid recipients who are aged, blind, disabled, or also enrolled in Medicare, to take certain actions regarding the duties of area agencies on aging relative to home and community-based waiver services.

Integrated Care Delivery System performance payments

- For FYs 2020 and 2021, requires the Department to continue to (1) make performance payments to Medicaid MCOs that provide care to participants of the Integrated Care Delivery System and (2) withhold a percentage of their premium payments for the purpose of providing the performance payments.

Care Innovation and Community Improvement Program

- Requires the Medicaid Director to continue the Care Innovation and Community Improvement Program for the FY 2020-2021 biennium.

Hospital Care Assurance, franchise permit fee

- Continues, for two additional years, the Hospital Care Assurance Program and the franchise permit fee imposed on hospitals under the Medicaid program.

Health information exchanges

- 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.

Health Care/Medicaid Support and Recoveries Fund

- Requires that money credited to the Health Care/Medicaid Support and Recoveries Fund additionally be used for (1) programs that serve youth involved with multiple government agencies and (2) innovative programs that promote access to health care or help achieve long-term cost savings.

Abolished funds

- Abolishes the Integrated Care Delivery Systems Fund.
- Abolishes the Managed Care Performance Payment Fund.
- Abolishes the Medicaid Administrative Reimbursement Fund.
- Abolishes the Medicaid School Program Administrative Fund in the state treasury.

Updating references

- Replaces references to the former U.S. Health Care Financing Administration with references to the U.S. Centers for Medicare and Medicaid Services.

Extended authority regarding employees

- Extends through July 1, 2021, the Medicaid Director's authority to establish, change, and abolish positions for the Department and to assign, reassign, classify, reclassify, transfer, reduce, promote, or demote employees who are not subject to collective bargaining.

Suspension of provider agreements and payments

(R.C. 5164.36, primary; R.C. 173.391 and 5164.37, repealed)

Suspensions because of disqualifying indictments

The bill makes the terms and procedures for suspending a Medicaid provider agreement because of certain types of indictments, which the bill refers to as disqualifying indictments, generally the same as those for suspending a provider agreement because of a credible allegation of fraud. The bill also makes the following revisions to the law governing the suspension of provider agreements because of a disqualifying indictment:

1. Under current law, the Department of Medicaid is required to suspend a provider agreement of a noninstitutional provider, other than an independent provider, if the provider or its owner, officer, authorized agent, associate, manager, or employee is indicted for an act that would be a felony or misdemeanor under Ohio law and the act relates to or results from furnishing or billing for Medicaid services or participating in the performance of management or administrative services relating to furnishing Medicaid services. The bill is generally the same except that (a) the provider agreement of an independent provider or an institutional provider also is to be suspended in this situation (unless, in the case of an institutional provider, the owner is indicted) and (b) the indictment may be for an act that would be a felony or misdemeanor under the laws of the jurisdiction within which the act occurred rather than only under Ohio law. An independent provider is a person who has a provider agreement to provide home and community-based services as an independent provider in a Medicaid waiver program that the Department administers. Hospitals, nursing facilities, and ICF/IIDs are institutional providers.
2. Current law requires the Department of Medicaid to terminate Medicaid payments to a provider when the provider agreement is suspended because of a disqualifying indictment. The termination applies only to payments for Medicaid services rendered after the date the Department sends notice of the suspension. Claims for payment for Medicaid services rendered before that date may be subject to prepayment review procedures under which the Department reviews claims to determine whether they are supported by sufficient documentation, in compliance with state and federal law, and otherwise complete. Under the bill, the Department must suspend, rather than terminate, the Medicaid payments, and the suspension applies to payments for all services regardless of the date the services are rendered.

The following table compares the provisions of current law and the bill regarding the suspension of Medicaid provider agreements because of disqualifying indictments.

Current law	The bill
Medicaid providers subject to suspension	
<p>Noninstitutional providers when the Department receives notice and a copy of an indictment that charges any of the following with committing certain acts:</p> <ol style="list-style-type: none"> 1. The provider; 2. The provider’s owner, officer, authorized agent, associate, manager, or employee. <i>(R.C. 5164.37(C).)</i> 	<p>Any provider, when the Department determines that an indictment has been issued that charges any of the following with committing certain acts:</p> <ol style="list-style-type: none"> 1. The provider; 2. The provider’s officer, authorized agent, associate, manager, or employee; 3. If the provider is a noninstitutional provider, the provider’s owner. <i>(R.C. 5164.36(A)(5) and (6) and (B)(1).)</i>
Indictments that require suspension	
<ol style="list-style-type: none"> 1. Except for an independent provider, an act that would be a felony or misdemeanor under Ohio law that relates to or results from furnishing or billing for Medicaid services or participating in management or administrative services related to furnishing Medicaid services; 2. For an independent provider, an offense that continuing law specifies is cause to deny or terminate a provider agreement. <i>(R.C. 5164.37(E).)</i> 	<ol style="list-style-type: none"> 1. Regardless of whether the provider is an independent provider, an act that would be a felony or misdemeanor under Ohio law or the law where the act occurred and that relates to or results from the furnishing or billing for Medicaid services or management or administrative services relating to furnishing Medicaid services; 2. Same. <i>(R.C. 5164.36(A)(2), (3), and (4).)</i>
Stopping Medicaid payments	
<p>The Department must terminate Medicaid payments to a suspended provider for Medicaid services rendered after the date when the Department sends the provider notice of the suspension. Claims for services rendered before the notice is sent may be subject to prepayment review procedures. <i>(R.C. 5164.37(C) and (D)(2).)</i></p>	<p>The Department must suspend all Medicaid payments to a suspended provider for services rendered, regardless of the date of service. <i>(R.C. 5164.37(B)(2).)</i></p>

Current law	The bill
Exceptions	
<p>No suspension or payment termination if:</p> <ol style="list-style-type: none"> 1. The provider or owner submits written evidence that the provider or owner did not directly or indirectly sanction the act that resulted in the indictment; 2. Circumstances that may be specified in rules apply. <i>(R.C. 5164.37(D)(1) and (H).)</i> 	<p>Same. <i>(R.C. 5164.36(C) and (I).)</i></p>
When suspension is lifted	
<ol style="list-style-type: none"> 1. The proceedings in <i>the criminal case</i> are completed through dismissal of the indictment, conviction, entry of a guilty plea, or finding of not guilty; 2. If the Department commences a process to terminate the suspended provider agreement, the termination process is concluded. <i>(R.C. 5164.37(C).)</i> 	<ol style="list-style-type: none"> 1. The proceedings in <i>any related case</i> are completed through dismissal of the indictment, conviction, entry of a guilty plea, or finding of not guilty; 2. Same. <i>(R.C. 5164.36(B)(3).)</i>
Restricted Medicaid activities	
<p>A provider, owner, officer, authorized agent, associate, manager, or employee cannot do any of the following during the suspension:</p> <ol style="list-style-type: none"> 1. Own or provide Medicaid services to any other Medicaid provider or risk contractor; 2. Arrange for, render, or order Medicaid services; 3. Receive direct payments under the Medicaid program or indirect payments of Medicaid funds in the form of a salary, shared 	<p>A provider; officer, authorized agent, associate, manager, or employee (if suspension results from an action taken by that person); or owner (if the provider is a noninstitutional provider and the suspension results from an action of the owner) cannot do any of the following during the suspension:</p> <ol style="list-style-type: none"> 1. Own services provided, or provide services, to any other Medicaid provider or risk contractor; 2. Arrange for, render to, or order services (a) to any other Medicaid provider or risk contractor or (b) for Medicaid recipients; 3. Same. <i>(R.C. 5164.36(B)(4).)</i>

Current law	The bill
<p>fees, contracts, kickbacks, or rebates from or through any other Medicaid provider or risk contractor. <i>(R.C. 5164.37(C).)</i></p>	
Notice of suspension	
<p>The Department must send notice of a provider agreement suspension to the provider or owner not later than five days after suspending the provider agreement. <i>(R.C. 5164.37(F).)</i></p>	<p>The Department must send notice of a provider agreement suspension to the provider or, if the provider is a noninstitutional provider, the owner:</p> <ol style="list-style-type: none"> 1. Not later than five days after the suspension unless a law enforcement agency makes a written request to temporarily delay the notice; 2. If such a request is made, not later than 30 days after the suspension. A law enforcement agency may request up to two renewed delays, but the notice must be issued not more than 90 days after the suspension. <i>(R.C. 5164.36(D) and (E).)</i>
Content of suspension notice	
<p>A notice of a provider agreement suspension must:</p> <ol style="list-style-type: none"> 1. Describe the indictment that was the cause of the suspension, without necessarily disclosing specific information concerning any ongoing civil or criminal investigation; 2. State how long the suspension will continue; 3. Inform the provider or owner of the opportunity to request a reconsideration. <i>(R.C. 5164.37(F).)</i> 	<p>A notice of a provider agreement suspension must:</p> <ol style="list-style-type: none"> 1. Describe the conduct leading to the suspension (without disclosing information concerning an ongoing investigation), the type of Medicaid claims or business units affected by the suspension, and that payments are being suspended; 2. Same; 3. Same. <i>(R.C. 5164.36(F).)</i>

Current law	The bill
Reconsideration	
<p>A suspended provider or owner may request a reconsideration within 30 days of receiving the suspension notice. The reconsideration is not subject to an adjudication hearing under the Administrative Procedure Act. The provider or owner must submit to the Department written information about whether (1) the suspension determination was based on a mistake of fact, (2) the indictment resulted from an offense for which the Department is authorized to suspend provider agreements, or (3) the provider or owner can demonstrate that they did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee that resulted in the indictment. The Department must review the information and documents. After the reviews, the information, the suspension may be affirmed, reversed, or modified, in whole or in part. The review and notification of its results must be completed not later than 45 days after the information and documents are received. (R.C. 5164.37(G).)</p>	<p>Same, except an owner may request a reconsideration only if the provider is a noninstitutional provider. (R.C. 5164.36(G) and (H).)</p>

Suspensions because of credible allegations of fraud

(R.C. 5164.36)

Current law requires the Department of Medicaid to terminate Medicaid payments to a provider when the provider agreement is suspended because of a credible allegation of fraud for which an investigation is pending under the Medicaid program. The termination applies only to payments for Medicaid services rendered after the date the Department sends the provider notice of the suspension. Claims for payment for Medicaid services rendered before that date may be subject to prepayment review procedures under which the Department reviews claims to determine whether they are supported by sufficient documentation, are in compliance with state and federal statutes and rules, and are otherwise complete. Under the bill, the Department must suspend, rather than terminate, the Medicaid payments, and the suspension applies to payments for all services regardless of the date the services are rendered.

Summary suspensions, danger of immediate and serious harm

(R.C. 5164.37 and 5164.38)

The bill permits the Department of Medicaid to suspend, without prior notice, a Medicaid provider agreement if there is evidence that the provider presents a danger of immediate and serious harm to the health, safety, or welfare of Medicaid recipients. When the Department suspends a provider agreement for this reason, it must:

1. Suspend all Medicaid payments to the provider for services rendered, regardless of the date that the services were rendered;
2. Not later than five days after suspending the provider agreement, notify the provider of the suspension; and
3. Not later than ten business days after suspending the provider agreement, notify the provider that the Department intends to terminate the provider agreement.

The notice that the Department sends regarding the intention to terminate a provider agreement must include the allegation that the provider presents a danger of immediate and serious harm to the health, safety, or welfare of Medicaid recipients. It may also include other grounds for terminating the provider agreement. When terminating the provider agreement, continuing law that requires the Department to issue an order pursuant to adjudication conducted in accordance with the Administrative Procedure Act (R.C. Chapter 119) applies.

The suspension of a provider agreement and Medicaid payments is to cease at the earliest of:

1. The Department's failure to provide within the required time a notice regarding the suspension or intent to terminate the provider agreement;
2. The Department rescinds its notice to terminate the provider agreement;
3. The Department issues an order regarding the termination of the provider agreement pursuant to an adjudication.

The bill states that this provision does not limit the Department's authority to suspend or terminate a provider agreement or Medicaid payments under any other provision of the Revised Code.

Current law provides that the Department is not required to issue an order pursuant to an adjudication when it refuses to enter into or revalidate a Medicaid provider agreement or suspends or terminates a provider agreement if the provider agreement and Medicaid payments are suspended because of a credible allegation of fraud or disqualifying indictment. The bill provides that an adjudication order also is not required if the provider agreement and Medicaid payments are suspended because the provider presents a danger of immediate and serious harm to the health, safety, or welfare of Medicaid recipients.

Medicaid payment rates for nursing facility services

Low resource utilization residents

(R.C. 5165.152)

The bill revises the Medicaid payment rate for nursing facility services provided to low resource utilization residents. A low resource utilization resident is a Medicaid recipient residing in a nursing facility who, for purposes of calculating the nursing facility's Medicaid payment rate, is placed in either of the two lowest resource utilization groups, excluding any resource utilization group that is a default group used for residents with incomplete assessment data.

Under current law, the rate is the following:

1. \$115 per day if the Department of Medicaid is satisfied that the nursing facility is cooperating with the Long-Term Care Ombudsman Program in efforts to help its low resource utilization residents receive the services that are most appropriate for their level of care needs;
2. \$91.70 per day if the Department is not satisfied.

The bill provides for the rate to be \$115 per day regardless of whether the nursing facility cooperates with the Long-Term Care Ombudsman Program.

Quality payment rates

(R.C. 5165.25)

The bill revises the law governing the quality payments that nursing facilities earn under the Medicaid program for satisfying quality indicators as follows:

1. Eliminates as a quality indicator a nursing facility's use of the nursing home version of the Preferences for Everyday Living Inventory for all of its residents;
2. Establishes as a quality indicator a nursing facility's obtaining at least a target score on the Department of Aging's resident satisfaction survey (for even-numbered state fiscal years) or the family satisfaction survey (for odd-numbered state fiscal years);
3. Requires the Department of Medicaid to specify the target score for the satisfaction surveys;
4. Eliminates a requirement that the Department, when determining the percentages of a nursing facility's short-stay residents who newly received an antipsychotic medication and long-stay residents who newly or otherwise received an antipsychotic medication, exclude residents who received the medication in conjunction with hospice care;
5. Provides for a nursing facility that undergoes a change of operator to receive, for the state fiscal year following the one during which the change of operator occurs, the mean quality payment regardless of whether the change of operator occurred before or during the last quarter of a calendar year.

Market basket index and budget reduction adjustment factor

(R.C. 5165.01, 5165.15, 5165.16, 5165.17, 5165.19, and 5165.21; R.C. 5165.361, repealed)

The bill revises the formula used to determine Medicaid payment rates for nursing facility services by removing an adjustment to the rates that was set to take effect beginning in FY 2020. The formula has several components and includes specific dollar amounts that are added and subtracted to the sum of the amounts determined for the different components.

For FYs 2018 and 2019, the formula contains a \$16.44 add-on, which became part of the formula on July 1, 2016. The bill extends this add-on amount to fiscal years beginning in FY 2020 and removes a requirement that, beginning with FY 2020 (other than the first fiscal year in a rebasing cycle), the add-on instead be the sum of the following:

1. The amount of the add-on for the preceding fiscal year;
2. The difference between (a) the Medicare skilled nursing facility market basket index determined for the federal fiscal year that began during the state fiscal year preceding the one for which the rate is being determined and (b) the budget reduction adjustment factor for the fiscal year for which the rate is being determined.

Beginning with FY 2020 (other than the first fiscal year in a rebasing cycle), the formula includes the difference between the Medicare skilled nursing facility market basket index and the budget reduction adjustment factor as part of the manner in which the rates for the four cost centers (ancillary and support costs, capital costs, direct care costs, and tax costs) are determined. The bill removes that amount as part of the rate calculation.

The bill also repeals a provision of law stating the General Assembly's intent to specify in statute the factor to be used for a fiscal year as the budget reduction adjustment factor. That factor cannot exceed the Medicare skilled nursing facility market basket index determined for the federal fiscal year that begins during the state fiscal year preceding the fiscal year for which the factor is being determined. If the General Assembly fails to specify the factor in statute, the budget reduction adjustment factor is zero.

Medicaid prompt payment requirements waiver

(R.C. 5167.25, repealed, with conforming changes in R.C. 3901.3814)

The bill repeals the requirement that the Medicaid Director apply to CMS 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.

Medicaid rates for community behavioral health services

(Section 333.180)

The bill permits the Department of Medicaid to establish Medicaid payment rates for community behavioral health services provided during FY 2020 and FY 2021 that exceed the authorized rates paid for the services under the Medicare program. This does not apply, however, to such services provided by hospitals on an inpatient basis, nursing facilities, or ICF/IIDs.

Medicaid managed care

Inclusion of behavioral health services

(R.C. 5167.03, primary; R.C. 103.416)

The bill provides that the Department of Medicaid is permitted instead of required to include alcohol, drug addiction, and mental health services in the Medicaid managed care system. Under current law, the Department is required to include the services in the system. The services have been included in the system since July 1, 2018.

Current law requires the Joint Medicaid Oversight Committee to periodically monitor the Department's inclusion of the services in the system. The bill provides that this requirement applies only if the Department includes them in the system and eliminates the monitoring requirement altogether on July 1, 2020.

Inclusion of prescribed drugs

(R.C. 5167.05, primary; R.C. 4729.20 and 5167.051)

The bill provides that the Department of Medicaid is permitted instead of required to include prescribed drugs in the Medicaid managed care system. Under current law, the Department must require Medicaid managed care organization (MCOs) to cover prescribed drugs.

The bill eliminates all of the following from the law governing the inclusion of prescribed drugs in the Medicaid managed care system:

1. A Medicaid MCO's permissive authority to use strategies for the management of drug utilization that are consistent with statutory limitations and requirements and the Department's approval;
2. A prohibition against the Department permitting a Medicaid MCO to impose a prior authorization requirement in the case of a drug that is (a) an antidepressant or antipsychotic, (b) administered or dispensed in a standard tablet or capsule form or, in the case of an antipsychotic, a long acting injectable form, (c) prescribed by certain types of healthcare professionals, and (d) prescribed for a use that is indicated on the drug's labeling, as approved by the U.S. Food and Drug Administration;
3. A requirement that the Department 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.

The bill also eliminates a requirement that the Department make Medicaid MCOs comply, as if they were the Department, with the following requirements concerning the Medicaid fee-for-service system's coverage of prescribed drugs:

1. A requirement that, except under certain circumstances, prior authorization requirements or other utilization review measures be applied as conditions of coverage of opioid analgesics prescribed for the treatment of chronic pain;

2. A requirement that medication synchronization be instituted under certain circumstances;
3. A requirement that, if a step therapy protocol is utilized under which it is recommended that prescribed drugs be taken in a specific sequence, the protocol be implemented in accordance with certain requirements.

Home visits and cognitive behavioral therapy

(R.C. 5167.16, repealed; R.C. 5167.03)

The bill repeals a requirement that Medicaid MCOs provide or arrange the following services to certain Medicaid recipients:

1. Home visits, including depression screenings, for which federal Medicaid funds are available under the targeted case management benefit;
2. Cognitive behavioral health therapy that is provided by a community mental health services provider and determined to be medically necessary through a depression screening conducted as part of a home visit.

The cognitive behavioral health therapy must be provided in a Medicaid recipient's home if requested by the recipient. Medicaid MCOs are required to inform Medicaid recipients of this right and how to request that the therapy be provided at home.

To qualify for the services, a Medicaid recipient must be (1) enrolled in the Department of Health's Help Me Grow program, (2) either pregnant or the birth mother of an infant or toddler under three, and (3) enrolled in the Medicaid MCO providing or arranging the services.

Community health worker and public health nurse services

(R.C. 5167.173, repealed, with conforming change in Sections 603.10 and 603.11)

The bill repeals a requirement that the Department of Medicaid make Medicaid MCOs provide or arrange the following services to certain Medicaid recipients:

1. Services provided by a certified community health worker or public health nurse employed by, or under contract with, a qualified community hub;
2. Other services performed for the purpose of ensuring the recipients are linked to employment services, housing, educational services, social services, or medically necessary physical and behavioral health services.

To qualify for the services, a Medicaid recipient must (1) be pregnant or capable of becoming pregnant, (2) reside in a community served by a qualified community hub, (3) have been recommended to receive the services by a physician, public health nurse, or another licensed health professional specified in the Medicaid Director's rules, and (4) be enrolled in the Medicaid MCO providing or arranging the services.

Clarification and simplification of statutes

(R.C. 5167.01, primary; R.C. 3701.612, 4729.80, 5166.01, 5167.03, 5167.04, 5167.05, 5167.051, 5167.10, 5167.101, 5167.102, 5167.11, 5167.13, 5167.14, 5167.17, 5167.171, 5167.172, 5167.18, 5167.20, 5167.201, 5167.26, 5167.41, and 5168.75)

The bill clarifies and simplifies statutes governing the Medicaid managed care system. For the sake of clarity, the bill provides for Medicaid recipients to enroll in Medicaid MCO plans rather than, as under current law, enrolling in Medicaid managed care organizations. “Medicaid MCO plan” is defined as a plan that a Medicaid MCO, pursuant to its contract with the Department of Medicaid, makes available to Medicaid recipients participating in the Medicaid managed care system. For the sake of simplicity, the bill requires Medicaid MCOs to comply with various requirements rather than, as under current law, requiring the contracts that the Department enters into with Medicaid MCOs to include the requirements.

Duties of area agencies on aging

(Section 333.190)

The bill requires the Department of Medicaid, if it expands the inclusion of the aged, blind, and disabled Medicaid eligibility group or Medicaid recipients who are also eligible for Medicare in the Medicaid managed care system during the FY 2020-2021 biennium, to do both of the following for the remainder of the biennium:

1. Require area agencies on aging to be the coordinators of home and community-based waiver services that the recipients receive and permit Medicaid MCOs to delegate to the agencies full-care coordination functions for those and other health care services;
2. In selecting Medicaid MCOs, give preference to organizations that will enter into subcapitation arrangements with area agencies on aging under which the agencies perform, in addition to other functions, network management and payment functions for services that those recipients receive.

Integrated Care Delivery System performance payments

(Section 333.60)

The Department of Medicaid is authorized under continuing law to implement a demonstration project to test and evaluate the integration of care received by individuals dually eligible for Medicaid and Medicare. In statute the project is called the Integrated Care Delivery System. It may be better known as MyCare Ohio.

The bill continues for FYs 2020 and 2021, a requirement that the Department provide performance payments to Medicaid MCOs that provide care under the Integrated Care Delivery System. The Department has been required to provide such performance payments since FY 2014.⁵⁹

If participants receive care through Medicaid MCOs under the system, the Department must both:

⁵⁹ Section 323.300 of H.B. 59 of the 130th General Assembly.

1. Develop quality measures designed specifically to determine the effectiveness of the health care and other services provided to participants by Medicaid MCOs; and
2. Determine an amount to be withheld from the Medicaid premium payments paid to Medicaid MCOs for participants.

For purposes of the amount to be withheld from premium payments, the Department must establish a percentage amount and apply the same percentage to all Medicaid MCOs providing care to participants of the Integrated Care Delivery System. Each organization must agree to the withholding as a condition of receiving or maintaining its Medicaid provider agreement. The bill provides that a Medicaid managed care organization providing care under the system is not subject to withholdings under the Medicaid Managed Care Performance Payment Program for premium payments attributed to participants of the system during FYs 2020 and 2021.

Care Innovation and Community Improvement Program

(Section 333.220)

The bill requires the Medicaid Director to continue the Care Innovation and Community Improvement Program for the FY 2020-2021 biennium. The Director was originally required to establish the program for the FY 2018-2019 biennium.⁶⁰

Any nonprofit hospital agency affiliated with a state university and any public hospital agency may volunteer to participate if it operates a hospital that has a Medicaid provider agreement. The nonprofit and public hospital agencies that participate in the program are responsible for the state share of the program's costs and must make or request the appropriate government entity to make intergovernmental transfers to pay for the costs. The Director must establish a schedule for making the transfers.

Each participating hospital agency must undertake at least one of the following tasks in accordance with strategies, and for the purpose of meeting goals designed to benefit Medicaid recipients, the Director is to establish:

1. Sustain and expand community-based patient centered medical home models;
2. Expand access to community-based dental services;
3. Improve the quality of community care by creating and sharing best practice models for emergency department diversions, care coordination at discharge and during transitions of care, and other matters related to community care;
4. Align community health improvement strategies and goals with the State Health Improvement Plan and local health improvement plans;
5. Expand access to ambulatory drug detoxification and withdrawal management services;
6. Train medical professionals on evidence-based protocols for opioid prescribing and drug addiction risk assessments;

⁶⁰ Section 333.320 of H.B. 49 of the 132nd General Assembly.

7. In collaboration with other nonprofit and public hospital agencies that also do this task, create and implement a plan to assist rural areas to (a) expand access to cost-effective detoxification, withdrawal management, and prevention services for opioid addiction and (b) disseminate evidence-based protocols for opioid prescribing and drug addiction risk assessment.

If a hospital agency chooses the task to expand access to ambulatory drug detoxification and withdrawal management services, or the task to create and implement a plan to assist rural areas, it must give priority to the areas of the community it serves with the greatest concentration of opioid overdoses and deaths. Regardless of the task chosen, a hospital agency must submit annual reports to the Joint Medicaid Oversight Committee summarizing its work on the task and progress in meeting the program's goals.

Each participating hospital agency is to receive supplemental Medicaid payments for physician and other professional services that are covered by Medicaid and provided to Medicaid recipients. The payments must equal the difference between the Medicaid rate and average commercial rates for the services. The Director may terminate, or adjust the amount of, the payments if funding for the program is inadequate.

The Director must establish a process to evaluate the work done under the program by nonprofit and public hospital agencies and their progress in meeting the program's goals. The process must be established by January 1, 2020. The Director may terminate a hospital agency's participation if the Director determines that it is not performing at least one of the tasks discussed above or making progress in meeting the program's goals.

The bill establishes in the state treasury the Care Innovation and Community Improvement Program Fund and requires that all intergovernmental transfers made under the program be deposited into the existing Care Innovation and Community Improvement Program Fund. Money in the Fund and the corresponding federal funds must continue to be used to make the supplemental payments to hospital agencies under the program.

Hospital Care Assurance, franchise permit fee

(Sections 601.22 and 601.23, amending Sections 125.10 and 125.11 of H.B. 59 of the 130th G.A.)

The bill continues the Hospital Care Assurance Program (HCAP) for two additional years. The program is scheduled to end October 16, 2019, but under the bill is to continue until October 16, 2021. Under HCAP, hospitals are annually assessed an amount based on their total facility costs, and government hospitals make annual intergovernmental transfers. The Department of Medicaid distributes to hospitals money generated by the assessments and intergovernmental transfers along with federal matching funds. A hospital compensated under the program must provide (without charge) basic, medically necessary, hospital-level services to Ohio residents who are not recipients of Medicare or Medicaid and whose income does not exceed the federal poverty line.

The bill also continues for two additional years another assessment imposed on hospitals; that assessment is to end on October 1, 2021, rather than October 1, 2019. The assessment is in addition to HCAP, but like that program, it raises money to help pay for the Medicaid program. To distinguish the assessment from HCAP, the assessment is sometimes called a hospital franchise permit fee.

Health information exchanges

(R.C. 3798.01 and 3798.07; R.C. 3798.06, 3798.08, 3798.14, 3798.15, and 3798.16, all repealed)

The bill eliminates all provisions regarding approved health information exchanges in statutes governing protected health information.⁶¹ Current law defines “approved health information exchange” as a health information exchange that has been approved by the Medicaid Director or that has been certified by the Office of the National Coordinator for Health Information Technology in the U.S. Department of Health and Human Services. A health information exchange is any person or government entity that provides a technical infrastructure to connect computer systems or other electronic devices used by covered entities to facilitate the secure transmission of health information.⁶²

Specifically, the bill repeals statutes that do the following:

1. Require the Medicaid Director to adopt rules that establish (a) standards and processes for approving health information exchanges, (b) processes for the Director to investigate and resolve concerns and complaints regarding approved health information exchanges, and (c) processes and content for agreements under which covered entities participate in approved health information exchanges (participation agreements);
2. Permit a covered entity to disclose an individual’s protected health information to a health information exchange without a valid authorization if (a) the exchange is an approved health information exchange, (b) the covered entity is a party to a valid participation agreement with the exchange, (c) the disclosure is consistent with all procedures established by the exchange, and (d) the covered entity, before making the disclosure, furnishes written notice to the individual or the individual’s personal representative;
3. Give covered entities and approved health information exchanges immunity to civil and criminal liability for actions authorized by the statutes governing approved health information exchanges.

The bill also eliminates a requirement that a covered entity, when it discloses an individual’s protected health information to a health information exchange, restrict disclosure

⁶¹ “Protected health information” is defined in a federal regulation generally as individually identifiable health information that is transmitted by or maintained in electronic media or any other form or medium. (45 C.F.R. 160.103.) “Individually identifiable health information” is defined in the same federal regulation as health information, including demographic information collected from an individual, that (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse, (2) relates to (a) the past, present, or future physical or mental health or condition of an individual, (b) the provision of health care to an individual, or (c) the past, present, or future payment for the provision of health care to an individual, and (3) identifies the individual or reasonably could be used to identify the individual.

⁶² “Covered entity” is defined in federal regulations as a health plan, health care clearinghouse, or health care provider that transmits any health information in electronic form in connection with a transaction covered by federal rules governing the privacy of personal health information (the HIPAA Privacy Rule). (45 C.F.R. 160.103.)

in a manner that is consistent with a written request from the individual or the individual's personal representative concerning specific categories of protected health information to the extent the Medicaid Director's rules require the covered entity to comply with such a request. The Director's duty to adopt such rules is eliminated as part of the bill's repeal of the statute that requires the Director to adopt rules establishing the content of participation agreements.

Health Care/Medicaid Support and Recoveries Fund

(R.C. 5162.52)

The bill establishes two additional purposes for which the ODM is to use money credited to the Health Care/Medicaid Support and Recoveries Fund. Specifically, the money is to be used to pay for (1) programs that serve youth involved with multiple government agencies and (2) innovative programs that ODM has the statutory authority to implement and that promote access to health care or help achieve long-term cost savings to the state.

Under continuing law, ODM must use money credited to the fund to pay for Medicaid services and costs associated with the administration of the Medicaid program.

Abolished funds

Integrated Care Delivery Systems Fund

(R.C. 5162.58, repealed; R.C. 5162.01)

The bill abolishes the Integrated Care Delivery Systems Fund, which is part of the state treasury. Under current law, a portion of the amounts that the Integrated Care Delivery System saves the Medicare program must be deposited into the Fund if the terms of an agreement with the federal government provide for the state to receive those amounts. The Department of Medicaid is required to use money in the Fund to further develop integrated delivery systems and improved care coordination for individuals eligible for both Medicare and Medicaid (dual eligible individuals).

The purpose of the Integrated Care Delivery System is to test and evaluate the integration of care that dual eligible individuals receive under Medicare and Medicaid.⁶³ The system is commonly called MyCare Ohio.

Managed Care Performance Payment Fund

(R.C. 5162.60, repealed)

The bill abolishes the Managed Care Performance Payment Fund. The Fund, which is part of the state treasury, consists of:

1. Amounts transferred to it for the Managed Care Performance Payment Program;
2. All fines imposed on and collected from Medicaid managed care organizations for failure to meet performance standards or other requirements specified in provider agreements with the Department of Medicaid or rules adopted by the Medicaid Director;
3. All of the Fund's investment earnings.

⁶³ R.C. 5164.91, not in the bill.

Current law requires that the Fund be used to do the following:

1. Make performance payments to Medicaid managed care organizations under the Managed Care Performance Payment Program;
2. Meet obligations specified in Medicaid provider agreements;
3. Pay for Medicaid services provided by Medicaid managed care organizations;
4. Reimburse a Medicaid managed care organization that has paid a fine for failure to meet performance standards or other requirements if the organization comes into compliance.

Medicaid Administrative Reimbursement Fund

(R.C. 5162.62, repealed)

The bill abolishes the Medicaid Administrative Reimbursement Fund. The balance of this fund was transferred to a different fund in FY 2018, and it currently has a zero cash balance.

Medicaid School Program Administrative Fund

(R.C. 5162.64, repealed)

The bill abolishes the Medicaid School Program Administrative Fund in the state treasury. Current law requires Medicaid to use money in the fund to pay for the school component of the Medicaid program, including repaying a Medicaid school provider a refund for any overpayment made by a provider to Medicaid. Although the fund was authorized in 2013, it was never created.

Updated references

(R.C. 3901.381, 5168.03, 5168.05, 5168.06, and 5168.08)

The bill replaces outdated Revised Code references to the former U.S. Health Care Financing Administration with references to the U.S. Centers for Medicare and Medicaid Services. The U.S. Department of Health and Human Services announced this name change in 2001.⁶⁴

Temporary authority regarding employees

(Section 333.20)

The bill extends until July 1, 2021, the Medicaid Director's authority to establish, change, and abolish positions for the Department of Medicaid, and to assign, reassign, classify, reclassify, transfer, reduce, promote, or demote employees who are not subject to the state's public employees collective bargaining law.

The Director has had this authority since July 1, 2013. It is currently scheduled to expire July 1, 2019.⁶⁵

⁶⁴ <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/AB01133.pdf>.

⁶⁵ Section 323.10.30 of H.B. 59 of the 130th General Assembly, Section 327.20 of H.B. 64 of the 131st General Assembly, and Section 333.20 of H.B. 49 of the 132nd General Assembly.

The authority includes assigning or reassigning an exempt employee to a bargaining unit classification if the Director determines that the bargaining unit classification is the proper classification for that employee.⁶⁶ The Director's actions must comply with a federal regulation establishing standards for a merit system of personnel administration. If an employee in the E-1 pay range is assigned, reassigned, classified, reclassified, transferred, reduced, or demoted to a position in a lower classification, the Director, or in the case of a transfer outside the Department, the Director of Administrative Services, must assign the employee to the appropriate classification and place the employee in Step X. The employee is not to receive any increase in compensation until the maximum rate of pay for that classification exceeds the employee's compensation. Actions either Director takes under this provision are not subject to appeal to the State Personnel Board of Review.

⁶⁶ An exempt employee is a permanent full-time or permanent part-time employee paid directly by warrant of the Director of Budget and Management whose position is included in the job classification plan established by the Director of Administrative Services, but who is not subject to the collective bargaining law. (R.C. 124.152, not in the bill.)