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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**R.C. 191.01 (repealed), 3798.01, 3798.07 Repeal: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**

Repeals statutes regarding the exchange of protected health information between, and disclosure of personally identifiable information by, certain state agencies.

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.

Fiscal effect: Potential decrease in rule promulgation costs.

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R.C. 191.01, 191.02, 191.04, 191.06, 191.08-191.10 (all repealed), 103.41, 3701.36, 3701.68, 3701.95, 3798.01, 3798.10, 3798.14-3798.16, 5101.061, 5162.12, 5164.01

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.

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.

MCDCD29 Fund abolishments

R.C. 5162.01, Repealed: 5162.58, 5162.60, 5162.62

Abolishes the following funds:

(1) The Integrated Care Delivery Systems Fund;

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- (2) The Medicaid Administrative Reimbursement Fund; and
(3) The Managed Care Performance Payment Fund.
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MCDCD18 Health Care/Medicaid Support and Recoveries Fund and multi-system youth**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.

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.

MCDCD19 Suspension of Medicaid provider agreements**R.C. 5164.36, 5164.37 (repealed and new enact),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.

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.

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 ODM 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 of serious harm to the health, safety, or welfare of Medicaid recipients.

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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.

MCDCD21 Medicaid rates for nursing facility services

R.C. 5165.01, 5165.15-5165.17, 5165.19, 5165.21, 5165.25, 5165.361 (repealed)

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.

Revises the law governing the quality payments that nursing facilities earn under the Medicaid Program for satisfying quality indicators.

Repeals provisions of law that do the following:

- (1) Provide for adjustments in nursing facility Medicaid rates beginning in state FY 2020 in an amount that equals the difference between the Medicare skilled nursing facility market basket index and a budget reduction adjustment factor.
- (2) State the General Assembly's intent to enact laws that specify the budget reduction adjustment factor for each state fiscal year.
- (3) Set 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.

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.

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

Clarifies and simplifies statutes governing the Medicaid managed care system.

Fiscal effect: None.

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MCD25 Behavioral health services**R.C. 5167.04**

Permits, instead of requires, ODM to include behavioral health services in the Medicaid managed care system.

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.

MCD24 Prescribed drugs**R.C. 5167.05, 4729.20, 5167.051**

Permits, instead of requires, ODM to include prescribed drugs in the Medicaid managed care system.

Eliminates the express authority of Medicaid 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.

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.

MCD26 Help Me Grow and qualified community hubs**R.C. 5167.16, 5167.03, 5167.173 (all repealed), with conforming changes: 603.10, 603.11**

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.

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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.

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.

MCDCD20 Medicaid prompt payment requirements waiver

**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.

Fiscal effect: None.

MCDCD23 Updating references

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.

Fiscal effect: None.

MCDCD1 Temporary authority regarding employees

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.

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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.

Fiscal effect: None.

MCDCD2 Medicaid Health Care Services**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.

MCDCD3 Lead abatement and related activities**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.

Allows the Medicaid Director to transfer federal funds for these transactions.

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.

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MCDCD5 Performance payments for Medicaid managed care**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.

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.

Requires that the withheld amount be established as a percentage of each premium payment. Requires MCOs to agree to the withholding. Requires ODM to certify the amount to the OBM Director.

MCDCD6 Hospital Franchise Fee Program**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.

MCDCD7 Medicare Part D**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.

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.

Requires the Director of OBM to adjust the federal share of item 651525, if the state share is adjusted.

Requires ODM to provide notification to the Controlling Board of any such transfers at their next scheduled meeting.

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MCDCD8 Health Care Services Support and Recoveries**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.

MCDCD9 Hospital Care Assurance match**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. 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 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.

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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.

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.

MCDCD13 Public assistance eligibility determination**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.

Prohibits these funds from being used for existing and ongoing operating expenses. Requires the Medicaid Director to establish criteria for distribution of funds and for CDJFS' to submit allowable expenses.

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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.

MCDLCD14 Medicaid payment rates for community behavioral health services**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.

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.

MCDLCD15 Area Agencies on Aging and Medicaid managed care**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:

- (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 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.
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Executive**MCDCD16 Work requirement - OhioMeansJobs costs****Section: 333.200**

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 5DLO 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 any increase in funding 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**

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.

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.

Requires each participating agency to do at least one of certain tasks in accordance with 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.

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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.

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 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.

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.

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.

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Other Education Provisions

EDUCD36 Medicaid School Program Administrative Fund

R.C. 5162.64 (repealed)

Abolishes the Medicaid School Program Administrative Fund in the state treasury.

Fiscal effect: None. According to OBM, this fund was never created in the state accounting system.

Executive**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.

Specifies the workgroup's membership.

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.

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.

Prohibits information in the form from being used for discriminatory or unauthorized purposes and from being further disclosed by the authorized recipients.

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**

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.

Fiscal effect: Potential minimal increase in administrative costs.

Executive**JMOCD2 Monitoring of behavioral health in managed care****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.

Fiscal effect: Potential decrease in administrative costs.
