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H.B. 780
136th General Assembly

Bill Analysis

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Version: As Introduced

Primary Sponsor: Rep. Brownlee

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SUMMARY

- Requires the Department of Medicaid to terminate the care management system within the Medicaid program and transition Medicaid recipients enrolled in a Medicaid managed care organization (MCO) plan to the fee-for-service component of the Medicaid program or a newly established managed fee-for-service component.
- Requires the Medicaid Director to contract with one or more administrative services organizations (ASOs) as a replacement for the care management system.
- Requires the Medicaid Director to ensure that 100% of all cost savings realized as a result of terminating the care management system be reinvested into the Medicaid program.
- Requires the Medicaid Director to convene a workgroup to provide recommendations concerning termination of the care management system and transition of Medicaid recipients.
- Designates the bill as the "Medicaid Savings Act."

DETAILED ANALYSIS

Elimination of the Medicaid care management system

Under current law, the Medicaid program provides payment for medical services rendered to Medicaid recipients through two delivery systems: fee-for-service and the care management system. Under the fee-for-service component, the Department directly pays Medicaid providers a set fee for the specific type of service rendered. Under the care management system, Medicaid managed care organizations (MCOs) are paid a capitated rate per

Medicaid recipient that is enrolled in the Medicaid MCO's plan. The bill requires the Department of Medicaid to undertake steps to terminate the Medicaid care management system.[1]

As part of this elimination, the Medicaid Director must not renew or enter into any new contracts between the Department and Medicaid MCOs, and instead contract with one or more administrative services organizations (ASOs) to provide administrative functions for the Department within the Medicaid program. The bill defines an "administrative services organization" as an entity under contract with the Department to perform administrative functions related to the Medicaid program, including claims processing, prior authorization review, provider credentialing and recruitment, customer service and grievance resolution, and data analytics and utilization monitoring.[2]

Additionally, the bill requires the Department to transition all Medicaid recipients enrolled in the care management system to the fee-for-service component of the Medicaid program or a newly established managed fee-for-service component of the Medicaid program. The bill defines "managed fee-for-service" as a Medicaid delivery model that combines direct payment to Medicaid providers for each encounter or service provided to a Medicaid recipient with periodic capitated payments for a range of additional indirect services, including care coordination and quality improvement.[3]

Workgroup

Members

In terminating the care management system, the bill requires the Medicaid Director, not later than 30 days after the bill's effective date, to convene a workgroup to establish a transition plan concerning the termination of the care management system. The workgroup must consist of Medicaid recipients, Medicaid providers, dentists, hospital representatives, nursing home representatives, representatives of the Ohio Association of Community Health Centers, representatives of the Ohio Association of Area Agencies on Aging, and any other stakeholders as determined by the Director.[4] Additionally, workgroup members must be evenly distributed from the following regions of the state:[5]

[1] R.C. 5162.73; R.C. Chapter 5167, repealed; conforming changes throughout the Revised Code.

[2] R.C. 5162.73(A)(1).

[3] R.C. 5162.73(A)(4).

[4] R.C. 5162.73(B).

[5] R.C. 5162.73(B)(2).

Workgroup regions	
Region	**Counties**
Region 1	Ashtabula, Cuyahoga, Geauga, Lake, Lorain
Region 2	Allen, Auglaize, Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Van Wert, Williams, Wood
Region 3	Athens, Belmont, Coshocton, Gallia, Guernsey, Harrison, Hocking, Jackson, Jefferson, Lawrence, Meigs, Monroe, Morgan, Muskingum, Noble, Perry, Pike, Ross, Scioto, Vinton, Washington
Region 4	Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, Warren
Region 5	Crawford, Delaware, Fairfield, Fayette, Franklin, Hardin, Knox, Licking, Logan, Madison, Marion, Morrow, Pickaway, Union, Wyandot
Region 6	Ashland, Carroll, Columbiana, Holmes, Mahoning, Medina, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas, Wayne
Region 7	Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble, Shelby

Recommendations

The bill requires the workgroup to establish recommendations for terminating the care management system and transitioning Medicaid recipients to an ASO-based model. The workgroup must consider all of the following when making recommendations:[6]

- The number of ASOs the Department should contract with to perform administrative functions related to the Medicaid program;
- The responsibilities related to the Medicaid program that will be overseen by ASOs;
- The Medicaid payment rate for services provided under the managed fee-for-service component of the Medicaid program, including whether providers should receive Medicaid payment in an amount that equals 100% of the Medicare payment rate for similar services;

[6] R.C. 5162.73(B)(3).

- How cost savings realized from the termination of the care management system should be redistributed within the Medicaid program;
- How to structure the care coordination component of the Medicaid program, including how to transition care coordination from Medicaid MCOs to Medicaid providers and how to provide providers with requisite training;
- How to structure and monitor office-based quality improvement activities.

In making recommendations concerning the structure of care coordination within the Medicaid program, the bill requires the workgroup to delineate the scope of care coordination activities that primary care providers will be responsible for overseeing and determine a capitated payment rate for care coordination services.[7] Similarly, when considering recommendations regarding quality improvement activities, the workgroup must consider (1) including a mechanism for determining high-impact clinical goals for improvement, (2) creation of metrics to measure quality improvements, and (3) establishing incentives for provider participation in quality improvement activities that include capitated payments, compensation for achieving intended outcomes, and continuing medical education credits.[8]

Not later than 12 months after the workgroup is convened, it must submit a report to the Medicaid Director detailing its recommendations for terminating the care management system.[9]

Procurement and rulemaking

Upon receiving the workgroup's report, the Medicaid Director must initiate a procurement process to select one or more ASOs as a replacement for the care management system. As part of the procurement process the Medicaid Director must (1) accept applications from entities seeking to become an ASO, (2) establish eligibility criteria that an entity must satisfy to become an ASO, and (3) not later than 180 days after receiving the workgroup's report, select and contract with one or more ASOs.[10]

Additionally, the bill requires the Medicaid Director to seek all necessary federal approval from the U.S. Centers for Medicare and Medicaid Services to implement the bill's requirements not later than 180 days after receiving the workgroup's recommendations.[11] The bill also requires the Medicaid Director to adopt all rules that are necessary to implement the workgroup's recommendations and the termination of the care management system.[12]

[7] R.C. 5162.73(B)(3)(e).

[8] R.C. 5162.73(B)(3)(f).

[9] R.C. 5162.73(B)(4).

[10] R.C. 5162.73(C)(2).

[11] R.C. 5162.73(C)(3).

[12] R.C. 5162.73(C)(1).

The bill also requires that the Medicaid Director ensure that 100% of all cost savings realized as a result of terminating the care management system are reinvested into the Medicaid program.[13]

Contract termination and transition

Beginning on the first day of the fiscal biennium that begins after the Medicaid Director enters into contracts with ASOs, the bill prohibits the Director from (1) renewing any existing contracts between the Department and Medicaid MCOs participating in the care management system or (2) entering into new contracts with Medicaid MCOs.[14] As soon as practicable after the start of that fiscal biennium, the Department must transition all Medicaid recipients enrolled in a Medicaid MCO plan to either the fee-for-service component of the Medicaid program or the managed fee-for-service component. The Department must also prepare and distribute guidance materials to assist individuals transitioning from a Medicaid MCO to a different service delivery model.[15]

After transitioning all necessary Medicaid recipients as described above, the bill requires the Medicaid Director to terminate all contracts and agreements between the Department and Medicaid MCOs. The Director must provide MCOs with at least 30 days' notice before terminating the contracts and agreements. The bill also requires each MCO to ensure that Medicaid providers receive payment for expenses incurred but not reported before the MCO's termination from participation in the care management system.[16]

Report

The bill requires the Medicaid Director to prepare and submit an annual report to the Governor and General Assembly detailing the actions the Department of Medicaid takes in terminating the care management system and transitioning Medicaid recipients. The report must include the following:[17]

- Medicaid program financial performance metrics related to the transition, including the total amount of savings experienced by the Medicaid program as a result of the transition;
- Clinical outcomes for and resource utilization by Medicaid recipients who transition from the care management system to the ASO system;
- Any other information that the Medicaid Director considers relevant regarding the transition.

[13] R.C. 5162.73(H).

[14] R.C. 5162.73(D).

[15] R.C. 5162.73(E).

[16] R.C. 5162.73(F).

[17] R.C. 5162.73(G).

Intent

The bill specifies that it is the intent of the General Assembly under the bill to terminate the care management system of the Medicaid program.[18]

HISTORY

Action	Date
Introduced	03-24-26

ANHB0780IN-136/ks

[18] R.C. 5162.73(I).