

As Reported by the House Health Committee

133rd General Assembly

Regular Session

2019-2020

Sub. H. B. No. 11

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 19
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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(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: 67
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(1) Inform state employees of the coverage required by this section; 70
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(2) Market the coverage required by this section to state employees. 72
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Sec. 3701.614. (A) The department of health shall develop educational materials describing the health risks of lead-based 74
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paint and measures that may be taken to reduce those risks. 76

(B) As part of the home visiting services described in 77
section 3701.61 of the Revised Code, each eligible family 78
residing in a house, apartment, or other residence built before 79
January 1, 1979, shall receive a copy of the educational 80
materials described in this section. If the date on which the 81
residence was built is unknown to the family or home visiting 82
services provider, the family shall receive a copy of the 83
educational materials. 84

(C) The educational materials developed and distributed 85
under this section shall be culturally and linguistically 86
appropriate for the families described in division (B) of this 87
section. 88

Sec. 3701.615. (A) As used in this section: 89

(1) "Certified nurse-midwife," "certified nurse 90
practitioner," and "clinical nurse specialist" have the same 91
meanings as in section 4723.01 of the Revised Code. 92

(2) "Physician" means an individual authorized under 93
Chapter 4731. of the Revised Code to practice medicine and 94
surgery or osteopathic medicine and surgery. 95

(3) "Physician assistant" means an individual authorized 96
under Chapter 4730. of the Revised Code to practice as a 97
physician assistant. 98

(B) The department of health shall establish a grant 99
program to address the provision of prenatal health care 100
services to pregnant women on a group basis. The aim of the 101
program is to increase the number of pregnant women who begin 102
prenatal care early in their pregnancies and to reduce the 103
number of infants born preterm. 104

(C) (1) An entity seeking to participate in the grant 105
program shall apply to the department of health in a manner 106
prescribed by the department. Participating entities may include 107
the following: 108

(a) Medical practices, including those operated by or 109
employing one or more physicians, physician assistants, 110
certified nurse-midwives, certified nurse practitioners, or 111
clinical nurse specialists; 112

(b) Health care facilities. 113

(2) To be eligible to participate in the grant program, an 114
entity must demonstrate to the department that it can meet all 115
of the following requirements: 116

(a) Has space to host groups of at least twelve pregnant 117
women; 118

(b) Has adequate in-kind resources, including existing 119
medical staff, to provide necessary prenatal health care 120
services on both an individual and group basis; 121

(c) Provides prenatal care based on either of the 122
following: 123

(i) The centering pregnancy model of care developed by the 124
centering healthcare institute; 125

(ii) Another model of care acceptable to the department. 126

(d) Integrates health assessments, education, and support 127
into a unified program in which pregnant women at similar stages 128
of pregnancy meet, learn care skills, and participate in group 129
discussions; 130

(e) Meets any other requirements established by the 131

<u>department.</u>	132
<u>(D) When distributing funds under the program, the</u>	133
<u>department shall give priority to entities that are both of the</u>	134
<u>following:</u>	135
<u>(1) Operating in areas of the state with high preterm</u>	136
<u>birth rates, including rural areas and Cuyahoga, Franklin,</u>	137
<u>Hamilton, and Summit counties;</u>	138
<u>(2) Providing care to medicaid recipients who are members</u>	139
<u>of the group described in division (B) of section 5163.06 of the</u>	140
<u>Revised Code.</u>	141
<u>(E) A participating entity may employ or contract with</u>	142
<u>licensed dental hygienists to educate pregnant women about the</u>	143
<u>importance of prenatal and postnatal dental care.</u>	144
<u>(F) The department may adopt rules as necessary to</u>	145
<u>implement this section. The rules shall be adopted in accordance</u>	146
<u>with Chapter 119. of the Revised Code.</u>	147
Sec. 5162.20. (A) The department of medicaid shall	148
institute cost-sharing requirements for the medicaid program.	149
The department shall not institute cost-sharing requirements in	150
a manner that does either of the following:	151
(1) Disproportionately impacts the ability of medicaid	152
recipients with chronic illnesses to obtain medically necessary	153
medicaid services;	154
(2) Violates section 5164.09 <u>or 5164.10</u> of the Revised	155
Code.	156
(B) (1) No provider shall refuse to provide a service to a	157
medicaid recipient who is unable to pay a required copayment for	158
the service.	159

(2) Division (B)(1) of this section shall not be 160
considered to do either of the following with regard to a 161
medicaid recipient who is unable to pay a required copayment: 162

(a) Relieve the medicaid recipient from the obligation to 163
pay a copayment; 164

(b) Prohibit the provider from attempting to collect an 165
unpaid copayment. 166

(C) Except as provided in division (F) of this section, no 167
provider shall waive a medicaid recipient's obligation to pay 168
the provider a copayment. 169

(D) No provider or drug manufacturer, including the 170
manufacturer's representative, employee, independent contractor, 171
or agent, shall pay any copayment on behalf of a medicaid 172
recipient. 173

(E) If it is the routine business practice of a provider 174
to refuse service to any individual who owes an outstanding debt 175
to the provider, the provider may consider an unpaid copayment 176
imposed by the cost-sharing requirements as an outstanding debt 177
and may refuse service to a medicaid recipient who owes the 178
provider an outstanding debt. If the provider intends to refuse 179
service to a medicaid recipient who owes the provider an 180
outstanding debt, the provider shall notify the recipient of the 181
provider's intent to refuse service. 182

(F) In the case of a provider that is a hospital, the 183
cost-sharing program shall permit the hospital to take action to 184
collect a copayment by providing, at the time services are 185
rendered to a medicaid recipient, notice that a copayment may be 186
owed. If the hospital provides the notice and chooses not to 187
take any further action to pursue collection of the copayment, 188

the prohibition against waiving copayments specified in division 189
(C) of this section does not apply. 190

(G) The department of medicaid may collaborate with a 191
state agency that is administering, pursuant to a contract 192
entered into under section 5162.35 of the Revised Code, one or 193
more components, or one or more aspects of a component, of the 194
medicaid program as necessary for the state agency to apply the 195
cost-sharing requirements to the components or aspects of a 196
component that the state agency administers. 197

Sec. 5164.10. (A) The medicaid program shall cover both of 198
the following, subject to division (C) of this section: 199

(1) All tobacco cessation medications approved by the 200
United States food and drug administration; 201

(2) All forms of tobacco cessation services recommended by 202
the United States preventive services task force, including 203
individual, group, and telephone counseling and any combination 204
thereof. 205

(B) The department of medicaid shall not impose any of the 206
following conditions with respect to the coverage required by 207
this section: 208

(1) Counseling requirements for tobacco cessation 209
medications; 210

(2) Except as provided in division (B)(4) of this section, 211
limits on the duration of services, including annual or lifetime 212
limits on the number of covered attempts to quit using tobacco; 213

(3) Cost-sharing requirements under section 5162.20 of the 214
Revised Code; 215

(4) Prior authorization requirements, step therapy 216

protocols as defined in section 5164.7512 of the Revised Code, 217
or any other utilization management requirements, except that 218
prior authorization may be required for either of the following: 219

(a) Treatment that exceeds the duration recommended in the 220
United States public health service clinical practice guidelines 221
on treating tobacco use and dependence; 222

(b) Services associated with more than two attempts to 223
quit using tobacco within a twelve-month period. 224

(C) The director of health shall adopt rules in accordance 225
with Chapter 119. of the Revised Code that establish standards 226
and procedures for approving the forms of tobacco cessation 227
medications and services that must be covered under this 228
section. The rules shall also establish standards and procedures 229
for updating the approved forms of tobacco cessation medications 230
and services that must be covered under this section when the 231
approved forms are modified by the United States food and drug 232
administration, United States public health service, or United 233
States preventive services task force. 234

(D) With respect to the coverage required by this section, 235
the department of medicaid shall do both of the following: 236

(1) Inform medicaid recipients about the coverage; 237

(2) Market the coverage to Medicaid recipients. 238

Sec. ~~5164.10~~ 5164.16. The medicaid program may cover one 239
or more state plan home and community-based services that the 240
department of medicaid selects for coverage. A medicaid 241
recipient of any age may receive a state plan home and 242
community-based service if the recipient has countable income 243
not exceeding two hundred twenty-five per cent of the federal 244
poverty line, has a medical need for the service, and meets all 245

other eligibility requirements for the service specified in 246
rules adopted under section 5164.02 of the Revised Code. The 247
rules may not require a medicaid recipient to undergo a level of 248
care determination to be eligible for a state plan home and 249
community-based service. 250

Sec. 5164.17. The medicaid program may cover tobacco 251
cessation services in addition to the services that must be 252
covered under section 5164.10 of the Revised Code or may exclude 253
coverage of additional tobacco cessation services. 254

Sec. 5167.01. As used in this chapter: 255

(A) "Care management system" means the system established 256
under section 5167.03 of the Revised Code. 257

(B) "Controlled substance" has the same meaning as in 258
section 3719.01 of the Revised Code. 259

~~(B)~~ (C) "Dual eligible individual" has the same meaning as 260
in section 5160.01 of the Revised Code. 261

~~(C)~~ (D) "Emergency services" has the same meaning as in 262
the "Social Security Act," section 1932(b)(2), 42 U.S.C. 1396u- 263
2(b)(2). 264

~~(D)~~ (E) "ICDS participant" has the same meaning as in 265
section 5164.01 of the Revised Code. 266

~~(E)~~ (F) "Medicaid managed care organization" means a 267
managed care organization under contract with the department of 268
medicaid pursuant to section 5167.10 of the Revised Code. 269

~~(F)~~ (G) "Medicaid MCO plan" means a plan that a medicaid 270
managed care organization, pursuant to its contract with the 271
department of medicaid under section 5167.10 of the Revised 272
Code, makes available to medicaid recipients participating in 273

<u>the care management system.</u>	274
<u>(H)</u> "Medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code.	275 276
(G) <u>(I)</u> "Nursing facility services" has the same meaning as in section 5165.01 of the Revised Code.	277 278
(H) <u>(J)</u> "Prescribed drug" has the same meaning as in section 5164.01 of the Revised Code.	279 280
(I) <u>(K)</u> "Provider" means any person or government entity that furnishes services to a medicaid recipient enrolled in a medicaid managed care organization <u>MCO plan</u> , regardless of whether the person or entity has a provider agreement.	281 282 283 284
(J) <u>(L)</u> "Provider agreement" has the same meaning as in section 5164.01 of the Revised Code.	285 286
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 <u>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.</u> In providing the required coverage, the health insuring corporation <u>the organization</u> 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.	287 288 289 290 291 292 293 294 295 296 297 298
(B) The department shall not permit a health insuring corporation to <u>A medicaid managed care organization shall not</u> impose a prior authorization requirement in the case of a drug to which all of the following apply:	299 300 301 302

(1) The drug is an antidepressant or antipsychotic.	303
(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.	304 305 306 307
(3) The drug is prescribed by any of the following:	308
(a) A physician who is allowed by the health insuring corporation <u>medicaid managed care organization</u> to provide care as a psychiatrist through its credentialing process, as described in division (C) of section 5167.10 of the Revised Code;	309 310 311 312 313
(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;	314 315 316 317 318
(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;	319 320 321 322
(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.	323 324 325 326
(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.	327 328 329
(C) Subject to division (E) <u>(D)</u> of this section, the	330

~~department shall authorize a health insuring corporation to a~~ 331
medicaid managed care organization may develop and implement a 332
pharmacy utilization management program under which prior 333
authorization through the program is established as a condition 334
of obtaining a controlled substance pursuant to a prescription. 335

(D) ~~The department shall require a health insuring~~ 336
~~corporation to~~ Each medicaid managed care organization shall 337
comply with sections 5164.091, 5164.10, 5164.7511, 5164.7512, 338
and 5164.7514 of the Revised Code, as if the ~~health insuring~~ 339
~~corporation~~ organization were the department. 340

Section 2. That existing sections 5162.20, 5164.10, 341
5167.01, and 5167.12 of the Revised Code are hereby repealed. 342

Section 3. (A) The Department of Medicaid shall establish 343
and administer a program to provide dental services to pregnant 344
Medicaid recipients. Under the program, a Medicaid recipient who 345
is a member of the group described in section 5163.06 of the 346
Revised Code shall be eligible to receive two dental cleanings 347
per year. The Department shall give priority to those recipients 348
residing in areas of the state with high preterm birth rates. 349
The Department also shall inform Medicaid recipients about the 350
program and market the program to Medicaid recipients. 351

(B) The Department of Medicaid shall establish 352
reimbursement rates for entities that educate Medicaid 353
recipients about the importance of prenatal and postnatal dental 354
care as part of the program described in section 3701.615 of the 355
Revised Code, including reimbursement rates for all or part of 356
the costs associated with developing and distributing 357
educational materials related to the importance of prenatal and 358
postnatal dental care. 359

Section 4. All items in this section are hereby 360
appropriated as designated out of any moneys in the state 361
treasury to the credit of the designated fund. For all 362
appropriations made in this act, those in the first column are 363
for fiscal year 2020 and those in the second column are for 364
fiscal year 2021. The appropriations made in this act are in 365
addition to any other appropriations made for the FY 2020-FY 366
2021 biennium. 367

DOH DEPARTMENT OF HEALTH 368

General Revenue Fund 369

GRF 440474 Infant Vitality	\$3,500,000	\$2,500,000	370
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TOTAL GRF General Revenue Fund	\$3,500,000	\$2,500,000	371
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TOTAL ALL BUDGET FUND GROUPS	\$3,500,000	\$2,500,000	372
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INFANT VITALITY 373

Of the foregoing appropriation item 440474, Infant 374
Vitality, \$500,000 in fiscal year 2020 shall be used to provide 375
planning grants to help entities meet the requirements of 376
division (C) (2) of section 3701.615 of the Revised Code. 377

Of the foregoing appropriation item 440474, Infant 378
Vitality, \$3,000,000 in fiscal year 2020 and \$2,500,000 in 379
fiscal year 2021 shall be used in accordance with section 380
3701.615 of the Revised Code. 381

MCD DEPARTMENT OF MEDICAID 382

General Revenue Fund 383

GRF 651531 Oral Healthcare	\$2,500,000	\$2,500,000	384
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TOTAL GRF General Revenue Fund	\$2,500,000	\$2,500,000	385
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TOTAL ALL BUDGET FUND GROUPS	\$2,500,000	\$2,500,000	386
ORAL HEALTHCARE			387
The foregoing appropriation item 651531, Oral Healthcare,			388
shall be used in accordance with Section 3 of this act.			389
Section 5. Within the limits set forth in this act, the			390
Director of Budget and Management shall establish accounts			391
indicating the source and amount of funds for each appropriation			392
made in this act, and shall determine the form and manner in			393
which appropriation accounts shall be maintained. Expenditures			394
from appropriations contained in this act shall be accounted for			395
as though made in the main operating appropriations act of the			396
133rd General Assembly.			397
The appropriations made in this act are subject to all			398
provisions of the main operating appropriations act of the 133rd			399
General Assembly that are generally applicable to such			400
appropriations.			401