

Am. Sub. H.B. 166  
As Passed by the Senate  
MCD50

\_\_\_\_\_ moved to amend as follows:

- In line 178 of the title, after "5126.053," insert "5162.138, 5162.139," 1  
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- In line 179 of the title, after "5166.09," insert "5166.43, 5166.50," 3  
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- In line 180 of the title, after "5167.104," insert "5167.105, 5167.106," 5  
6
- In line 181 of the title, delete "5167.15,"; after "5167.22," insert "5167.29, 5167.35, 5167.36," 7  
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- In line 353, after "5126.053," insert "5162.138, 5162.139,"; after "5166.09," insert "5166.43, 5166.50," 9  
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- In line 354, after "5167.104," insert "5167.105, 5167.106," 11
- In line 355, delete "5167.15,"; after "5167.22," insert "5167.29, 5167.35, 5167.36," 12  
13
- In line 49963, after "shall" delete the balance of the line 14  
Delete line 49964 15
- In line 49965, delete "to" 16
- In line 49966, delete "by direct data transfer or" 17
- After line 65680, insert: 18

"Sec. 5162.138. At the end of each year that the shared savings program established under section 5167.35 of the Revised Code is operated, the department of medicaid shall complete a report detailing the department's findings and recommendations regarding the program for that year. The department shall submit the reports to the governor and, in accordance with section 101.68 of the Revised Code, the general assembly."

Sec. 5162.139. At the end of each year that the quality incentive program established under section 5167.36 of the Revised Code is operated, the department of medicaid shall complete a report detailing the department's findings and recommendations regarding the program for that year. The department shall submit the reports to the governor and, in accordance with section 101.68 of the Revised Code, the general assembly."

After line 66888, insert:

"Enrollee" has the same meaning as in section 5167.01 of the Revised Code."

After line 66914, insert:

"Medicaid MCO plan" has the same meaning as in section 5167.01 of the Revised Code."

After line 67063, insert:

"Sec. 5166.43. The medicaid director shall establish a medicaid waiver component under which medicaid MCO plans may cover any service or product that would have a beneficial effect on the health of enrollees and, 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. 46

Sec. 5166.50. (A) The medicaid director shall request that 47  
the United States secretary of health and human services enter 48  
into an enforceable agreement with the director that provides for 49  
no federal financial participation to be withheld due to any of 50  
the following: 51

(1) Implementation of sections 5167.35 and 5167.36 of the 52  
Revised Code; 53

(2) For the purpose of section 5167.10 of the Revised Code, 54  
enrollment of individuals designated for participation in the care 55  
management system pursuant to section 5167.03 of the Revised Code 56  
in medicaid managed care organizations that are regional networks 57  
consisting of hospitals. 58

(B) Unless the agreement specified in division (A) of this 59  
section is in effect: 60

(1) Sections 5167.35 and 5167.36 of the Revised Code shall 61  
not be implemented. 62

(2) For the purpose of section 5167.10 of the Revised Code, 63  
the department shall not enroll individuals designated for 64  
participation in the care management system pursuant to section 65  
5167.03 of the Revised Code in medicaid managed care organizations 66  
that are regional networks consisting of hospitals." 67

In line 67147, strike through ", including health" 68

In line 67148, strike through "insuring corporations," 69

In line 67171, after the period insert "The managed care 70  
organizations with which the department may enter into contracts 71  
include both of the following: 72

(A) Health insuring corporations; 73

(B) Subject to section 5166.50 of the Revised Code, regional networks consisting of hospitals that accept a capitated payment from the department that is not more than ninety per cent of the lowest capitated payment made to a medicaid managed care organization that is a health insuring corporation."

After line 67206, insert:

"Sec. 5167.105. If a medicaid managed care organization establishes a payment rate for a service covered by its medicaid MCO plan that is greater than the payment rate for the service under the fee-for-service component of the medicaid program, the organization shall require any provider of the service that seeks to be part of the organization's provider panel available to the organization's enrollees to enter into a value-based contract with the organization.

Sec. 5167.106. A medicaid managed care organization shall not permit a provider to be part of the organization's provider panel available to the organization's enrollees unless the provider assures the organization that the provider, once a member of the provider panel, will, in accordance with section 3962.05 of the Revised Code, provide to the organization the information specified in that section if the provider chooses to have the organization provide to the organization's enrollees the reasonable, good faith cost estimate described in section 3962.04 of the Revised Code."

Delete lines 67355 through 67360

In line 67466, strike through the first "the" and insert "an"; strike through "derived from" and insert "equal to ninety per cent of"

After line 67525, insert: 102

"Sec. 5167.29. (A) As used in this section: 103

(1) "Covered health care" means a health care product, 104  
service, or procedure covered by a medicaid MCO plan. 105

(2) "Emergency service" has the same meaning as in section 106  
1753.28 of the Revised Code. 107

(3) "High quality and efficient participating provider" means 108  
a participating provider to which both of the following apply: 109

(a) The provider has a high rating under division (C) of this 110  
section. 111

(b) The cost to a medicaid managed care organization for 112  
covered health care the provider furnishes to an enrollee is less 113  
than the cost the organization would have incurred if the enrollee 114  
had obtained the covered health care from another participating 115  
provider with which the enrollee initially scheduled an 116  
appointment for the covered health care. 117

(4) "Participating provider" means a provider who is a member 118  
of a medicaid managed care organization's provider panel. 119

(B) Each medicaid managed care organization shall establish 120  
and implement a program that incentivizes enrollees to obtain 121  
covered health care from high quality and efficient participating 122  
providers. The incentives shall be in the form of points awarded 123  
to enrollees under division (E) of this section which the 124  
organization shall enable the enrollees to redeem for merchandise 125  
available through the organization's internet web site. 126

(C) As part of the program instituted under this section, a 127  
medicaid managed care organization shall do both of the following: 128

(1) Rate participating providers based on quality metrics. 129  
The quality metrics for hospitals shall be the measures used for 130  
the medicare hospital value-based purchasing program. The 131  
department of medicaid shall establish the quality metrics for 132  
other types of providers. In rating participating providers, an 133  
organization shall award providers between one and five stars 134  
based on the providers' scores on the quality metrics. 135

(2) Establish on the organization's internet web site a 136  
system under which enrollees rate and provide comments about 137  
participating providers after appointments with the providers. The 138  
system shall be similar to internet web sites that enable 139  
consumers to rate and provide comments about commercial products. 140  
The organization shall encourage enrollees to use the system after 141  
each appointment with a participating provider. The system shall 142  
enable all enrollees to see the ratings and comments that other 143  
enrollees have made for each participating provider. 144

(D) A medicaid managed care organization shall provide an 145  
enrollee all of the following before any covered health care, 146  
other than an emergency service, is furnished to the enrollee by a 147  
participating provider with which the enrollee has scheduled an 148  
appointment for the covered health care: 149

(1) A reasonable, good faith cost estimate for the covered 150  
health care described in section 3962.04 of the Revised Code, 151  
regardless of whether the provider also provides the cost estimate 152  
to the enrollee or the enrollee's representative; 153

(2) The provider's quality rating under division (C)(1) of 154  
this section and average enrollee rating under division (C)(2) of 155  
this section; 156

(3) The address of the organization's internet web site at 157  
which the enrollee may access the enrollee rating system 158

established under division (C)(2) of this section so that the 159  
enrollee can read the ratings and comments made by other enrollees 160  
about the provider and other participating providers; 161

(4) A list of high quality and efficient participating 162  
providers who could furnish the covered health care to the 163  
enrollee and the providers' quality ratings under division (C)(1) 164  
of this section and average enrollee ratings under division (C)(2) 165  
of this section. 166

(E)(1) Subject to division (E)(2) of this section, a medicaid 167  
managed care organization shall award points to an enrollee if the 168  
enrollee cancels an appointment for covered health care with a 169  
participating provider that is not a high quality and efficient 170  
participating provider and instead obtains the covered health care 171  
from a high quality and efficient participating provider. The 172  
number of points awarded shall be sufficient to incentivize the 173  
enrollee to cancel the initial appointment and obtain the covered 174  
health care from the high quality and efficient participating 175  
provider. 176

(2) A medicaid managed care organization shall monitor 177  
enrollees' behavior under the program to thwart abuse of the 178  
program. An enrollee found to have abused or attempted to abuse 179  
the program shall not be awarded points. 180

(F) The department of medicaid shall monitor each medicaid 181  
managed care organization as the organization establishes and 182  
implements the program under this section and determine the 183  
effectiveness of each organization's program. 184

**Sec. 5167.35. (A) As used in this section:** 185

(1) "Mandatory services" has the same meaning as in section 186  
5164.01 of the Revised Code. 187

<u>(2) "Optional services" has the same meaning as in section</u>	188
<u>5164.01 of the Revised Code.</u>	189
<u>(3) "Specified states" means the following states: Illinois,</u>	190
<u>Indiana, Michigan, Ohio, Pennsylvania, and West Virginia.</u>	191
<u>(B) This section is subject to section 5166.50 of the Revised</u>	192
<u>Code.</u>	193
<u>(C) The department of medicaid shall establish the shared</u>	194
<u>savings bonus program. Under the program, the department shall,</u>	195
<u>subject to division (D) of this section, do both of the following</u>	196
<u>before the beginning of each fiscal year:</u>	197
<u>(1) Determine the average of the per recipient capitated</u>	198
<u>payment rate, not including any shared savings bonus received</u>	199
<u>under division (D) of this section, for each medicaid managed care</u>	200
<u>organization for the three fiscal years immediately preceding the</u>	201
<u>fiscal year for which the determination is made;</u>	202
<u>(2) Determine the average per recipient cost to the medicaid</u>	203
<u>programs in the specified states for the eligibility groups that</u>	204
<u>are designated for participation in the care management system</u>	205
<u>pursuant to section 5167.03 of the Revised Code for the three</u>	206
<u>fiscal years immediately preceding the fiscal year for which the</u>	207
<u>determination is made.</u>	208
<u>(D) In making the determinations under divisions (C)(1) and</u>	209
<u>(2) of this section, the department shall include only the costs</u>	210
<u>for mandatory services and the costs for those optional services</u>	211
<u>that are covered by the medicaid program in this state and the</u>	212
<u>medicaid programs in all of the specified states.</u>	213
<u>(E)(1) Subject to division (E)(3) of this section, the amount</u>	214
<u>of a medicaid managed care organization's shared savings bonus for</u>	215
<u>a fiscal year shall be determined as follows:</u>	216

<u>(a) Subtract the organization's three-year average determined</u>	217
<u>under division (C)(1) of this section for the fiscal year from the</u>	218
<u>three-year average determined under division (C)(2) of this</u>	219
<u>section for the fiscal year;</u>	220
<u>(b) Subject to division (E)(2) of this section, subtract the</u>	221
<u>organization's three-year average determined under division (C)(1)</u>	222
<u>of this section for the fiscal year from the organization's</u>	223
<u>initial three-year average determined under that division;</u>	224
<u>(c) Determine the sum of the differences determined under</u>	225
<u>divisions (E)(1)(a) and (b) of this section;</u>	226
<u>(d) Multiply the sum determined under division (E)(1)(c) of</u>	227
<u>this section by twenty per cent.</u>	228
<u>(2) The amount determined under division (E)(1)(b) of this</u>	229
<u>section for a medicaid managed care organization for the first</u>	230
<u>fiscal year that the determination is made for the organization</u>	231
<u>shall be zero.</u>	232
<u>(3) If the amount determined under division (E)(1)(c) of this</u>	233
<u>section for a medicaid managed care organization for the first or</u>	234
<u>second fiscal year for which the determination is made is a</u>	235
<u>negative number, the organization's shared savings bonus for that</u>	236
<u>fiscal year shall be zero. If the amount determined under that</u>	237
<u>division for a medicaid managed care organization for the third or</u>	238
<u>a subsequent fiscal year for which the determination is made is a</u>	239
<u>negative number, the department shall terminate the organization's</u>	240
<u>contract with the department and enter into a contract with</u>	241
<u>another managed care organization under section 5167.10 of the</u>	242
<u>Revised Code. The effective date of the contract termination shall</u>	243
<u>be the same as the effective date of the contract with the other</u>	244
<u>managed care organization so as to avoid a disruption in medicaid</u>	245
<u>recipients' access to services under the care management system.</u>	246

<u>Sec. 5167.36. (A) As used in this section:</u>	247
<u>(1) "Assignment share percentage" means the percentage of</u>	248
<u>medicaid recipients who are randomly assigned to enroll in a</u>	249
<u>particular participating MCO's medicaid MCO plan under division</u>	250
<u>(D) of this section.</u>	251
<u>(2) "Participating MCO" means a medicaid managed care</u>	252
<u>organization participating in the quality incentive program</u>	253
<u>established under this section.</u>	254
<u>(B) This section is subject to section 5166.50 of the Revised</u>	255
<u>Code.</u>	256
<u>(C) The department of medicaid shall establish the quality</u>	257
<u>incentive program. Under the program, if a medicaid recipient</u>	258
<u>participating in the care management system does not select a</u>	259
<u>medicaid MCO plan in which to enroll, the department shall</u>	260
<u>randomly assign the recipient to enroll in a medicaid MCO plan</u>	261
<u>offered by one of the participating MCOs. The number of recipients</u>	262
<u>randomly assigned to enroll in each participating MCO's medicaid</u>	263
<u>MCO plan shall be determined in accordance with that participating</u>	264
<u>MCO's assignment share percentage calculated under division (D) of</u>	265
<u>this section for the year the enrollment takes place.</u>	266
<u>All of the following shall participate in the quality</u>	267
<u>incentive program:</u>	268
<u>(1) Each medicaid managed care organization that has a</u>	269
<u>contract under section 5167.10 of the Revised Code on the</u>	270
<u>effective date of this section;</u>	271
<u>(2) Other managed care organizations that become medicaid</u>	272
<u>managed care organizations after the effective date of this</u>	273
<u>section and are selected by the department.</u>	274

(D)(1) During the first calendar year that the quality incentive program is operated, the assignment share percentage shall be the same for all of the participating MCOs. Each year thereafter, each participating MCO shall be ranked according to the number of points it is awarded under division (E) of this section, and each participating MCO's assignment share percentage shall be adjusted as follows: 275  
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(a) The assignment share percentage of the participating MCO ranked at the top shall be increased by twenty-five per cent. 282  
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(b) The assignment share percentage of the participating MCO ranked at the bottom shall be decreased by twenty-five per cent. 284  
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(c) The assignment share percentage of all of the other participating MCOs shall be increased or decreased in a corresponding, linear, and proportional manner based on their ranks. 286  
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(2) If a medicaid managed care organization becomes a participating MCO after the other participating MCOs' assignment share percentages have been assigned, the department shall do both of the following: 290  
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(a) Assign to the new participating MCO an initial assignment share percentage which shall be the percentage determined by dividing one hundred by the total number of participating MCOs; 294  
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(b) Adjust the assignment share percentages of all of the other participating MCOs proportionally. 297  
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(E)(1) The department shall award points annually to each participating MCO based on health and quality metrics taken from the previous calendar year. Subject to divisions (E)(2) and (3) of this section, the department shall determine how points are awarded to participating MCOs. The number of points awarded to a 299  
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participating MCO based on quality metrics shall not be more than 304  
twenty per cent of the total number of points awarded to the 305  
participating MCO. 306

(2) The health metrics used to determine the number of points 307  
awarded to a participating MCO shall include the following health 308  
measurements for the group of medicaid recipients who have been 309  
randomly assigned under division (C) of this section to enroll in 310  
a medicaid MCO plan offered by the participating MCO: 311

(a) Smoking rate; 312

(b) Infant mortality rate; 313

(c) Hemoglobin a1c levels; 314

(d) Obesity rate; 315

(e) Incidence of relapse of alcohol or drug addiction; 316

(f) Health measurements developed by the department in 317  
consultation with groups representing individuals with 318  
developmental disabilities. 319

(3) The quality metrics used to determine the number of 320  
points awarded to a participating MCO shall include the following 321  
quality measurements as measured through a survey established by 322  
the department: 323

(a) How promptly the participating MCO pays claims for 324  
services rendered to enrollees; 325

(b) The participating MCO's responsiveness to provider and 326  
enrollee requests; 327

(c) Provider user satisfaction; 328

(d) The effectiveness of the participating MCO's program 329  
established under section 5167.29 of the Revised Code; 330

(e) Any other measurements the department considers 331  
appropriate. 332

(4) The department shall publish each participating MCO's 333  
point totals annually and provide the information to medicaid 334  
recipients before they enroll in a medicaid MCO plan. 335

(F) If, for the second or a subsequent calendar year that the 336  
quality incentive program is operated, a participating MCO's 337  
assignment share percentage is decreased under division (D)(1) of 338  
this section to an amount that is equal to or less than fifty per 339  
cent of its assignment share percentage for the first calendar 340  
year that the program is operated, the department shall terminate 341  
the participating MCO's participation in the program. 342

(G) A participating MCO shall not treat medicaid recipients 343  
who are randomly assigned to enroll in the participating MCO's 344  
medicaid MCO plan under division (C) of this section differently 345  
than how the participating MCO treats medicaid recipients who 346  
select the plan on their own." 347

After line 89942, insert: 348

"**Section 333.195.** SHARED SAVINGS BONUS AND QUALITY INCENTIVE 349  
PROGRAMS 350

Each contract that the Department of Medicaid enters into 351  
with a managed care organization under section 5167.10 of the 352  
Revised Code during the periods that the Shared Savings Bonus 353  
Program and Quality Incentive Program are operated under sections 354  
5167.35 and 5167.36 of the Revised Code shall include terms about 355  
the programs that are consistent with those sections." 356

Delete lines 97646 through 97648 357

The motion was \_\_\_\_\_ agreed to.

SYNOPSIS

**Medicaid managed care** 358

R.C. 5167.35 (primary), 4729.80, 4729.801, 5162.138, 359  
5162.139, 5166.01, 5166.43, 5166.50, 5167.10, 5167.105, 5167.106, 360  
5167.15 (removed), 5167.29, and 5167.36; Sections 333.195 361  
(restored) and 812.40 (removed) 362

Replaces the Senate provision that would have authorized a 363  
Medicaid managed care organization (MCO) to include in its plans 364  
any service or product meeting certain requirements regarding 365  
beneficial effects with the similar House provision that requires 366  
the Medicaid Director to accomplish this through a Medicaid waiver 367  
program. 368

Restores all of the following House provisions: 369

(1) A requirement that the Department of Medicaid do all of 370  
the following if the U.S. Secretary of Health and Human Services 371  
agrees to enter into an enforceable agreement that safeguards the 372  
state's receipt of federal Medicaid funds: 373

-Establish the Shared Savings Bonus Program under which a 374  
Medicaid MCO earns a bonus if its three-year average per recipient 375  
capitated payment rate is less than the three-year average per 376  
recipient cost of certain other states' Medicaid programs. 377

-Establish the Quality Incentive Program under which the 378  
Department randomly assigns certain Medicaid recipients to MCOs 379  
participating in the program based on the MCOs' points earned for 380  
meeting health and quality metrics. 381

-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.

(2) A requirement that each Medicaid MCO establish a program that incentivizes enrollees to obtain covered health care from high quality and efficient providers.

(3) A requirement that 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.

(4) A prohibition against a Medicaid MCO 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.

(5) A requirement that, with certain exceptions, a hospital 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.

Removes the following Senate provisions that would have modified the House provision that 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:

(1) The provision that would have required the Board to collaborate with the Office of InnovateOhio to provide the

information;	411
(2) The provision that would have specified that the	412
information could also be provided by direct data transfer;	413
(3) The provision that would have specified that the	414
provision does not take effect until March 1, 2020.	415