Sub. H.B. 49 As Passed by the House

_____ moved to amend as follows:

In line 3 of the title, delete "103.42,"	1
In line 212 of the title, after "5164.753," insert "5164.76,"	2
In line 245 of the title, delete "103.42 (103.416),"	3
In line 258 of the title, after "102.023," insert "103.416,"	4
In line 292 of the title, after "5164.69," insert "5164.761,	5
5164.762, 5164.763, 5164.764,"	б
In line 293 of the title, after "5166.38," insert "5167.041,"	7
In line 302 of the title, after "sections" insert "103.42,"	8
In line 500, delete "103.42,"	9
In line 630, after "5164.753," insert "5164.76,"	10
In line 653, delete "103.42"	11
In line 654, delete "(103.416),"	12
In line 659, after "102.023," insert "103.416,"	13
In line 679, after "5164.69," insert "5164.761, 5164.762,	14
5164.763, 5164.764,"	15
In line 680, after "5166.38," insert "5167.041,"	16
In line 2258, after "(1)" insert " <u>"Care management system"</u>	17
means the system established under section 5167.03 of the Revised	18

Code.	19
(2) "Community behavioral health services" has the same	20
meaning as in section 5164.01 of the Revised Code.	21
<u>(3)</u> "	22
In line 2260, strike through "(2)" and insert " (4) "	23
In line 2274, strike through "(2)" and insert " (4) "	24
Strike through lines 2289 through 2292	25
In line 2293, strike through "beginning January 1, 2014, and ending January 15, 2014."	26 27
In line 2294, strike through "subsequent"	28
Delete lines 2343 through 2368 and insert:	29
"Sec. 103.416. (A) JMOC shall oversee changes to the medicaid	30
program's coverage of community behavioral health services. As	31
part of its oversight duties, JMOC shall do all of the following:	32
(1) Receive and consider the reports from the successful	33
transition and evaluation program workgroup established by section	34
5164.764 of the Revised Code;	35
(2) Receive and consider information provided to JMOC by the	36
department of medicaid, department of mental health and addiction	37
services, providers of the services, and other persons about the	38
medicaid program's coverage of the services;	39
(3) Determine, by a majority vote, whether to do any of the	40
<u>following:</u>	41
(a) For the purpose of division (A)(3) of section 5164.761 of	42
the Revised Code, permit the department of medicaid to implement	43
new medicaid billing codes and payment rates for the services.	44
(b) Approve the process that the department establishes under	45

division (B) of section 5164.761 of the Revised Code to ensure	46
that medicaid providers of the services are not put at financial	47
risk as a result of any such new medicaid billing codes and	48
payment rates.	49
(c) For the purpose of division (C) of section 5167.04 of the	50
Revised Code, permit the department to include the services in the	51
care management system.	52
(d) Approve the process that the department establishes under	53
division (A)(1) of section 5167.041 of the Revised Code to ensure	54
that providers of the services are not put at financial risk as a	55
result of the services being included in the care management	56
system.	57
(e) For the purpose of division (F) of section 5164.764 of	58
the Revised Code and subject to division (B) of this section,	59
specify the date that the successful transition and evaluation	60
program workgroup is to cease to exist.	61
(B) The date that JMOC specifies under division (A)(3)(e) of	62
this section for the successful transition and evaluation program	63
workgroup to cease to exist shall not be sooner than seven years	64
after the date that medicaid-covered community behavioral health	65
services begin to be included in the care management system."	66
In line 84504, reinsert the semicolon	67
Reinsert lines 84505 and 84506	68
In line 84507, reinsert the first "health"; after the first	69
stricken comma insert "and, subject to sections 5167.04 and	70
5167.041 of the Revised Code, community"; reinsert "behavioral	71
health"	72
In line 84508, reinsert "services covered by medicaid"	73

In line 84546, after "(B)" insert " <u>"Care management system"</u>	74
means the system established under section 5167.03 of the Revised	75
<u>Code.</u>	76
(C) "Clean claim" has the same meaning as in 42 C.F.R.	77
<u>447.45(b).</u>	78
(D) "Community behavioral health services" means both of the	79
following:	80
(1) Alcohol and drug addiction services provided by a	81
community addiction services provider, as defined in section	82
5119.01 of the Revised Code;	83
(2) Mental health services provided by a community mental	84
health services provider, as defined in section 5119.01 of the	85
Revised Code.	86
<u>(E)</u> "	87
In line 84549, strike through "(C)" and insert " (F) "	88
In line 84551, strike through "(D)" and insert " <u>(G)</u> "	89
In line 84553, delete " (E) " and insert " (H) "	90
In line 84556, delete " (F) " and insert " (I) "	91
In line 84559, delete " (G) " and insert " (J) "	92
In line 84561, delete " <u>(H)</u> " and insert " <u>(K)</u> "	93
In line 84563, delete " <u>(I)</u> " and insert " <u>(L)</u> "	94
In line 84565, delete " <u>(J)</u> " and insert " <u>(M)</u> "	95
In line 84568, delete " <u>(K)</u> " and insert " <u>(N)</u> "	96
In line 84572, delete " <u>(L)</u> " and insert " <u>(O)</u> "	97
In line 84574, delete " <u>(M)</u> " and insert " <u>(P)</u> "	98
In line 84580, delete "(N)" and insert "(Q)"	99

In line 84584, delete " <u>(O)</u> " and inse	rt " <u>(R)</u> " 100
In line 84586, delete " <u>(P)</u> " and inse	rt " <u>(S)</u> " 101
In line 84590, delete " <u>(O)</u> " and inse	rt " <u>(T)</u> " 102
In line 84592, delete " <u>(R)</u> " and inse	rt " <u>(U)</u> " 103
In line 84599, delete " <u>(S)</u> " and inse	rt " <u>(V)</u> " 104
In line 84604, delete " <u>(T)</u> " and inse	rt " <u>(W)</u> " 105
Between lines 85606 and 85607, inser	106

"Sec. 5164.76. (A) In Subject to sections 5164.761 and 107
5164.762 of the Revised Code, the medicaid director, in rules 108
adopted under section 5164.02 of the Revised Code, the medicaid 109
director shall modify the manner or establish a new manner in 110
which the following are paid under medicaid: 111

(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;
114

(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.

implement new medicaid billing codes or payment rates for 120	<u>Sec. 5164.761.</u>	(A) Before the department of medicaid may	125
	implement new medica	aid billing codes or payment rates for	126

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community behavioral health services during the period that begins	127
on the effective date of this section and ends on the date that	128
the successful transition and evaluation program workgroup	129
established under section 5164.764 of the Revised Code ceases to	130
exist, all of the following must occur:	131
(1) The department must require all medicaid providers of	132
community behavioral health services to participate in a beta test	133
of the new codes and rates as a condition of participating in	134
medicaid.	135
(2) The beta test must be successfully completed as evidenced	136
by showing to the satisfaction of the successful transition and	137
evaluation program workgroup that, had the new codes and rates for	138
the services been in effect during the beta test, at least fifty	139
per cent of the medicaid providers that submitted clean claims	140
under the beta test would have been paid the correct amount for	141
the services not later than ten days after the date the clean	142
<u>claim was submitted.</u>	143
(3) The joint medicaid oversight committee must have voted,	144
pursuant to section 103.416 of the Revised Code to permit the	145
department to implement the new codes and rates.	146
(4) The department must notify all medicaid providers of	147
community behavioral health services that the new codes and rates	148
are to take effect on a date specified in the notice, which shall	149
not be sooner than sixty days after the date of the notice.	150
(B) If the department implements new medicaid billing codes	151
or payment rates for community behavioral health services, the	152
department shall establish a process to ensure that medicaid	153
providers of the services are not put at financial risk as a	154
result of the implementation. The process is subject to the	155
approval of the joint medicaid oversight committee pursuant to	156

section 103.416 of the Revised Code and shall do both of the	157
<u>following:</u>	158
(1) Authorize a medicaid provider to notify the department if	159
the provider does not receive, within ten days after a clean claim	160
for the service is properly submitted, a full medicaid payment for	161
the service;	162
(2) Require the department to pay the clean claim in full not	163
later than ten days after receiving the medicaid provider's	164
notice.	165
Sec. 5164.762. Until two years after the effective date of	166
this section, the medicaid payment rate for a community behavioral	167
health service provided by an individual without a postgraduate	168
degree may not be less than the medicaid payment rate for the same	169
service provided by an individual with a postgraduate degree. If	170
the department of medicaid implements such a revision to the	171
medicaid payment rates for community behavioral health services	172
after the two-year period, the revision shall be phased in over	173
<u>five years as follows:</u>	174
(A) During the first year, the percentage difference between	175
the payment rates shall be one-fifth of the total percentage	176
difference that is to go into effect in the fifth year.	177
(B) During the second year, the percentage difference between	178
the payment rates shall be two-fifths of the total percentage	179
difference that is to go into effect in the fifth year.	180
(C) During the third year, the percentage difference between	181
the payment rates shall be three-fifths of the total percentage	182
difference that is to go into effect in the fifth year.	183
(D) During the fourth year, the percentage difference between	184

the payment rates shall be four-fifths of the total percentage	185
difference that is to go into effect in the fifth year.	186
(E) Beginning with the fifth year, the percentage difference	187
is the full amount intended by the revision.	188
Sec. 5164.763. (A) During the first seven years after the	189
effective date of this section, the department of medicaid shall	190
not make any changes to the medicaid program's coverage of	191
community behavioral health services that would decrease the	192
number of willing and qualified medicaid providers of the services	193
or impair the ability of a medicaid provider to employ or contract	194
for individuals to provide the services on the provider's behalf.	195
This includes both of the following:	196
(1) Except as otherwise required by federal or state law and	197
notwithstanding section 5164.33 of the Revised Code, doing either	198
of the following for any reason not related to a provider's	199
competence to provide the services:	200
(a) Denying, refusing to revalidate, suspending, or	201
terminating a provider agreement;	202
(b) Otherwise excluding an individual, provider, or other	203
entity from participation in the medicaid program.	204
(2) Impairing the ability of an individual to complete	205
clinical training with a provider of community behavioral health	206
services needed to obtain a relevant postgraduate degree,	207
including by requiring the individual to work under direct	208
supervision.	209
(B) Changes to the medicaid program's coverage of community	210
behavioral health services made in accordance with section	211
5164.761, 5164.762, or 5167.04 of the Revised Code do not violate	212

division (A) of this section.

sec. 5164.764. (A) There is hereby established the successful 214 transition and evaluation program workgroup. The workgroup shall 215 consist of all of the following: 216 (1) The medicaid director, or the director's designee, and 217 representatives of the department of medicaid appointed to the 218 workgroup by the director; 219 (2) The director of mental health and addiction services, or 220 the director's designee, and representatives of the department of 221 mental health and addiction services appointed to the workgroup by 222 223 the director; (3) Representatives of providers of community behavioral 224 health services appointed by the medicaid director. 225 (B) Appointments to the workgroup shall be made not later 226 than thirty days after the effective date of this section. Each 227 member shall serve without compensation or reimbursement for 228 expenses incurred while serving on the workgroup, except to the 229 extent that serving on the workgroup is considered to be among the 230 member's employment duties. 231 (C) The medicaid director, or the director's designee, shall 232 serve as chairperson of the workgroup. The department of medicaid 233 shall provide the workgroup with any necessary administrative 234 assistance. 235 (D) The workgroup shall do all of the following: 236 (1) Determine, in accordance with division (A)(2) of section 237 5164.761 of the Revised Code, whether the beta test of new 238 medicaid billing codes and payment rates for community behavioral 239 health services has been successfully completed. 240

213

(2) Determine, in accordance with division (B) of section	241
5167.04 of the Revised Code, whether the beta test of the	242
inclusion of medicaid-covered community behavioral health services	243
in the care management system has been successfully completed.	244
(3) Assess changes to the medicaid program's coverage of	245
community behavioral health services in an effort to maintain the	246
stability of the state's community behavioral health system and	247
the access of the residents of this state to community behavioral	248
health services.	249
(E) The workgroup shall regularly report to the joint	250
medicaid oversight committee about its determinations and	251
assessments under division (D) of this section.	252
(F) The workgroup shall cease to exist on the date specified	253
by the joint medicaid oversight committee pursuant to section	254
103.416 of the Revised Code."	255
In line 87862, after "(A)" insert " <u>"Clean claim" has the same</u>	256
<u>meaning as in 42 C.F.R. 447.45(b).</u>	257
(B) "Community behavioral health services" has the same	258
meaning as in section 5164.01 of the Revised Code.	259
<u>(C)</u> "	260
In line 87864, strike through "(B)" and insert " <u>(D)</u> "	261
In line 87866, strike through "(C)" and insert " (E) "	262
In line 87869, strike through "(D)"	263
In line 87870, after " component" " insert " <u>(F)</u> "	264
In line 87872, strike through "(E)" and insert " <u>(G)</u> "	265
In line 87875, strike through "(F)" and insert " <u>(H)</u> "	266
In line 87877, strike through "(G)" and insert " <u>(I)</u> "	267

In line 87879, strike through "(H)" and insert " <u>(J)</u> "	268
In line 87881, strike through "(I)" and insert " (K) "	269
In line 87885, strike through "(J)" and insert " (L) "	270
Delete lines 87915 through 87936 and insert:	271

"Sec. 5167.04. (A) Subject to division (B) of this section, 272 <u>Before</u> the department of medicaid shall <u>may</u> include alcohol, drug 273 addiction, and mental health services covered by medicaid 274 medicaid-covered community behavioral health services in the care 275 management system established under section 5167.03 of the Revised 276 Code during the period that begins on the effective date of this 277 amendment and ends on the date that the successful transition and 278 evaluation program workgroup established under section 5164.764 of 279 the Revised Code ceases to exist, all of the following must occur: 280

(A) The department must require all medicaid providers of the281services to participate in a beta test of the inclusion as a282condition of participating in medicaid.283

(B) The beta test must be successfully completed as evidenced 284 by showing to the satisfaction of the successful transition and 285 evaluation program workgroup that, had the services been included 286 in the care management system at that time, at least fifty per 287 cent of the providers that submitted clean claims to medicaid 288 managed care organizations under the beta test would have been 289 paid the correct amount for the services not later than ten days 290 after the date the clean claim was submitted. 291

(C) The joint medicaid oversight committee must have voted292pursuant to section 103.416 of the Revised Code to permit the293department to include the services in the care management system.294

(D) The department must notify all medicaid providers of the 295

services of both of the following:	296
(1) That the services are to begin to be included in the care	297
management system beginning on a date specified in the notice,	298
which shall not be sooner than sixty days after the date of the	299
<u>notice;</u>	300
(2) The procedures for becoming providers under the care	301
management system.	302
(B) All of the following apply to the manner in which	303
division (A) of this section is implemented:	304
(1) The department shall begin to include the services in the	305
system not later than January 1, 2018.	306
(2) Before January 1, 2018, any proposal by the department to	307
include all or part of the services in all or part of the system	308
is subject to review by the joint medicaid oversight committee	309
under division (B) of section 103.42 of the Revised Code. The	310
department may implement the proposal only if the committee	311
approves the proposal.	312
(3) On and after January 1, 2018, any proposal by the	313
department to include all or part of the services in all or part	314
of the system is subject to monitoring by the committee under	315
division (A) or (C) of section 103.42 of the Revised Code, but	316
approval by the committee is no longer required before the	317
proposal may be implemented.	318
Dec. F1CT 041 (N) If modified community behaviour	210
Sec. 5167.041. (A) If medicaid-covered community behavioral	319
health services begin to be included in the care management system	320
established under section 5167.03 of the Revised Code, both of the	321
following shall apply:	322
(1) The department of medicaid shall establish a process	323

consistent with division (B) of this section to ensure that	324
providers of the services are not put at financial risk as a	325
result of the services being included in the care management	326
system.	327
(2) Each contract between the department and a medicaid	328
managed care organization shall include all of the following:	329
(a) A prohibition against the organization doing any of the	330
following:	331
(i) Requiring that providers submit payment claims to the	332
organization sooner than one year after the date the provider	333
provides the service to a medicaid recipient enrolled in the	334
organization;	335
	555
(ii) Requiring that prior authorization be obtained for	336
services provided on an outpatient basis;	337
(iii) Excluding a provider from the organization's provider	338
panel if the provider's certifiable services and supports, as	339
defined in section 5119.01 of the Revised Code, are certified and	340
in good standing under section 5119.36 of the Revised Code.	341
(b) A provision that permits medicaid recipients to disenroll	342
from one medicaid managed care organization and enroll in another	343
medicaid managed care organization only once a year and only	344
during an annual open enrollment period;	345
(c) A requirement that the medicaid managed care organization	346
comply with sections 5164.762 and 5164.763 of the Revised Code as	347
if the organization were the department.	348
(B) The process established under division (A)(1) of this	349
section is subject to the approval of the joint medicaid oversight	350
committee pursuant to section 103.416 of the Revised Code and	351
shall do all of the following:	352

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(1) Authorize a provider of community behavioral health	353		
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;	356		
(2) Require the department to pay the clean claim in full not	357		
later than ten days after receiving the provider's notice;	358		
(3) Require the medicaid managed care organization to	359		
reimburse the department in full for the payment."			
In line 105414, delete "103.42,"	361		
In line 105544, after "5164.753," insert "5164.76,"	362		
In line 105568, after "sections" insert "103.42,"	363		
Delete lines 134533 through 134563	364		
In line 142889, after "amendment" insert ", enactment, or	365		
repeal"; delete "section" and insert "sections 103.416, 103.42,	366		
5162.70,"; after "5164.753" insert ", 5164.76, 5164.761, 5164.762,	367		
5164.763, 5164.764, 5167.01, 5167.04, and 5167.041"	368		
Between lines 142901 and 142902, insert:	369		
"Section 812 The sections that are listed in the	370		
left-hand column of the following table combine amendments by this	371		
act that are and that are not exempt from the referendum under	372		
Ohio Constitution, Article II, sections 1c and 1d and section	373		
1.471 of the Revised Code.	374		
The middle column identifies the amendments to the listed	375		
sections that are subject to the referendum under Ohio	376		
Constitution, Article II, section 1c and therefore take effect on	377		
the ninety-first day after this act is filed with the Secretary of	378		
State or, if a later effective date is specified, on that date.	379		
The right-hand column identifies the amendments to the listed	380		

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sections that are exempt from the referendum under Ohio			
Constitution, Article II, section 1d and section 1.471 of the			
Revised Code and therefore take effect immediately when this act			383
becomes law or, if a later effective date is specified, on that			384
date.			385
Section of	Amendments subject to the	Amendments exempt from	386
law	referendum	the referendum	
103.41	All amendments except for	The amendments in	387
	those described in the	division (A) take	
	right-hand column	effect July 1, 2017	
5164.01	The amendments adding	All amendments except	388
	definitions for the terms	for those described in	
	"federal poverty line" and	the middle column take	
	"state plan home and	effect July 1, 2017"	
	community-based services" in		
	what will be, because of the		
	amendments, divisions (G) and		
	(V)		

The motion was _____ agreed to.

SYNOPSIS

Medicaid coverage of community behavioral health services	389
R.C. 5164.761 (primary), 103.41, 103.416, 103.42 (repealed),	390
5162.70, 5164.01, 5164.76, 5164.762, 5164.763, 5164.764, 5167.01,	391
5167.04, and 5167.041; Sections 333.260 (removed from the bill),	392
812.20, and 812	393

Removes the House provisions that would have prohibited (1) 394 alcohol, drug addiction, and mental health services from being 395

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included in Medicaid managed care before July 1, 2018, and (2) 396 other elements of the behavioral health redesign from being 398 implemented before January 1, 2018.

Establishes requirements that must be met, including a 399 requirement that a beta test succeed, before the Department of 400 Medicaid may implement new Medicaid billing codes and payment 401 rates for community behavioral health services. 402

Requires the Department, if new codes and rates for the 403 services are implemented, to pay a claim for a service not later 404 than ten days after the Department is notified by a provider that 405 the provider was not paid within ten days after submitting a clean 406 claim. 407

Restricts the Department's authority to make the Medicaid408payment rate for such a service provided by an individual without409a postgraduate degree less than the rate for the same service410provided by an individual with a postgraduate degree.411

Establishes requirements that must be met before the 412 Department may include the services in Medicaid managed care, 413 including a requirement that a beta test succeed. 414

Specifies provisions that must be included in a Medicaid 415 managed care contract if the services are included in Medicaid 416 managed care. 417

Requires the Department, if the services are included in 418 Medicaid managed care, to pay a claim for a service not later than 419 ten days after the Department is notified by a provider that the 420 provider was not paid within ten days after submitting a clean 421 claim to a Medicaid managed care organization. 422

Requires a Medicaid managed care organization to reimburse 423 the Department for such a payment. 424 Establishes a seven-year prohibition against the Department 425 making other changes to the Medicaid program's coverage of the 426 services that negatively impact access to providers or the ability 427 of providers to employ and contract with workers. 428

Establishes the Successful Transition and Evaluation Program 429 Workgroup to determine whether the required beta tests succeed and 430 to assess other changes to the Medicaid program's coverage of the 431 services. 432

Gives the Joint Medicaid Oversight Committee ongoing duties 433 to oversee the Medicaid program's coverage of the services, 434 including voting on whether to permit the Department to (1) 435 implement the new codes and rates for the services and (2) include 436 the services in Medicaid managed care. 437