**As Introduced**

**131st General Assembly**
**Regular Session**
**2015-2016**

**H. B. No. 251**

**Representatives Sprague, Driehaus**
**Cosponsors: Representatives Antonio, Bishoff, Green, Lepore-Hagan, Reineke, Rezabek, Rogers**

# A BILL

To amend sections 103.41, 5164.01, 5167.01, and 5167.03 and to enact sections 103.416, 103.417, 5164.151, and 5167.04 of the Revised Code to establish certain requirements regarding the Medicaid program's coverage of community behavioral health services.

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

**Section 1.** That sections 103.41, 5164.01, 5167.01, and 5167.03 be amended and sections 103.416, 103.417, 5164.151, and 5167.04 of the Revised Code be enacted to read as follows:

**Sec. 103.41.** (A) As used in sections 103.41 to ~~103.415~~ 103.417 of the Revised Code:

(1) "JMOC" means the joint medicaid oversight committee created under this section.

(2) "State and local government medicaid agency" means all of the following:

(a) The department of medicaid;

(b) The office of health transformation;

(c) Each state agency and political subdivision with which the department of medicaid contracts under section 5162.35 of the Revised Code to have the state agency or political subdivision administer one or more components of the medicaid program, or one or more aspects of a component, under the department's supervision;

(d) Each agency of a political subdivision that is responsible for administering one or more components of the medicaid program, or one or more aspects of a component, under the supervision of the department or a state agency or political subdivision described in division (A)(2)(c) of this section.

(B) There is hereby created the joint medicaid oversight committee. JMOC shall consist of the following members:

(1) Five members of the senate appointed by the president of the senate, three of whom are members of the majority party and two of whom are members of the minority party;

(2) Five members of the house of representatives appointed by the speaker of the house of representatives, three of whom are members of the majority party and two of whom are members of the minority party.

(C) The term of each JMOC member shall begin on the day of appointment to JMOC and end on the last day that the member serves in the house (in the case of a member appointed by the speaker) or senate (in the case of a member appointed by the president) during the general assembly for which the member is appointed to JMOC. The president and speaker shall make the initial appointments not later than fifteen days after March 20, 2014. However, if this section takes effect before January 1,

2014, the president and speaker shall make the initial appointments during the period beginning January 1, 2014, and ending January 15, 2014. The president and speaker shall make subsequent appointments not later than fifteen days after the commencement of the first regular session of each general assembly. JMOC members may be reappointed. A vacancy on JMOC shall be filled in the same manner as the original appointment.

(D) In odd-numbered years, the speaker shall designate one of the majority members from the house as the JMOC chairperson and the president shall designate one of the minority members from the senate as the JMOC ranking minority member. In even-numbered years, the president shall designate one of the majority members from the senate as the JMOC chairperson and the speaker shall designate one of the minority members from the house as the JMOC ranking minority member.

(E) In appointing members from the minority, and in designating ranking minority members, the president and speaker shall consult with the minority leader of their respective houses.

(F) JMOC shall meet at the call of the JMOC chairperson. The chairperson shall call JMOC to meet not less often than once each calendar month, unless the chairperson and ranking minority member agree that the chairperson should not call JMOC to meet for a particular month.

(G) Notwithstanding section 101.26 of the Revised Code, the members, when engaged in their duties as members of JMOC on days when there is not a voting session of the member's house of the general assembly, shall be paid at the per diem rate of one hundred fifty dollars, and their necessary traveling expenses, which shall be paid from the funds appropriated for the payment

of expenses of legislative committees.

(H) JMOC may employ professional, technical, and clerical employees as are necessary for JMOC to be able successfully and efficiently to perform its duties. All such employees are in the unclassified service and serve at JMOC's pleasure. JMOC may contract for the services of persons who are qualified by education and experience to advise, consult with, or otherwise assist JMOC in the performance of its duties.

(I) The JMOC chairperson, when authorized by JMOC and the president and speaker, may issue subpoenas and subpoenas duces tecum in aid of JMOC's performance of its duties. A subpoena may require a witness in any part of the state to appear before JMOC at a time and place designated in the subpoena to testify. A subpoena duces tecum may require witnesses or other persons in any part of the state to produce books, papers, records, and other tangible evidence before JMOC at a time and place designated in the subpoena duces tecum. A subpoena or subpoena duces tecum shall be issued, served, and returned, and has consequences, as specified in sections 101.41 to 101.45 of the Revised Code.

(J) The JMOC chairperson may administer oaths to witnesses appearing before JMOC.

**Sec. 103.416.** JMOC shall hold at least one public hearing regarding proposed revisions to the medicaid program's coverage of community behavioral health services that the department of medicaid notifies JMOC of pursuant to section 5164.151 of the Revised Code. Not later than three months after receiving the notice, JMOC shall either approve or reject the proposed revisions.

**Sec. 103.417.** JMOC may approve an order of phase-in of the inclusion of community behavioral health services in the care management system that differs from the order specified in section 5167.04 of the Revised Code.

JMOC shall hold a public hearing regarding each report about the phase-in that the department of medicaid submits to JMOC under section 5167.04 of the Revised Code. Not later than one month after receiving such a report, JMOC shall either approve or reject the implementation of the next phase.

**Sec. 5164.01.** As used in this chapter:

(A) "Early and periodic screening, diagnostic, and treatment services" has the same meaning as in the "Social Security Act," section 1905(r), 42 U.S.C. 1396d(r).

(B) "Federal financial participation" has the same meaning as in section 5160.01 of the Revised Code.

(C) "Healthcheck" means the component of the medicaid program that provides early and periodic screening, diagnostic, and treatment services.

(D) "Home and community-based services medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code.

(E) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(F) "ICDS participant" means a dual eligible individual who participates in the integrated care delivery system.

(G) "ICF/IID" has the same meaning as in section 5124.01 of the Revised Code.

(H) "Integrated care delivery system" and "ICDS" mean the demonstration project authorized by section 5164.91 of the Revised Code.

(I) "JMOC" means the joint medicaid oversight committee created under section 103.41 of the Revised Code.

(J) "Mandatory services" means the health care services and items that must be covered by the medicaid state plan as a condition of the state receiving federal financial participation for the medicaid program.

~~(J)~~ (K) "Medicaid managed care organization" has the same meaning as in section 5167.01 of the Revised Code.

~~(K)~~ (L) "Medicaid provider" means a person or government entity with a valid provider agreement to provide medicaid services to medicaid recipients. To the extent appropriate in the context, "medicaid provider" includes a person or government entity applying for a provider agreement, a former medicaid provider, or both.

~~(L)~~ (M) "Medicaid services" means either or both of the following:

(1) Mandatory services;

(2) Optional services that the medicaid program covers.

~~(M)~~ (N) "Nursing facility" has the same meaning as in section 5165.01 of the Revised Code.

~~(N)~~ (O) "Optional services" means the health care services and items that may be covered by the medicaid state plan or a federal medicaid waiver and for which the medicaid program receives federal financial participation.

~~(O)~~ (P) "Prescribed drug" has the same meaning as in 42 C.F.R. 440.120.

~~(P)~~ (Q) "Provider agreement" means an agreement to which all of the following apply:

(1) It is between a medicaid provider and the department of medicaid;

(2) It provides for the medicaid provider to provide medicaid services to medicaid recipients;

(3) It complies with 42 C.F.R. 431.107(b).

~~(Q)~~ (R) "Terminal distributor of dangerous drugs" has the same meaning as in section 4729.01 of the Revised Code.

**Sec. 5164.151.** (A) Except as provided in division (B) of this section, the department of medicaid shall submit to JMOC written notice of any proposed revisions to the medicaid program's coverage of community behavioral health services before implementing the revisions. The department may not implement the revisions unless JMOC approves the revisions or fails to approve or reject them within the time specified in section 103.416 of the Revised Code.

(B) This section does not apply to either of the following:

(1) Revisions to the medicaid program's coverage of community behavioral health services that must be made to avoid a loss in federal financial participation;

(2) Including community behavioral health services in the care management system pursuant to section 5167.04 of the Revised Code.

**Sec. 5167.01.** As used in this chapter:

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

(B) "Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.

(C) "Emergency services" has the same meaning as in the "Social Security Act," section 1932(b)(2), 42 U.S.C. 1396u-2(b)(2).

(D) "Home and community-based services medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code.

(E) "JMOC" means the joint medicaid oversight committee created under section 103.41 of the Revised Code.

(F) "Medicaid managed care organization" means a managed care organization under contract with the department of medicaid pursuant to section 5167.10 of the Revised Code.

~~(F)~~ (G) "Medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code.

~~(G)~~ (H) "Nursing facility" has the same meaning as in section 5165.01 of the Revised Code.

~~(H)~~ (I) "Prescribed drug" has the same meaning as in section 5164.01 of the Revised Code.

~~(I)~~ (J) "Provider" means any person or government entity that furnishes services to a medicaid recipient enrolled in a medicaid managed care organization, regardless of whether the person or entity has a provider agreement.

~~(J)~~ (K) "Provider agreement" has the same meaning as in

section 5164.01 of the Revised Code.

**Sec. 5167.03.** (A) As part of the medicaid program, the department of medicaid shall establish a care management system.

(B) The department shall implement the care management system in some or all counties and shall designate the medicaid recipients who are required or permitted to participate in the system. In the department's implementation of the system and designation of participants, ~~all~~ both of the following apply:

(1) In the case of individuals who receive medicaid on the basis of being included in the category identified by the department as covered families and children, the department shall implement the care management system in all counties. All individuals included in the category shall be designated for participation, except for individuals included in one or more of the medicaid recipient groups specified in 42 C.F.R. 438.50(d). The department shall ensure that all participants are enrolled in medicaid managed care organizations that are health insuring corporations.

(2) In the case of individuals who receive medicaid on the basis of being aged, blind, or disabled, the department shall implement the care management system in all counties. Except as provided in division (C) of this section, all individuals included in the category shall be designated for participation. The department shall ensure that all participants are enrolled in medicaid managed care organizations that are health insuring corporations.

~~(3) Alcohol, drug addiction, and mental health services covered by medicaid shall not be included in any component of the care management system when the nonfederal share of the cost~~

~~of those services is provided by a board of alcohol, drug addiction, and mental health services or a state agency other than the department of medicaid, but the recipients of those services may otherwise be designated for participation in the system.~~

(C)(1) In designating participants who receive medicaid on the basis of being aged, blind, or disabled, the department shall not include any of the following, except as provided under division (C)(2) of this section:

(a) Individuals who are under twenty-one years of age;

(b) Individuals who are institutionalized;

(c) Individuals who become eligible for medicaid by spending down their income or resources to a level that meets the medicaid program's financial eligibility requirements;

(d) Dual eligible individuals;

(e) Individuals to the extent that they are receiving medicaid services through a medicaid waiver component.

(2) The department may designate any of the following individuals who receive medicaid on the basis of being aged, blind, or disabled as individuals who are permitted or required to participate in the care management system:

(a) Individuals who are under twenty-one years of age;

(b) Individuals who reside in a nursing facility;

(c) Individuals who, as an alternative to receiving nursing facility services, are participating in a home and community-based services medicaid waiver component;

(d) Dual eligible individuals.

(D) Subject to division (B) of this section, the department may do both of the following under the care management system:

(1) Require or permit participants in the system to obtain health care services from providers designated by the department;

(2) Require or permit participants in the system to obtain health care services through medicaid managed care organizations.

**Sec. 5167.04.** (A) Community behavioral health services shall not be included in the care management system until at least one year and nine months after the effective date of this section. The department of medicaid may begin to include community behavioral health services in the care management system after that time if JMOC, not later than one year and nine months after the effective date of this section, approves, or has failed to approve or reject, the inclusion of community behavioral health services in the care management system.

(B) If the department includes community behavioral health services in the care management system, it shall include the services in phases. Subject to division (C) of this section, the department shall phase-in inclusion of the services in the following order unless JMOC approves a different order pursuant to section 103.417 of the Revised Code:

(1) Community mental health services for adults with severe and persistent mental illness may be included first;

(2) Community mental health services for other adults may be included second;

(3) Community alcohol and drug addiction services for

adults may be included third;

(4) Community mental health services for children with serious emotional disorders may be included fourth;

(5) Community mental health services for children who do not have serious emotional disorders but have been adjudicated abused, neglected, dependent, delinquent, or unruly or have multiple needs and receive or are eligible to receive services from multiple state or local government agencies may be included fifth;

(6) Community mental health services for other children may be included sixth;

(7) Community alcohol and drug addiction services for children may be included seventh.

(C) Not later than one hundred twenty days after the first day of the implementation of each phase of the inclusion of community behavioral health services in the care management system, the department shall submit to JMOC a written report summarizing how well the phase worked during its first ninety days. The department shall not implement any subsequent phases unless JMOC, not later than one month after receiving the report, approves, or has failed to approve or reject, implementation of the next phase.

(D) If the department includes community behavioral health services in the care management system, all of the following apply:

(1) The portion of the premiums paid to medicaid managed care organizations that represents the costs of the community behavioral health services shall be based on at least the medicaid payment rates under the fee-for-service system for the

services in effect on June 30, 2016.

(2) In accordance with the phase-in of community-behavioral health services, each medicaid managed care organization shall be responsible for providing or arranging for the provision of, on behalf of the medicaid recipients enrolled in the organization, all community behavioral health services included in the continuum of care that boards of alcohol, drug addiction, and mental health services are required to establish under section 340.03 of the Revised Code.

(3) A medicaid managed care organization shall not do any of the following:

(a) Establish prior authorization requirements for the community behavioral health services;

(b) Limit the number of treatment visits a medicaid recipient enrolled in the organization may have with a provider of community behavioral health services or otherwise place arbitrary limits on other treatment units of the services;

(c) In the case of medicaid recipients enrolled in the organization who are children who have been adjudicated abused, neglected, dependent, delinquent, or unruly, limit access to community behavioral health services in a manner that is more restrictive than the access the children have to community behavioral health services under the child welfare system;

(d) Except as provided in division (D)(3)(e) of this section, refuse to permit a qualified and willing provider of community behavioral health services to join the organization's provider network;

(e) Include specialty pharmacies in the organization's provider network.

(4) If a medicaid managed care organization, not later than forty-five days after a payment is due for a claim for a community behavioral health service provided to a medicaid recipient enrolled in the organization, fails to pay the claim in full, the department shall do both of the following:

(a) Pay the provider of the service the balance due plus the following percentage of the balance:

(i) Ten per cent if the department makes the payment not later than sixty days after the organization's deadline for paying the claim;

(ii) Twenty per cent if the department makes the payment later than sixty days but not later than seventy-five days after the organization's deadline for paying the claim;

(iii) Thirty per cent if the department makes the payment later than seventy-five days after the organization's deadline for paying the claim.

(b) Collect from the organization the amount the department pays the provider under division (D)(4)(a) of this section in a manner the department determines is best, which may include reducing premiums the department pays the organization.

**Section 2.** That existing sections 103.41, 5164.01, 5167.01, and 5167.03 of the Revised Code are hereby repealed.

**Section 3.** (A) There is hereby established the Medicaid Coverage of Community Behavioral Health Services Study Group. The group shall consist of all of the following:

(1) The Medicaid Director or the Director's designee;

(2) The Director of Mental Health and Addiction Services or the Director's designee;

(3) One representative of each of the following appointed by the Medicaid Director:

(a) The Ohio Association of Health Plans;

(b) The Ohio Council of Behavioral Health and Family Services Providers;

(c) The Public Children Services Association of Ohio;

(d) The Ohio Association of Child Caring Agencies;

(e) The Ohio Association of County Behavioral Health Authorities;

(f) The National Alliance on Mental Illness of Ohio;

(g) The Ohio Citizen Advocates for Addiction Recovery;

(h) The Ohio Alliance of Recovery Providers.

(4) Three consumers of community behavioral health services appointed by the Medicaid Director;

(5) Three family members of consumers of community behavioral health services appointed by the Medicaid Director.

(B) The Medicaid Director shall make the appointments to the group not later than three months after the effective date of this section. The group's members shall serve without compensation, except to the extent that serving on the group is part of the members' regular employment duties. The members shall not receive reimbursement for their expenses incurred in serving as part of the group.

(C) The Medicaid Director shall serve as the group's chairperson. The Department of Medicaid shall provide necessary support services for the group.

(D) The group shall study the issue of revising the Medicaid program's coverage of community behavioral health services. In studying this issue, the group shall study and develop recommendations for all of the following:

(1) Standardizing the admittance criteria for providers of drug addiction services;

(2) Having Medicaid pay for community behavioral health services on the basis of a recipient's episode of needed services in a manner that emphasizes payment for long-term, low intensity maintenance services that help keep people stable or in recovery;

(3) Disaggregating community psychiatric supportive treatment, case management, and health home service;

(4) Redefining the terms "pharmacologic management services" and "medical/somatic services" in order to align the service coding for the services with national standards and to create discrete payment rates;

(5) Ensuring Medicaid coverage of assertive community treatment services, intensive home-based treatment services, high fidelity wrap around services, peer services, supportive employment services, and substance use disorder residential services and implementing a standardized assessment tool to access these services;

(6) Delegating community behavioral health services to specialty plans offered by Medicaid managed care organizations;

(7) Having Medicaid managed care organizations do both of the following:

(a) Delegate care coordination to community behavioral

health services providers or networks of such providers;

(b) Oversee the delegated care coordination.

(8) Having the Department of Medicaid contract with a Medicaid managed care organization that specializes in behavioral health services to provide both of the following:

(a) Comprehensive services to Medicaid recipients with an intense need for community behavioral health services;

(b) Non-comprehensive services to Medicaid recipients with a non-intense need for community behavioral health services.

(9) Making the revisions to the Medicaid program budget neutral.

(E)(1) The group shall complete a report of its study and recommendations not later than nine months after the effective date of this section. The group shall submit the report to all of the following:

(a) The Governor;

(b) In accordance with section 101.68 of the Revised Code, the General Assembly;

(c) The Joint Medicaid Oversight Committee.

(2) The group shall cease to exist on submission of the report.