

As Introduced

133rd General Assembly

Regular Session

2019-2020

H. B. No. 11

Representatives Manning, G., Howse

A BILL

To amend sections 5162.20, 5167.01, and 5167.12; to
amend, for the purpose of adopting a new section
number as indicated in parentheses, section
5164.10 (5164.16); and to enact new section
5164.10 and sections 124.825, 3701.614,
3701.615, and 5164.17 of the Revised Code
regarding tobacco cessation and prenatal
initiatives and to make an appropriation.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 5162.20, 5167.01, and 5167.12 be
amended; section 5164.10 (5164.16) be amended for the purpose of
adopting a new section number as indicated in parentheses; and
new section 5164.10 and sections 124.825, 3701.614, 3701.615,
and 5164.17 of the Revised Code be enacted to read as follows:

Sec. 124.825. (A) As used in this section:

(1) "Cost-sharing requirement" means any expenditure
required by or on behalf of an individual receiving health care
benefits provided under section 124.82 of the Revised Code.
"Cost-sharing requirement" includes deductibles, coinsurance,
copayments, or similar charges. "Cost-sharing requirement" does

not include premiums, balance billing amounts for non-network 20
providers, or spending for noncovered services. 21

(2) "Step therapy protocol" has the same meaning as in 22
section 3901.83 of the Revised Code. 23

(B) Notwithstanding section 3901.71 of the Revised Code or 24
any other provision of the Revised Code, the health care 25
benefits provided under section 124.82 of the Revised Code to 26
state employees shall include coverage of both of the following, 27
subject to division (E) of this section: 28

(1) All tobacco cessation medications approved by the 29
United States food and drug administration; 30

(2) All forms of tobacco cessation services recommended by 31
the United States preventive services task force, including 32
individual, group, and telephone counseling and any combination 33
thereof. 34

(C) None of the following conditions shall be imposed with 35
respect to the coverage required by this section: 36

(1) Counseling requirements for tobacco cessation 37
medication; 38

(2) Except as provided in division (C)(4) of this section, 39
limits on the duration of services, including annual or lifetime 40
limits on the number of covered attempts to quit using tobacco; 41

(3) Cost-sharing requirements; 42

(4) Prior authorization requirements, step therapy 43
protocols, or any other utilization management requirements, 44
except that prior authorization may be required for either of 45
the following: 46

(a) Treatment that exceeds the duration recommended in the United States public health service clinical practice guidelines on treating tobacco use and dependence; 47
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(b) Services associated with more than two attempts to quit using tobacco within a twelve-month period. 50
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(D) The health care benefits provided under section 124.82 of the Revised Code may cover tobacco cessation services in addition to the services that must be covered under this section or may exclude coverage of additional tobacco cessation services. 52
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(E) The director of health shall adopt rules in accordance with Chapter 119. of the Revised Code that establish standards and procedures for approving the forms of tobacco cessation medications and services that must be covered under this section. The rules shall also establish standards and procedures for updating the approved forms of tobacco cessation medications and services that must be covered under this section when the approved forms are modified by the United States food and drug administration, United States public health service, or United States preventive services task force. 57
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Sec. 3701.614. (A) The department of health shall develop educational materials describing the health risks of lead-based paint and measures that may be taken to reduce those risks. 67
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(B) As part of the home visiting services described in section 3701.61 of the Revised Code, each eligible family residing in a house, apartment, or other residence built before January 1, 1979, shall receive a copy of the educational materials described in this section. If the date on which the residence was built is unknown to the family or home visiting 70
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services provider, the family shall receive a copy of the 76
educational materials. 77

Sec. 3701.615. (A) As used in this section: 78

(1) "Certified nurse-midwife," "certified nurse 79
practitioner," and "clinical nurse specialist" have the same 80
meanings as in section 4723.01 of the Revised Code. 81

(2) "Physician" means an individual authorized under 82
Chapter 4731. of the Revised Code to practice medicine and 83
surgery or osteopathic medicine and surgery. 84

(3) "Physician assistant" means an individual authorized 85
under Chapter 4730. of the Revised Code to practice as a 86
physician assistant. 87

(B) The department of health shall establish a grant 88
program to address the provision of prenatal health care 89
services to pregnant women on a group basis. The aim of the 90
program is to increase the number of pregnant women who begin 91
prenatal care early in their pregnancies and to reduce the 92
number of infants born preterm. 93

(C) (1) An entity seeking to participate in the grant 94
program shall apply to the department of health in a manner 95
prescribed by the department. Participating entities may include 96
the following: 97

(a) Medical practices, including those operated by or 98
employing one or more physicians, physician assistants, 99
certified nurse-midwives, certified nurse practitioners, or 100
clinical nurse specialists; 101

(b) Health care facilities. 102

(2) To be eligible to participate in the grant program, an 103

entity must demonstrate to the department that it can meet all 104
of the following requirements: 105

(a) Has space to host groups of at least 12 pregnant 106
women; 107

(b) Has adequate in-kind resources, including existing 108
medical staff, to provide necessary prenatal health care 109
services on both an individual and group basis; 110

(c) Provides prenatal care based on either of the 111
following: 112

(i) The centering pregnancy model of care developed by the 113
centering healthcare institute; 114

(ii) Another model of care acceptable to the department. 115

(d) Integrates health assessments, education, and support 116
into a unified program in which pregnant women at similar stages 117
of pregnancy meet, learn care skills, and participate in group 118
discussions; 119

(e) Meets any other requirements established by the 120
department. 121

(D) When distributing funds under the program, the 122
department shall give priority to entities that are both of the 123
following: 124

(1) Operating in areas of the state with high preterm 125
birth rates, including rural areas and Cuyahoga, Franklin, 126
Hamilton, and Summit counties; 127

(2) Providing care to medicaid recipients who are members 128
of the group described in division (B) of section 5163.06 of the 129
Revised Code. 130

(E) A participating entity may coordinate with licensed dental hygienists to educate pregnant women about the importance of prenatal dental care. 131
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(F) The department may adopt rules as necessary to implement this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code. 134
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Sec. 5162.20. (A) The department of medicaid shall 137
institute cost-sharing requirements for the medicaid program. 138
The department shall not institute cost-sharing requirements in 139
a manner that does either of the following: 140

(1) Disproportionately impacts the ability of medicaid recipients with chronic illnesses to obtain medically necessary medicaid services; 141
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(2) Violates section 5164.09 or 5164.10 of the Revised Code. 144
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(B) (1) No provider shall refuse to provide a service to a medicaid recipient who is unable to pay a required copayment for the service. 146
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(2) Division (B) (1) of this section shall not be considered to do either of the following with regard to a medicaid recipient who is unable to pay a required copayment: 149
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(a) Relieve the medicaid recipient from the obligation to pay a copayment; 152
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(b) Prohibit the provider from attempting to collect an unpaid copayment. 154
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(C) Except as provided in division (F) of this section, no provider shall waive a medicaid recipient's obligation to pay the provider a copayment. 156
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(D) No provider or drug manufacturer, including the
manufacturer's representative, employee, independent contractor,
or agent, shall pay any copayment on behalf of a medicaid
recipient.

(E) If it is the routine business practice of a provider
to refuse service to any individual who owes an outstanding debt
to the provider, the provider may consider an unpaid copayment
imposed by the cost-sharing requirements as an outstanding debt
and may refuse service to a medicaid recipient who owes the
provider an outstanding debt. If the provider intends to refuse
service to a medicaid recipient who owes the provider an
outstanding debt, the provider shall notify the recipient of the
provider's intent to refuse service.

(F) In the case of a provider that is a hospital, the
cost-sharing program shall permit the hospital to take action to
collect a copayment by providing, at the time services are
rendered to a medicaid recipient, notice that a copayment may be
owed. If the hospital provides the notice and chooses not to
take any further action to pursue collection of the copayment,
the prohibition against waiving copayments specified in division
(C) of this section does not apply.

(G) The department of medicaid may collaborate with a
state agency that is administering, pursuant to a contract
entered into under section 5162.35 of the Revised Code, one or
more components, or one or more aspects of a component, of the
medicaid program as necessary for the state agency to apply the
cost-sharing requirements to the components or aspects of a
component that the state agency administers.

Sec. 5164.10. (A) The medicaid program shall cover both of
the following, subject to division (C) of this section:

<u>(1) All tobacco cessation medications approved by the</u>	189
<u>United States food and drug administration;</u>	190
<u>(2) All forms of tobacco cessation services recommended by</u>	191
<u>the United States preventive services task force, including</u>	192
<u>individual, group, and telephone counseling and any combination</u>	193
<u>thereof.</u>	194
<u>(B) The department of medicaid shall not impose any of the</u>	195
<u>following conditions with respect to the coverage required by</u>	196
<u>this section:</u>	197
<u>(1) Counseling requirements for tobacco cessation</u>	198
<u>medications;</u>	199
<u>(2) Except as provided in division (B)(4) of this section,</u>	200
<u>limits on the duration of services, including annual or lifetime</u>	201
<u>limits on the number of covered attempts to quit using tobacco;</u>	202
<u>(3) Cost-sharing requirements under section 5162.20 of the</u>	203
<u>Revised Code;</u>	204
<u>(4) Prior authorization requirements, step therapy</u>	205
<u>protocols as defined in section 5164.7512 of the Revised Code,</u>	206
<u>or any other utilization management requirements, except that</u>	207
<u>prior authorization may be required for either of the following:</u>	208
<u>(a) Treatment that exceeds the duration recommended in the</u>	209
<u>United States public health service clinical practice guidelines</u>	210
<u>on treating tobacco use and dependence;</u>	211
<u>(b) Services associated with more than two attempts to</u>	212
<u>quit using tobacco within a twelve-month period.</u>	213
<u>(C) The director of health shall adopt rules in accordance</u>	214
<u>with Chapter 119. of the Revised Code that establish standards</u>	215
<u>and procedures for approving the forms of tobacco cessation</u>	216

medications and services that must be covered under this 217
section. The rules shall also establish standards and procedures 218
for updating the approved forms of tobacco cessation medications 219
and services that must be covered under this section when the 220
approved forms are modified by the United States food and drug 221
administration, United States public health service, or United 222
States preventive services task force. 223

Sec. ~~5164.10~~ 5164.16. The medicaid program may cover one 224
or more state plan home and community-based services that the 225
department of medicaid selects for coverage. A medicaid 226
recipient of any age may receive a state plan home and 227
community-based service if the recipient has countable income 228
not exceeding two hundred twenty-five per cent of the federal 229
poverty line, has a medical need for the service, and meets all 230
other eligibility requirements for the service specified in 231
rules adopted under section 5164.02 of the Revised Code. The 232
rules may not require a medicaid recipient to undergo a level of 233
care determination to be eligible for a state plan home and 234
community-based service. 235

Sec. 5164.17. The medicaid program may cover tobacco 236
cessation services in addition to the services that must be 237
covered under section 5164.10 of the Revised Code or may exclude 238
coverage of additional tobacco cessation services. 239

Sec. 5167.01. As used in this chapter: 240

(A) "Care management system" means the system established 241
under section 5167.03 of the Revised Code. 242

(B) "Controlled substance" has the same meaning as in 243
section 3719.01 of the Revised Code. 244

~~(B)~~ (C) "Dual eligible individual" has the same meaning as 245

in section 5160.01 of the Revised Code.	246
(C) <u>(D)</u> "Emergency services" has the same meaning as in	247
the "Social Security Act," section 1932(b)(2), 42 U.S.C. 1396u-	248
2(b)(2).	249
(D) <u>(E)</u> "ICDS participant" has the same meaning as in	250
section 5164.01 of the Revised Code.	251
(E) <u>(F)</u> "Medicaid managed care organization" means a	252
managed care organization under contract with the department of	253
medicaid pursuant to section 5167.10 of the Revised Code.	254
(F) <u>(G)</u> " <u>Medicaid MCO plan" means a plan that a medicaid</u>	255
<u>managed care organization, pursuant to its contract with the</u>	256
<u>department of medicaid under section 5167.10 of the Revised</u>	257
<u>Code, makes available to medicaid recipients participating in</u>	258
<u>the care management system.</u>	259
<u>(H)</u> "Medicaid waiver component" has the same meaning as in	260
section 5166.01 of the Revised Code.	261
(G) <u>(I)</u> "Nursing facility services" has the same meaning	262
as in section 5165.01 of the Revised Code.	263
(H) <u>(J)</u> "Prescribed drug" has the same meaning as in	264
section 5164.01 of the Revised Code.	265
(I) <u>(K)</u> "Provider" means any person or government entity	266
that furnishes services to a medicaid recipient enrolled in a	267
medicaid managed care organization <u>MCO plan</u> , regardless of	268
whether the person or entity has a provider agreement.	269
(J) <u>(L)</u> "Provider agreement" has the same meaning as in	270
section 5164.01 of the Revised Code.	271
Sec. 5167.12. (A) When contracting under section 5167.10-	272

~~of the Revised Code with a managed care organization that is a~~ 273
~~health insuring corporation, the department of medicaid shall~~ 274
~~require the health insuring corporation to provide coverage of~~ 275
Each medicaid managed care organization shall cover prescribed 276
drugs for medicaid recipients enrolled in ~~the health insuring~~ 277
~~corporation~~ a medicaid MCO plan offered by the organization. In 278
providing the required coverage, ~~the health insuring corporation~~ 279
the organization may use strategies for the management of drug 280
utilization, but any such strategies are subject to the 281
limitations and requirements of this section and the 282
~~department's approval of the department of medicaid.~~ 283

(B) ~~The department shall not permit a health insuring~~ 284
~~corporation to~~ A medicaid managed care organization shall not 285
impose a prior authorization requirement in the case of a drug 286
to which all of the following apply: 287

(1) The drug is an antidepressant or antipsychotic. 288

(2) The drug is administered or dispensed in a standard 289
tablet or capsule form, except that in the case of an 290
antipsychotic, the drug also may be administered or dispensed in 291
a long-acting injectable form. 292

(3) The drug is prescribed by any of the following: 293

(a) A physician who is allowed by the ~~health insuring~~ 294
~~corporation~~ medicaid managed care organization to provide care 295
as a psychiatrist through its credentialing process, as 296
described in division (C) of section 5167.10 of the Revised 297
Code; 298

(b) A psychiatrist who is practicing at a location on 299
behalf of a community mental health services provider whose 300
mental health services are certified by the department of mental 301

health and addiction services under section 5119.36 of the Revised Code;

(c) A certified nurse practitioner, as defined in section 4723.01 of the Revised Code, who is certified in psychiatric mental health by a national certifying organization approved by the board of nursing under section 4723.46 of the Revised Code;

(d) A clinical nurse specialist, as defined in section 4723.01 of the Revised Code, who is certified in psychiatric mental health by a national certifying organization approved by the board of nursing under section 4723.46 of the Revised Code.

(4) The drug is prescribed for a use that is indicated on the drug's labeling, as approved by the federal food and drug administration.

(C) Subject to division ~~(E)~~ (D) of this section, ~~the department shall authorize a health insuring corporation to a~~ medicaid managed care organization may develop and implement a pharmacy utilization management program under which prior authorization through the program is established as a condition of obtaining a controlled substance pursuant to a prescription.

(D) ~~The department shall require a health insuring corporation to~~ Each medicaid managed care organization shall comply with sections 5164.091, 5164.10, 5164.7511, 5164.7512, and 5164.7514 of the Revised Code, as if the ~~health insuring corporation organization~~ organization were the department.

Section 2. That existing sections 5162.20, 5164.10, 5167.01, and 5167.12 of the Revised Code are hereby repealed.

Section 3. (A) (1) The Department of Medicaid shall establish and administer a program to provide dental hygiene services to pregnant Medicaid recipients. Under the program, a

Medicaid recipient who is a member of the group described in 331
section 5163.06 of the Revised Code shall be eligible to receive 332
two dental cleanings per year. The Department shall give 333
priority to those recipients residing in areas of the state with 334
high preterm birth rates. 335

(2) To be eligible to provide dental hygiene services 336
under the program, a dental hygienist must apply to the 337
Department and be licensed as a dental hygienist by the State 338
Dental Board. 339

(B) The Department of Medicaid shall establish 340
reimbursement rates for dental hygienists who educate Medicaid 341
recipients about the importance of oral care as part of the 342
program described in section 3701.615 of the Revised Code. In 343
the case of a dental hygienist who develops and distributes 344
educational materials as part of the program described in 345
section 3701.615 of the Revised Code, the Department shall 346
reimburse the dental hygienist for all or part of the costs 347
associated with developing and distributing the materials. 348

Section 4. All items in this section are hereby 349
appropriated as designated out of any moneys in the state 350
treasury to the credit of the designated fund. For all 351
appropriations made in this act, those in the first column are 352
for fiscal year 2020 and those in the second column are for 353
fiscal year 2021. The appropriations made in this act are in 354
addition to any other appropriations made for the FY 2020-FY 355
2021 biennium. 356

DOH DEPARTMENT OF HEALTH 357

General Revenue Fund 358

GRF 440474 Infant Vitality \$3,500,000 \$2,500,000 359

TOTAL GRF General Revenue Fund	\$3,500,000	\$2,500,000	360
TOTAL ALL BUDGET FUND GROUPS	\$3,500,000	\$2,500,000	361
INFANT VITALITY			362
Of the foregoing appropriation item 440474, Infant			363
Vitality, \$500,000 in fiscal year 2020 shall be used to provide			364
planning grants to help entities meet the requirements of			365
division (C) (2) of section 3701.615 of the Revised Code. The			366
entities that receive these planning grants shall be located in			367
counties without any existing programs that provide prenatal			368
health care services to pregnant women on a group basis.			369
Of the foregoing appropriation item 440474, Infant			370
Vitality, \$3,000,000 in fiscal year 2020 and \$2,500,000 in			371
fiscal year 2021 shall be used in accordance with section			372
3701.615 of the Revised Code.			373
MCD DEPARTMENT OF MEDICAID			374
General Revenue Fund			375
GRF 651531 Oral Healthcare	\$2,500,000	\$2,500,000	376
TOTAL GRF General Revenue Fund	\$2,500,000	\$2,500,000	377
TOTAL ALL BUDGET FUND GROUPS	\$2,500,000	\$2,500,000	378
ORAL HEALTHCARE			379
The foregoing appropriation item 651531, Oral Healthcare,			380
shall be used in accordance with Section 3 of this act.			381
Section 5. Within the limits set forth in this act, the			382
Director of Budget and Management shall establish accounts			383
indicating the source and amount of funds for each appropriation			384
made in this act, and shall determine the form and manner in			385
which appropriation accounts shall be maintained. Expenditures			386

from appropriations contained in this act shall be accounted for 387
as though made in the main operating appropriations act of the 388
133rd General Assembly. 389

The appropriations made in this act are subject to all 390
provisions of the main operating appropriations act of the 133rd 391
General Assembly that are generally applicable to such 392
appropriations. 393