

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 1
5167.03 and to enact sections 103.416, 103.417, 2
5164.151, and 5167.04 of the Revised Code to 3
establish certain requirements regarding the 4
Medicaid program's coverage of community 5
behavioral health services. 6

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

Section 1. That sections 103.41, 5164.01, 5167.01, and 7
5167.03 be amended and sections 103.416, 103.417, 5164.151, and 8
5167.04 of the Revised Code be enacted to read as follows: 9

Sec. 103.41. (A) As used in sections 103.41 to ~~103.415~~ 10
103.417 of the Revised Code: 11

(1) "JMOC" means the joint medicaid oversight committee 12
created under this section. 13

(2) "State and local government medicaid agency" means all 14
of the following: 15

(a) The department of medicaid; 16

(b) The office of health transformation; 17

(c) Each state agency and political subdivision with which 18
the department of medicaid contracts under section 5162.35 of 19
the Revised Code to have the state agency or political 20
subdivision administer one or more components of the medicaid 21
program, or one or more aspects of a component, under the 22
department's supervision; 23

(d) Each agency of a political subdivision that is 24
responsible for administering one or more components of the 25
medicaid program, or one or more aspects of a component, under 26
the supervision of the department or a state agency or political 27
subdivision described in division (A) (2) (c) of this section. 28

(B) There is hereby created the joint medicaid oversight 29
committee. JMOC shall consist of the following members: 30

(1) Five members of the senate appointed by the president 31
of the senate, three of whom are members of the majority party 32
and two of whom are members of the minority party; 33

(2) Five members of the house of representatives appointed 34
by the speaker of the house of representatives, three of whom 35
are members of the majority party and two of whom are members of 36
the minority party. 37

(C) The term of each JMOC member shall begin on the day of 38
appointment to JMOC and end on the last day that the member 39
serves in the house (in the case of a member appointed by the 40
speaker) or senate (in the case of a member appointed by the 41
president) during the general assembly for which the member is 42
appointed to JMOC. The president and speaker shall make the 43
initial appointments not later than fifteen days after March 20, 44
2014. However, if this section takes effect before January 1, 45

2014, the president and speaker shall make the initial 46
appointments during the period beginning January 1, 2014, and 47
ending January 15, 2014. The president and speaker shall make 48
subsequent appointments not later than fifteen days after the 49
commencement of the first regular session of each general 50
assembly. JMOC members may be reappointed. A vacancy on JMOC 51
shall be filled in the same manner as the original appointment. 52

(D) In odd-numbered years, the speaker shall designate one 53
of the majority members from the house as the JMOC chairperson 54
and the president shall designate one of the minority members 55
from the senate as the JMOC ranking minority member. In even- 56
numbered years, the president shall designate one of the 57
majority members from the senate as the JMOC chairperson and the 58
speaker shall designate one of the minority members from the 59
house as the JMOC ranking minority member. 60

(E) In appointing members from the minority, and in 61
designating ranking minority members, the president and speaker 62
shall consult with the minority leader of their respective 63
houses. 64

(F) JMOC shall meet at the call of the JMOC chairperson. 65
The chairperson shall call JMOC to meet not less often than once 66
each calendar month, unless the chairperson and ranking minority 67
member agree that the chairperson should not call JMOC to meet 68
for a particular month. 69

(G) Notwithstanding section 101.26 of the Revised Code, 70
the members, when engaged in their duties as members of JMOC on 71
days when there is not a voting session of the member's house of 72
the general assembly, shall be paid at the per diem rate of one 73
hundred fifty dollars, and their necessary traveling expenses, 74
which shall be paid from the funds appropriated for the payment 75

of expenses of legislative committees. 76

(H) JMOC may employ professional, technical, and clerical 77
employees as are necessary for JMOC to be able successfully and 78
efficiently to perform its duties. All such employees are in the 79
unclassified service and serve at JMOC's pleasure. JMOC may 80
contract for the services of persons who are qualified by 81
education and experience to advise, consult with, or otherwise 82
assist JMOC in the performance of its duties. 83

(I) The JMOC chairperson, when authorized by JMOC and the 84
president and speaker, may issue subpoenas and subpoenas duces 85
tecum in aid of JMOC's performance of its duties. A subpoena may 86
require a witness in any part of the state to appear before JMOC 87
at a time and place designated in the subpoena to testify. A 88
subpoena duces tecum may require witnesses or other persons in 89
any part of the state to produce books, papers, records, and 90
other tangible evidence before JMOC at a time and place 91
designated in the subpoena duces tecum. A subpoena or subpoena 92
duces tecum shall be issued, served, and returned, and has 93
consequences, as specified in sections 101.41 to 101.45 of the 94
Revised Code. 95

(J) The JMOC chairperson may administer oaths to witnesses 96
appearing before JMOC. 97

Sec. 103.416. JMOC shall hold at least one public hearing 98
regarding proposed revisions to the medicaid program's coverage 99
of community behavioral health services that the department of 100
medicaid notifies JMOC of pursuant to section 5164.151 of the 101
Revised Code. Not later than three months after receiving the 102
notice, JMOC shall either approve or reject the proposed 103
revisions. 104

Sec. 103.417. JMOC may approve an order of phase-in of the 105
inclusion of community behavioral health services in the care 106
management system that differs from the order specified in 107
section 5167.04 of the Revised Code. 108

JMOC shall hold a public hearing regarding each report 109
about the phase-in that the department of medicaid submits to 110
JMOC under section 5167.04 of the Revised Code. Not later than 111
one month after receiving such a report, JMOC shall either 112
approve or reject the implementation of the next phase. 113

Sec. 5164.01. As used in this chapter: 114

(A) "Early and periodic screening, diagnostic, and 115
treatment services" has the same meaning as in the "Social 116
Security Act," section 1905(r), 42 U.S.C. 1396d(r). 117

(B) "Federal financial participation" has the same meaning 118
as in section 5160.01 of the Revised Code. 119

(C) "Healthcheck" means the component of the medicaid 120
program that provides early and periodic screening, diagnostic, 121
and treatment services. 122

(D) "Home and community-based services medicaid waiver 123
component" has the same meaning as in section 5166.01 of the 124
Revised Code. 125

(E) "Hospital" has the same meaning as in section 3727.01 126
of the Revised Code. 127

(F) "ICDS participant" means a dual eligible individual 128
who participates in the integrated care delivery system. 129

(G) "ICF/IID" has the same meaning as in section 5124.01 130
of the Revised Code. 131

(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. 159
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~~(P)~~~~(Q)~~ "Provider agreement" means an agreement to which all of the following apply: 161
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(1) It is between a medicaid provider and the department of medicaid; 163
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(2) It provides for the medicaid provider to provide medicaid services to medicaid recipients; 165
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(3) It complies with 42 C.F.R. 431.107(b). 167

~~(Q)~~~~(R)~~ "Terminal distributor of dangerous drugs" has the same meaning as in section 4729.01 of the Revised Code. 168
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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. 170
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(B) This section does not apply to either of the following: 178
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(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; 180
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(2) Including community behavioral health services in the care management system pursuant to section 5167.04 of the Revised Code. 183
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Sec. 5167.01. As used in this chapter:	186
(A) "Controlled substance" has the same meaning as in section 3719.01 of the Revised Code.	187 188
(B) "Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.	189 190
(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).	191 192 193
(D) "Home and community-based services medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code.	194 195 196
(E) <u>"JMOC" means the joint medicaid oversight committee created under section 103.41 of the Revised Code.</u>	197 198
<u>(F)</u> "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.	199 200 201
(F) <u>(G)</u> "Medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code.	202 203
(G) <u>(H)</u> "Nursing facility" has the same meaning as in section 5165.01 of the Revised Code.	204 205
(H) <u>(I)</u> "Prescribed drug" has the same meaning as in section 5164.01 of the Revised Code.	206 207
(I) <u>(J)</u> "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.	208 209 210 211
(J) <u>(K)</u> "Provider agreement" has the same meaning as in	212

section 5164.01 of the Revised Code. 213

Sec. 5167.03. (A) As part of the medicaid program, the 214
department of medicaid shall establish a care management system. 215

(B) The department shall implement the care management 216
system in some or all counties and shall designate the medicaid 217
recipients who are required or permitted to participate in the 218
system. In the department's implementation of the system and 219
designation of participants, all both of the following apply: 220

(1) In the case of individuals who receive medicaid on the 221
basis of being included in the category identified by the 222
department as covered families and children, the department 223
shall implement the care management system in all counties. All 224
individuals included in the category shall be designated for 225
participation, except for individuals included in one or more of 226
the medicaid recipient groups specified in 42 C.F.R. 438.50(d). 227
The department shall ensure that all participants are enrolled 228
in medicaid managed care organizations that are health insuring 229
corporations. 230

(2) In the case of individuals who receive medicaid on the 231
basis of being aged, blind, or disabled, the department shall 232
implement the care management system in all counties. Except as 233
provided in division (C) of this section, all individuals 234
included in the category shall be designated for participation. 235
The department shall ensure that all participants are enrolled 236
in medicaid managed care organizations that are health insuring 237
corporations. 238

~~(3) Alcohol, drug addiction, and mental health services 239
covered by medicaid shall not be included in any component of 240
the care management system when the nonfederal share of the cost 241~~

~~of those services is provided by a board of alcohol, drug 242
addiction, and mental health services or a state agency other 243
than the department of medicaid, but the recipients of those 244
services may otherwise be designated for participation in the 245
system. 246~~

(C) (1) In designating participants who receive medicaid on 247
the basis of being aged, blind, or disabled, the department 248
shall not include any of the following, except as provided under 249
division (C) (2) of this section: 250

(a) Individuals who are under twenty-one years of age; 251

(b) Individuals who are institutionalized; 252

(c) Individuals who become eligible for medicaid by 253
spending down their income or resources to a level that meets 254
the medicaid program's financial eligibility requirements; 255

(d) Dual eligible individuals; 256

(e) Individuals to the extent that they are receiving 257
medicaid services through a medicaid waiver component. 258

(2) The department may designate any of the following 259
individuals who receive medicaid on the basis of being aged, 260
blind, or disabled as individuals who are permitted or required 261
to participate in the care management system: 262

(a) Individuals who are under twenty-one years of age; 263

(b) Individuals who reside in a nursing facility; 264

(c) Individuals who, as an alternative to receiving 265
nursing facility services, are participating in a home and 266
community-based services medicaid waiver component; 267

(d) Dual eligible individuals. 268

(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; 298

(4) Community mental health services for children with serious emotional disorders may be included fourth; 299
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(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; 301
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(6) Community mental health services for other children may be included sixth; 307
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(7) Community alcohol and drug addiction services for children may be included seventh. 309
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(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. 311
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(D) If the department includes community behavioral health services in the care management system, all of the following apply: 320
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(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 323
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services in effect on June 30, 2016. 327

(2) In accordance with the phase-in of community- 328
behavioral health services, each medicaid managed care 329
organization shall be responsible for providing or arranging for 330
the provision of, on behalf of the medicaid recipients enrolled 331
in the organization, all community behavioral health services 332
included in the continuum of care that boards of alcohol, drug 333
addiction, and mental health services are required to establish 334
under section 340.03 of the Revised Code. 335

(3) A medicaid managed care organization shall not do any 336
of the following: 337

(a) Establish prior authorization requirements for the 338
community behavioral health services; 339

(b) Limit the number of treatment visits a medicaid 340
recipient enrolled in the organization may have with a provider 341
of community behavioral health services or otherwise place 342
arbitrary limits on other treatment units of the services; 343

(c) In the case of medicaid recipients enrolled in the 344
organization who are children who have been adjudicated abused, 345
neglected, dependent, delinquent, or unruly, limit access to 346
community behavioral health services in a manner that is more 347
restrictive than the access the children have to community 348
behavioral health services under the child welfare system; 349

(d) Except as provided in division (D)(3)(e) of this 350
section, refuse to permit a qualified and willing provider of 351
community behavioral health services to join the organization's 352
provider network; 353

(e) Include specialty pharmacies in the organization's 354
provider network. 355

(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: 356
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(a) Pay the provider of the service the balance due plus the following percentage of the balance: 361
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(i) Ten per cent if the department makes the payment not later than sixty days after the organization's deadline for paying the claim; 363
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(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; 366
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(iii) Thirty per cent if the department makes the payment later than seventy-five days after the organization's deadline for paying the claim. 369
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(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. 372
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Section 2. That existing sections 103.41, 5164.01, 5167.01, and 5167.03 of the Revised Code are hereby repealed. 376
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Section 3. (A) There is hereby established the Medicaid Coverage of Community Behavioral Health Services Study Group. 378
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The group shall consist of all of the following: 380

(1) The Medicaid Director or the Director's designee; 381

(2) The Director of Mental Health and Addiction Services or the Director's designee; 382
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(3) One representative of each of the following appointed by the Medicaid Director:	384 385
(a) The Ohio Association of Health Plans;	386
(b) The Ohio Council of Behavioral Health and Family Services Providers;	387 388
(c) The Public Children Services Association of Ohio;	389
(d) The Ohio Association of Child Caring Agencies;	390
(e) The Ohio Association of County Behavioral Health Authorities;	391 392
(f) The National Alliance on Mental Illness of Ohio;	393
(g) The Ohio Citizen Advocates for Addiction Recovery;	394
(h) The Ohio Alliance of Recovery Providers.	395
(4) Three consumers of community behavioral health services appointed by the Medicaid Director;	396 397
(5) Three family members of consumers of community behavioral health services appointed by the Medicaid Director.	398 399
(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.	400 401 402 403 404 405 406
(C) The Medicaid Director shall serve as the group's chairperson. The Department of Medicaid shall provide necessary support services for the group.	407 408 409

(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; 438

(b) Oversee the delegated care coordination. 439

(8) Having the Department of Medicaid contract with a 440
Medicaid managed care organization that specializes in 441
behavioral health services to provide both of the following: 442

(a) Comprehensive services to Medicaid recipients with an 443
intense need for community behavioral health services; 444

(b) Non-comprehensive services to Medicaid recipients with 445
a non-intense need for community behavioral health services. 446

(9) Making the revisions to the Medicaid program budget 447
neutral. 448

(E) (1) The group shall complete a report of its study and 449
recommendations not later than nine months after the effective 450
date of this section. The group shall submit the report to all 451
of the following: 452

(a) The Governor; 453

(b) In accordance with section 101.68 of the Revised Code, 454
the General Assembly; 455

(c) The Joint Medicaid Oversight Committee. 456

(2) The group shall cease to exist on submission of the 457
report. 458