H.B. 49
As Introduced

_____ moved to amend as follows:

In line 1 of the title, after "102.03," insert "103.41,"

In line 199 of the title, after "5162.66," insert "5162.70,"

In line 201 of the title, after "5164.7510," insert "5164.76,"

In line 203 of the title, after "5166.408," insert "5167.01, 5167.04,"

In line 237 of the title, after "sections" insert "103.416,"

In line 258 of the title, after "5164.29," insert "5164.761, 5164.762, 5164.763, 5164.764, 5167.041,"

In line 268 of the title, after "sections" insert "103.42,"

In line 331, after "102.03," insert "103.41,"

In line 474, after "5162.66," insert "5162.70,"

In line 476, after "5164.7510," insert "5164.76,"

In line 477, after "5166.408," insert "5167.01, 5167.04,"

In line 502, after "sections" insert "103.416,"

In line 518, after "5164.29," insert "5164.761, 5164.762, 5164.763, 5164.764, 5167.041,"

Between lines 1347 and 1348, insert:

"**Sec. 103.41.** (A) As used in sections 103.41 to ~~103.415~~ 103.416 of the Revised Code:

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

(2) "Community behavioral health services" has the same meaning as in section 5164.01 of the Revised Code.

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

~~(2)~~(4) "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)~~(4)(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. (A) JMOC shall oversee changes to the medicaid program's coverage of community behavioral health services. As part of its oversight duties, JMOC shall do all of the following:

(1) Receive and consider the reports from the successful transition and evaluation program workgroup established by section 5164.764 of the Revised Code;

(2) Receive and consider information provided to JMOC by the department of medicaid, department of mental health and addiction services, providers of the services, and other persons about the medicaid program's coverage of the services;

(3) Determine, by a majority vote, whether to do any of the following:

(a) For the purpose of division (A)(3) of section 5164.761 of the Revised Code, permit the department of medicaid to implement new medicaid billing codes and payment rates for the services.

(b) Approve the process that the department establishes under division (B) of section 5164.761 of the Revised Code to ensure that medicaid providers of the services are not put at financial risk as a result of any such new medicaid billing codes and payment rates.

(c) For the purpose of division (C) of section 5167.04 of the Revised Code, permit the department to include the services in the care management system.

(d) Approve the process that the department establishes under division (A)(1) of section 5167.041 of the Revised Code to ensure

that providers of the services are not put at financial risk as a result of the services being included in the care management system.

(e) For the purpose of division (F) of section 5164.764 of the Revised Code and subject to division (B) of this section, specify the date that the successful transition and evaluation program workgroup is to cease to exist.

(B) The date that JMOC specifies under division (A)(3)(e) of this section for the successful transition and evaluation program workgroup to cease to exist shall not be sooner than seven years after the date that medicaid-covered community behavioral health services begin to be included in the care management system."

Between lines 76192 and 76193, insert:

"**Sec. 5162.70.** (A) As used in this section:

(1) "CPI" means the consumer price index for all urban consumers as published by the United States bureau of labor statistics.

(2) "CPI medical inflation rate" means the inflation rate for medical care, or the successor term for medical care, for the midwest region as specified in the CPI.

(3) "JMOC projected medical inflation rate" means the following:

(a) The projected medical inflation rate for a fiscal biennium determined by the actuary with which the joint medicaid oversight committee contracts under section 103.414 of the Revised Code if the committee agrees with the actuary's projected medical inflation rate for that fiscal biennium;

(b) The different projected medical inflation rate for a

fiscal biennium determined by the joint medicaid oversight committee under section 103.414 of the Revised Code if the committee disagrees with the projected medical inflation rate determined for that fiscal biennium by the actuary with which the committee contracts under that section.

(4) "Successor term" means a term that the United States bureau of labor statistics uses in place of another term in revisions to the CPI.

(B) The medicaid director shall implement reforms to the medicaid program that do all of the following:

(1) Limit the growth in the per recipient per month cost of the medicaid program, as determined on an aggregate basis for all eligibility groups, for a fiscal biennium to not more than the lesser of the following:

(a) The average annual increase in the CPI medical inflation rate for the most recent three-year period for which the necessary data is available as of the first day of the fiscal biennium, weighted by the most recent year of the three years;

(b) The JMOC projected medical inflation rate for the fiscal biennium.

(2) Achieve the limit in the growth of the per recipient per month cost of the medicaid program under division (B)(1) of this section by doing all of the following:

(a) Improving the physical and mental health of medicaid recipients;

(b) Providing for medicaid recipients to receive medicaid services in the most cost-effective and sustainable manner;

(c) Removing barriers that impede medicaid recipients'

ability to transfer to lower cost, and more appropriate, medicaid services, including home and community-based services;

(d) Establishing medicaid payment rates that encourage value over volume and result in medicaid services being provided in the most efficient and effective manner possible;

(e) Implementing fraud and abuse prevention and cost avoidance mechanisms to the fullest extent possible;

(f) Integrating in the care management system established under section 5167.03 of the Revised Code the delivery of physical health, ~~behavioral health,~~ nursing facility, ~~and~~ home and community-based services covered by medicaid, and, subject to sections 5167.04 and 5167.041 of the Revised Code, community behavioral health services.

(3) Reduce the prevalence of comorbid health conditions among, and the mortality rates of, medicaid recipients;

(4) Reduce infant mortality rates among medicaid recipients.

(C) The medicaid director shall implement the reforms under this section in accordance with evidence-based strategies that include measurable goals.

(D) The reforms implemented under this section shall, without making the medicaid program's eligibility requirements more restrictive, reduce the relative number of individuals enrolled in the medicaid program who have the greatest potential to obtain the income and resources that would enable them to cease enrollment in medicaid and instead obtain health care coverage through employer-sponsored health insurance or an exchange."

In line 76196, after "(B)" insert ""Care management system" means the system established under section 5167.03 of the Revised Code.

(C) "Clean claim" has the same meaning as in 42 C.F.R. 447.45(b).

(D) "Community behavioral health services" means both of the following:

(1) Alcohol and drug addiction services provided by a community addiction services provider, as defined in section 5119.01 of the Revised Code;

(2) Mental health services provided by a community mental health services provider, as defined in section 5119.01 of the Revised Code.

(E)"

In line 76199, strike through "(C)" and insert "(F)"

In line 76201, strike through "(D)" and insert "(G)"

In line 76203, delete "(E)" and insert "(H)"

In line 76206, delete "(F)" and insert "(I)"

In line 76209, delete "(G)" and insert "(J)"

In line 76211, delete "(H)" and insert "(K)"

In line 76213, delete "(I)" and insert "(L)"

In line 76215, delete "(J)" and insert "(M)"

In line 76218, delete "(K)" and insert "(N)"

In line 76222, delete "(L)" and insert "(O)"

In line 76224, delete "(M)" and insert "(P)"

In line 76230, delete "(N)" and insert "(Q)"

In line 76234, delete "(O)" and insert "(R)"

In line 76236, delete "(P)" and insert "(S)"

In line 76240, delete "(Q)" and insert "(T)"

In line 76242, delete "(R)" and insert "(U)"

In line 76249, delete "(S)" and insert "(V)"

In line 76254, delete "(T)" and insert "(W)"

Between lines 77189 and 77190, insert:

"**Sec. 5164.76.** (A) ~~In~~ Subject to sections 5164.761 and 5164.762 of the Revised Code, the medicaid director, in rules adopted under section 5164.02 of the Revised Code, ~~the medicaid director~~ shall modify the manner or establish a new manner in which the following are paid under medicaid:

(1) Community mental health service providers or facilities for providing community mental health services covered by the medicaid program pursuant to section 5164.15 of the Revised Code;

(2) Providers of alcohol and drug addiction services for providing alcohol and drug addiction services covered by the medicaid program.

(B) The director's authority to modify the manner, or to establish a new manner, for medicaid to pay for the services specified in division (A) of this section is not limited by any rules adopted under section 5119.22 or 5164.02 of the Revised Code that are in effect on June 26, 2003, and govern the way medicaid pays for those services. This is the case regardless of what state agency adopted the rules.

Sec. 5164.761. (A) Before the department of medicaid may implement new medicaid billing codes or payment rates for community behavioral health services during the period that begins on the effective date of this section and ends on the date that

the successful transition and evaluation program workgroup established under section 5164.764 of the Revised Code ceases to exist, all of the following must occur:

(1) The department must require all medicaid providers of community behavioral health services to participate in a beta test of the new codes and rates as a condition of participating in medicaid.

(2) The beta test must be successfully completed as evidenced by showing to the satisfaction of the successful transition and evaluation program workgroup that, had the new codes and rates for the services been in effect during the beta test, at least fifty per cent of the medicaid providers that submitted clean claims under the beta test would have been paid the correct amount for the services not later than ten days after the date the clean claim was submitted.

(3) The joint medicaid oversight committee must have voted, pursuant to section 103.416 of the Revised Code to permit the department to implement the new codes and rates.

(4) The department must notify all medicaid providers of community behavioral health services that the new codes and rates are to take effect on a date specified in the notice, which shall not be sooner than sixty days after the date of the notice.

(B) If the department implements new medicaid billing codes or payment rates for community behavioral health services, the department shall establish a process to ensure that medicaid providers of the services are not put at financial risk as a result of the implementation. The process is subject to the approval of the joint medicaid oversight committee pursuant to section 103.416 of the Revised Code and shall do both of the following:

(1) Authorize a medicaid provider to notify the department if the provider does not receive, within ten days after a clean claim for the service is properly submitted, a full medicaid payment for the service;

(2) Require the department to pay the clean claim in full not later than ten days after receiving the medicaid provider's notice.

Sec. 5164.762. Until two years after the effective date of this section, the medicaid payment rate for a community behavioral health service provided by an individual without a postgraduate degree may not be less than the medicaid payment rate for the same service provided by an individual with a postgraduate degree. If the department of medicaid implements such a revision to the medicaid payment rates for community behavioral health services after the two-year period, the revision shall be phased in over five years as follows:

(A) During the first year, the percentage difference between the payment rates shall be one-fifth of the total percentage difference that is to go into effect in the fifth year.

(B) During the second year, the percentage difference between the payment rates shall be two-fifths of the total percentage difference that is to go into effect in the fifth year.

(C) During the third year, the percentage difference between the payment rates shall be three-fifths of the total percentage difference that is to go into effect in the fifth year.

(D) During the fourth year, the percentage difference between the payment rates shall be four-fifths of the total percentage difference that is to go into effect in the fifth year.

(E) Beginning with the fifth year, the percentage difference is the full amount intended by the revision.

Sec. 5164.763. (A) During the first seven years after the effective date of this section, the department of medicaid shall not make any changes to the medicaid program's coverage of community behavioral health services that would decrease the number of willing and qualified medicaid providers of the services or impair the ability of a medicaid provider to employ or contract for individuals to provide the services on the provider's behalf. This includes both of the following:

(1) Except as otherwise required by federal or state law and notwithstanding section 5164.33 of the Revised Code, doing either of the following for any reason not related to a provider's competence to provide the services:

(a) Denying, refusing to revalidate, suspending, or terminating a provider agreement;

(b) Otherwise excluding an individual, provider, or other entity from participation in the medicaid program.

(2) Impairing the ability of an individual to complete clinical training with a provider of community behavioral health services needed to obtain a relevant postgraduate degree, including by requiring the individual to work under direct supervision.

(B) Changes to the medicaid program's coverage of community behavioral health services made in accordance with section 5164.761, 5164.762, or 5167.04 of the Revised Code do not violate division (A) of this section.

Sec. 5164.764. (A) There is hereby established the successful

transition and evaluation program workgroup. The workgroup shall consist of all of the following:

(1) The medicaid director, or the director's designee, and representatives of the department of medicaid appointed to the workgroup by the director;

(2) The director of mental health and addiction services, or the director's designee, and representatives of the department of mental health and addiction services appointed to the workgroup by the director;

(3) Representatives of providers of community behavioral health services appointed by the medicaid director.

(B) Appointments to the workgroup shall be made not later than thirty days after the effective date of this section. Each member shall serve without compensation or reimbursement for expenses incurred while serving on the workgroup, except to the extent that serving on the workgroup is considered to be among the member's employment duties.

(C) The medicaid director, or the director's designee, shall serve as chairperson of the workgroup. The department of medicaid shall provide the workgroup with any necessary administrative assistance.

(D) The workgroup shall do all of the following:

(1) Determine, in accordance with division (A)(2) of section 5164.761 of the Revised Code, whether the beta test of new medicaid billing codes and payment rates for community behavioral health services has been successfully completed.

(2) Determine, in accordance with division (B) of section 5167.04 of the Revised Code, whether the beta test of the inclusion of medicaid-covered community behavioral health services

in the care management system has been successfully completed.

(3) Assess changes to the medicaid program's coverage of community behavioral health services in an effort to maintain the stability of the state's community behavioral health system and the access of the residents of this state to community behavioral health services.

(E) The workgroup shall regularly report to the joint medicaid oversight committee about its determinations and assessments under division (D) of this section.

(F) The workgroup shall cease to exist on the date specified by the joint medicaid oversight committee pursuant to section 103.416 of the Revised Code."

Between lines 77722 and 77723, insert:

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

(A) "Clean claim" has the same meaning as in 42 C.F.R. 447.45(b).

(B) "Community behavioral health services" has the same meaning as in section 5164.01 of the Revised Code.

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

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

~~(C)~~(E) "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)~~(F) "Home and community-based services medicaid waiver component" has the same meaning as in section 5166.01 of the

Revised Code.

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

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

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

~~(I)~~(K) "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)~~(L) "Provider agreement" has the same meaning as in section 5164.01 of the Revised Code.

Sec. 5167.04. ~~(A) Subject to division (B) of this section,~~ Before the department of medicaid ~~shall~~ may include ~~alcohol, drug addiction, and mental health services covered by medicaid~~ medicaid-covered community behavioral health services in the care management system established under section 5167.03 of the Revised Code during the period that begins on the effective date of this amendment and ends on the date that the successful transition and evaluation program workgroup established under section 5164.764 of the Revised Code ceases to exist, all of the following must occur:

(A) The department must require all medicaid providers of the services to participate in a beta test of the inclusion as a condition of participating in medicaid.

(B) The beta test must be successfully completed as evidenced by showing to the satisfaction of the successful transition and evaluation program workgroup that, had the services been included in the care management system at that time, at least fifty per cent of the providers that submitted clean claims to medicaid managed care organizations under the beta test would have been paid the correct amount for the services not later than ten days after the date the clean claim was submitted.

(C) The joint medicaid oversight committee must have voted pursuant to section 103.416 of the Revised Code to permit the department to include the services in the care management system.

(D) The department must notify all medicaid providers of the services of both of the following:

(1) That the services are to begin to be included in the care management system beginning on a date specified in the notice, which shall not be sooner than sixty days after the date of the notice;

(2) The procedures for becoming providers under the care management system.

~~(B) All of the following apply to the manner in which division (A) of this section is implemented:~~

~~(1) The department shall begin to include the services in the system not later than January 1, 2018.~~

~~(2) Before January 1, 2018, any proposal by the department to include all or part of the services in all or part of the system is subject to review by the joint medicaid oversight committee under division (B) of section 103.42 of the Revised Code. The department may implement the proposal only if the committee approves the proposal.~~

~~(3) On and after January 1, 2018, any proposal by the department to include all or part of the services in all or part of the system is subject to monitoring by the committee under division (A) or (C) of section 103.42 of the Revised Code, but approval by the committee is no longer required before the proposal may be implemented.~~

Sec. 5167.041. (A) If medicaid-covered community behavioral health services begin to be included in the care management system established under section 5167.03 of the Revised Code, both of the following shall apply:

(1) The department of medicaid shall establish a process consistent with division (B) of this section to ensure that providers of the services are not put at financial risk as a result of the services being included in the care management system.

(2) Each contract between the department and a medicaid managed care organization shall include all of the following:

(a) A prohibition against the organization doing any of the following:

(i) Requiring that providers submit payment claims to the organization sooner than one year after the date the provider provides the service to a medicaid recipient enrolled in the organization;

(ii) Requiring that prior authorization be obtained for services provided on an outpatient basis;

(iii) Excluding a provider from the organization's provider panel if the provider's certifiable services and supports, as defined in section 5119.01 of the Revised Code, are certified and

in good standing under section 5119.36 of the Revised Code.

(b) A provision that permits medicaid recipients to disenroll from one medicaid managed care organization and enroll in another medicaid managed care organization only once a year and only during an annual open enrollment period;

(c) A requirement that the medicaid managed care organization comply with sections 5164.762 and 5164.763 of the Revised Code as if the organization were the department.

(B) The process established under division (A)(1) of this section is subject to the approval of the joint medicaid oversight committee pursuant to section 103.416 of the Revised Code and shall do all of the following:

(1) Authorize a provider of community behavioral health services to notify the department if the provider does not receive full payment for a community behavioral health service within ten days after a clean claim for the service is properly submitted;

(2) Require the department to pay the clean claim in full not later than ten days after receiving the provider's notice;

(3) Require the medicaid managed care organization to reimburse the department in full for the payment."

In line 92425, after "102.03," insert "103.41,"

In line 92569, after "5162.66," insert "5162.70,"

In line 92570, after "5164.7510," insert "5164.76,"

In line 92572, after "5166.408," insert "5167.01, 5167.04,"

In line 92592, after "sections" insert "103.42,"

Between lines 106874 and 106875, insert:

"Sections 103.41, 103.416, 103.42, 5162.70, 5164.76,

5164.761, 5164.762, 5164.763, 5164.764, 5167.01, 5167.04, and 5167.041 of the Revised Code take effect July 1, 2017."

Between lines 106914b and 106915, insert:

"5164.01	The amendments adding definitions for the terms "federal poverty line" and "state plan home and community-based services" in what will be, because of the amendments, divisions (G) and (V)	All amendments except as described in the middle column take effect July 1, 2017"

The motion was _____ agreed to.

SYNOPSIS

Medicaid coverage of community behavioral health services

R.C. 5164.761 (primary), 103.41, 103.416, 103.42 (repealed), 5162.70, 5164.01, 5164.76, 5164.762, 5164.763, 5164.764, 5167.01, 5167.04, and 5167.041; Sections 812.20 and 812.30

Establishes requirements that must be met, including a requirement that a beta test succeed, before the Department of Medicaid may implement new Medicaid billing codes and payment rates for community behavioral health services.

Requires the Department, if new codes and rates for the services are implemented, to pay a claim for a service not later than ten days after the Department is notified by a provider that the provider was not paid within ten days after submitting a clean claim.

Restricts the Department's authority to make the Medicaid payment rate for such a service provided by an individual without a postgraduate degree less than the rate for the same service provided by an individual with a postgraduate degree.

Establishes requirements that must be met before the Department may include the services in Medicaid managed care, including a requirement that a beta test succeed.

Specifies provisions that must be included in a Medicaid managed care contract if the services are included in Medicaid managed care.

Requires the Department, if the services are included in Medicaid managed care, to pay a claim for a service not later than ten days after the Department is notified by a provider that the provider was not paid within ten days after submitting a clean claim to a Medicaid managed care organization.

Requires a Medicaid managed care organization to reimburse the Department for such a payment.

Establishes a seven-year prohibition against the Department making other changes to the Medicaid program's coverage of the services that negatively impact access to providers or the ability of providers to employ and contract with workers.

Establishes the Successful Transition and Evaluation Program Workgroup to determine whether the required beta tests succeed and to assess other changes to the Medicaid program's coverage of the services.

Gives the Joint Medicaid Oversight Committee ongoing duties to oversee the Medicaid program's coverage of the services, including voting on whether to permit the Department to (1) implement the new codes and rates for the services and (2) include

the services in Medicaid managed care. 571