As Re-Referred by the House Rules and Reference Committee

133rd General Assembly
Regular Session **Sub. H. B. No. 11**
2019-2020

Representatives Manning, G., Howse
Cosponsors: Representatives Boyd, Russo, West

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 to address 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 providers, or spending for noncovered services.

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

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

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

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

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

(1) Counseling requirements for tobacco cessation medication;

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

(3) Cost-sharing requirements;

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

(a) Treatment that exceeds the duration recommended in the United States public health service clinical practice guidelines on treating tobacco use and dependence;

(b) Services associated with more than two attempts to quit using tobacco within a twelve-month period.

(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.

(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.

(F) Each insurance company or health plan providing health care benefits under section 124.82 of the Revised Code to state employees shall do both of the following:

(1) Inform state employees of the coverage required by this section;

(2) Market the coverage required by this section to state employees.

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.

(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 services provider, the family shall receive a copy of the educational materials.

(C) The educational materials developed and distributed under this section shall be culturally and linguistically appropriate for the families described in division (B) of this section.

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

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

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

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

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

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

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

(b) Health care facilities.

(2) To be eligible to participate in the grant program, an entity must demonstrate to the department that it can meet all of the following requirements:

(a) Has space to host groups of at least twelve pregnant women;

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

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

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

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

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

(e) Meets any other requirements established by the

department.

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

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

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

(E) A participating entity may employ or contract with licensed dental hygienists to educate pregnant women about the importance of prenatal and postnatal dental care.

(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.

Sec. 5162.20. (A) The department of medicaid shall institute cost-sharing requirements for the medicaid program. The department shall not institute cost-sharing requirements in a manner that does either of the following:

(1) Disproportionately impacts the ability of medicaid recipients with chronic illnesses to obtain medically necessary medicaid services;

(2) Violates section 5164.09 or 5164.10 of the Revised Code.

(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.

(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:

(a) Relieve the medicaid recipient from the obligation to pay a copayment;

(b) Prohibit the provider from attempting to collect an unpaid copayment.

(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.

(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:

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

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

(B) The department of medicaid shall not impose any of the following conditions with respect to the coverage required by this section:

(1) Counseling requirements for tobacco cessation medications;

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

(3) Cost-sharing requirements under section 5162.20 of the Revised Code;

(4) Prior authorization requirements, step therapy

protocols as defined in section 5164.7512 of the Revised Code, or any other utilization management requirements, except that prior authorization may be required for either of the following:

(a) Treatment that exceeds the duration recommended in the United States public health service clinical practice guidelines on treating tobacco use and dependence;

(b) Services associated with more than two attempts to quit using tobacco within a twelve-month period.

(C) 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.

(D) With respect to the coverage required by this section, the department of medicaid shall do both of the following:

(1) Inform medicaid recipients about the coverage;

(2) Market the coverage to Medicaid recipients.

Sec. ~~5164.10~~ 5164.16. The medicaid program may cover one or more state plan home and community-based services that the department of medicaid selects for coverage. A medicaid recipient of any age may receive a state plan home and community-based service if the recipient has countable income not exceeding two hundred twenty-five per cent of the federal poverty line, has a medical need for the service, and meets all

other eligibility requirements for the service specified in rules adopted under section 5164.02 of the Revised Code. The rules may not require a medicaid recipient to undergo a level of care determination to be eligible for a state plan home and community-based service.

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

Sec. 5167.01. As used in this chapter:

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

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

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

~~(C)~~ (D) "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)~~ (E) "ICDS participant" has the same meaning as in section 5164.01 of the Revised Code.

~~(E)~~ (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 MCO plan" means a plan that a medicaid managed care organization, pursuant to its contract with the department of medicaid under section 5167.10 of the Revised Code, makes available to medicaid recipients participating in

the care management system.

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

~~(G)~~ (I) "Nursing facility services" 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~~ MCO plan, 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. 5167.12. (A) ~~When contracting under section 5167.10 of the Revised Code with a managed care organization that is a health insuring corporation, the department of medicaid shall require the health insuring corporation to provide coverage of~~ Each medicaid managed care organization shall cover prescribed drugs for medicaid recipients enrolled in ~~the health insuring corporation~~ a medicaid MCO plan offered by the organization. In providing the required coverage, ~~the health insuring corporation~~ the organization may use strategies for the management of drug utilization, but any such strategies are subject to the limitations and requirements of this section and the ~~department's~~ approval of the department of medicaid.

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

(1) The drug is an antidepressant or antipsychotic.

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

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

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

(b) A psychiatrist who is practicing at a location on behalf of a community mental health services provider whose mental health services are certified by the department of mental 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 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) The Department of Medicaid shall establish and administer a program to provide dental services to pregnant Medicaid recipients. Under the program, a Medicaid recipient who is a member of the group described in section 5163.06 of the Revised Code shall be eligible to receive two dental cleanings per year. The Department shall give priority to those recipients residing in areas of the state with high preterm birth rates. The Department also shall inform Medicaid recipients about the program and market the program to Medicaid recipients.

(B) The Department of Medicaid shall establish reimbursement rates for entities that educate Medicaid recipients about the importance of prenatal and postnatal dental care as part of the program described in section 3701.615 of the Revised Code, including reimbursement rates for all or part of the costs associated with developing and distributing educational materials related to the importance of prenatal and postnatal dental care.

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

DOH DEPARTMENT OF HEALTH

General Revenue Fund		
GRF 440474 Infant Vitality	$3,500,000	$2,500,000
TOTAL GRF General Revenue Fund	$3,500,000	$2,500,000
TOTAL ALL BUDGET FUND GROUPS	$3,500,000	$2,500,000

INFANT VITALITY

Of the foregoing appropriation item 440474, Infant Vitality, $500,000 in fiscal year 2020 shall be used to provide planning grants to help entities meet the requirements of division (C)(2) of section 3701.615 of the Revised Code.

Of the foregoing appropriation item 440474, Infant Vitality, $3,000,000 in fiscal year 2020 and $2,500,000 in fiscal year 2021 shall be used in accordance with section 3701.615 of the Revised Code.

MCD DEPARTMENT OF MEDICAID

General Revenue Fund		
GRF 651531 Oral Healthcare	$2,500,000	$2,500,000
TOTAL GRF General Revenue Fund	$2,500,000	$2,500,000

TOTAL ALL BUDGET FUND GROUPS	$2,500,000	$2,500,000	386

ORAL HEALTHCARE 387

The foregoing appropriation item 651531, Oral Healthcare, shall be used in accordance with Section 3 of this act. 388 389

Section 5. Within the limits set forth in this act, the Director of Budget and Management shall establish accounts indicating the source and amount of funds for each appropriation made in this act, and shall determine the form and manner in which appropriation accounts shall be maintained. Expenditures from appropriations contained in this act shall be accounted for as though made in the main operating appropriations act of the 133rd General Assembly. 390 391 392 393 394 395 396 397

The appropriations made in this act are subject to all provisions of the main operating appropriations act of the 133rd General Assembly that are generally applicable to such appropriations. 398 399 400 401