Sub. H.B. 49

As Passed by the House

_____ moved to amend as follows:

In line 3 of the title, delete "103.42,"

In line 212 of the title, after "5164.753," insert "5164.76,"

In line 245 of the title, delete "103.42 (103.416),"

In line 258 of the title, after "102.023," insert "103.416,"

In line 292 of the title, after "5164.69," insert "5164.761, 5164.762, 5164.763, 5164.764,"

In line 293 of the title, after "5166.38," insert "5167.041,"

In line 302 of the title, after "sections" insert "103.42,"

In line 500, delete "103.42,"

In line 630, after "5164.753," insert "5164.76,"

In line 653, delete "103.42"

In line 654, delete "(103.416),"

In line 659, after "102.023," insert "103.416,"

In line 679, after "5164.69," insert "5164.761, 5164.762, 5164.763, 5164.764,"

In line 680, after "5166.38," insert "5167.041,"

In line 2258, after "(1)" insert "<u>"Care management system" means the system established under section 5167.03 of the Revised</u>

Code.

(2) "Community behavioral health services" has the same meaning as in section 5164.01 of the Revised Code.

(3)"

In line 2260, strike through "(2)" and insert "(4)"

In line 2274, strike through "(2)" and insert "(4)"

Strike through lines 2289 through 2292

In line 2293, strike through "beginning January 1, 2014, and ending January 15, 2014."

In line 2294, strike through "subsequent"

Delete lines 2343 through 2368 and insert:

"**Sec. 103.416.** (A) JMOC shall oversee changes to the medicaid program's coverage of community behavioral health services. As part of its oversight duties, JMOC shall do all of the following:

(1) Receive and consider the reports from the successful transition and evaluation program workgroup established by section 5164.764 of the Revised Code;

(2) Receive and consider information provided to JMOC by the department of medicaid, department of mental health and addiction services, providers of the services, and other persons about the medicaid program's coverage of the services;

(3) Determine, by a majority vote, whether to do any of the following:

(a) For the purpose of division (A)(3) of section 5164.761 of the Revised Code, permit the department of medicaid to implement new medicaid billing codes and payment rates for the services.

(b) Approve the process that the department establishes under

division (B) of section 5164.761 of the Revised Code to ensure that medicaid providers of the services are not put at financial risk as a result of any such new medicaid billing codes and payment rates.

(c) For the purpose of division (C) of section 5167.04 of the Revised Code, permit the department to include the services in the care management system.

(d) Approve the process that the department establishes under division (A)(1) of section 5167.041 of the Revised Code to ensure that providers of the services are not put at financial risk as a result of the services being included in the care management system.

(e) For the purpose of division (F) of section 5164.764 of the Revised Code and subject to division (B) of this section, specify the date that the successful transition and evaluation program workgroup is to cease to exist.

(B) The date that JMOC specifies under division (A)(3)(e) of this section for the successful transition and evaluation program workgroup to cease to exist shall not be sooner than seven years after the date that medicaid-covered community behavioral health services begin to be included in the care management system."

In line 84504, reinsert the semicolon

Reinsert lines 84505 and 84506

In line 84507, reinsert the first "health"; after the first stricken comma insert "and, subject to sections 5167.04 and 5167.041 of the Revised Code, community"; reinsert "behavioral health"

In line 84508, reinsert "services covered by medicaid"

In line 84546, after "(B)" insert ""Care management system" means the system established under section 5167.03 of the Revised Code.

(C) "Clean claim" has the same meaning as in 42 C.F.R. 447.45(b).

(D) "Community behavioral health services" means both of the following:

(1) Alcohol and drug addiction services provided by a community addiction services provider, as defined in section 5119.01 of the Revised Code;

(2) Mental health services provided by a community mental health services provider, as defined in section 5119.01 of the Revised Code.

(E)"

In line 84549, strike through "(C)" and insert "(F)"

In line 84551, strike through "(D)" and insert "(G)"

In line 84553, delete "(E)" and insert "(H)"

In line 84556, delete "(F)" and insert "(I)"

In line 84559, delete "(G)" and insert "(J)"

In line 84561, delete "(H)" and insert "(K)"

In line 84563, delete "(I)" and insert "(L)"

In line 84565, delete "(J)" and insert "(M)"

In line 84568, delete "(K)" and insert "(N)"

In line 84572, delete "(L)" and insert "(O)"

In line 84574, delete "(M)" and insert "(P)"

In line 84580, delete "(N)" and insert "(Q)"

In line 84584, delete "(O)" and insert "(R)"

In line 84586, delete "(P)" and insert "(S)"

In line 84590, delete "(Q)" and insert "(T)"

In line 84592, delete "(R)" and insert "(U)"

In line 84599, delete "(S)" and insert "(V)"

In line 84604, delete "(T)" and insert "(W)"

Between lines 85606 and 85607, insert:

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

(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;

(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.

Sec. 5164.761. (A) Before the department of medicaid may implement new medicaid billing codes or payment rates for

community behavioral health services during the period that begins on the effective date of this section and ends on the date that the successful transition and evaluation program workgroup established under section 5164.764 of the Revised Code ceases to exist, all of the following must occur:

(1) The department must require all medicaid providers of community behavioral health services to participate in a beta test of the new codes and rates as a condition of participating in medicaid.

(2) The beta test must be successfully completed as evidenced by showing to the satisfaction of the successful transition and evaluation program workgroup that, had the new codes and rates for the services been in effect during the beta test, at least fifty per cent of the medicaid providers that submitted clean claims under the beta test would have been paid the correct amount for the services not later than ten days after the date the clean claim was submitted.

(3) The joint medicaid oversight committee must have voted, pursuant to section 103.416 of the Revised Code to permit the department to implement the new codes and rates.

(4) The department must notify all medicaid providers of community behavioral health services that the new codes and rates are to take effect on a date specified in the notice, which shall not be sooner than sixty days after the date of the notice.

(B) If the department implements new medicaid billing codes or payment rates for community behavioral health services, the department shall establish a process to ensure that medicaid providers of the services are not put at financial risk as a result of the implementation. The process is subject to the approval of the joint medicaid oversight committee pursuant to

section 103.416 of the Revised Code and shall do both of the following:

(1) Authorize a medicaid provider to notify the department if the provider does not receive, within ten days after a clean claim for the service is properly submitted, a full medicaid payment for the service;

(2) Require the department to pay the clean claim in full not later than ten days after receiving the medicaid provider's notice.

Sec. 5164.762. Until two years after the effective date of this section, the medicaid payment rate for a community behavioral health service provided by an individual without a postgraduate degree may not be less than the medicaid payment rate for the same service provided by an individual with a postgraduate degree. If the department of medicaid implements such a revision to the medicaid payment rates for community behavioral health services after the two-year period, the revision shall be phased in over five years as follows:

(A) During the first year, the percentage difference between the payment rates shall be one-fifth of the total percentage difference that is to go into effect in the fifth year.

(B) During the second year, the percentage difference between the payment rates shall be two-fifths of the total percentage difference that is to go into effect in the fifth year.

(C) During the third year, the percentage difference between the payment rates shall be three-fifths of the total percentage difference that is to go into effect in the fifth year.

(D) During the fourth year, the percentage difference between

the payment rates shall be four-fifths of the total percentage difference that is to go into effect in the fifth year.

(E) Beginning with the fifth year, the percentage difference is the full amount intended by the revision.

Sec. 5164.763. (A) During the first seven years after the effective date of this section, the department of medicaid shall not make any changes to the medicaid program's coverage of community behavioral health services that would decrease the number of willing and qualified medicaid providers of the services or impair the ability of a medicaid provider to employ or contract for individuals to provide the services on the provider's behalf. This includes both of the following:

(1) Except as otherwise required by federal or state law and notwithstanding section 5164.33 of the Revised Code, doing either of the following for any reason not related to a provider's competence to provide the services:

(a) Denying, refusing to revalidate, suspending, or terminating a provider agreement;

(b) Otherwise excluding an individual, provider, or other entity from participation in the medicaid program.

(2) Impairing the ability of an individual to complete clinical training with a provider of community behavioral health services needed to obtain a relevant postgraduate degree, including by requiring the individual to work under direct supervision.

(B) Changes to the medicaid program's coverage of community behavioral health services made in accordance with section 5164.761, 5164.762, or 5167.04 of the Revised Code do not violate

division (A) of this section.

Sec. 5164.764. (A) There is hereby established the successful transition and evaluation program workgroup. The workgroup shall consist of all of the following:

(1) The medicaid director, or the director's designee, and representatives of the department of medicaid appointed to the workgroup by the director;

(2) The director of mental health and addiction services, or the director's designee, and representatives of the department of mental health and addiction services appointed to the workgroup by the director;

(3) Representatives of providers of community behavioral health services appointed by the medicaid director.

(B) Appointments to the workgroup shall be made not later than thirty days after the effective date of this section. Each member shall serve without compensation or reimbursement for expenses incurred while serving on the workgroup, except to the extent that serving on the workgroup is considered to be among the member's employment duties.

(C) The medicaid director, or the director's designee, shall serve as chairperson of the workgroup. The department of medicaid shall provide the workgroup with any necessary administrative assistance.

(D) The workgroup shall do all of the following:

(1) Determine, in accordance with division (A)(2) of section 5164.761 of the Revised Code, whether the beta test of new medicaid billing codes and payment rates for community behavioral health services has been successfully completed.

(2) Determine, in accordance with division (B) of section 5167.04 of the Revised Code, whether the beta test of the inclusion of medicaid-covered community behavioral health services in the care management system has been successfully completed.

(3) Assess changes to the medicaid program's coverage of community behavioral health services in an effort to maintain the stability of the state's community behavioral health system and the access of the residents of this state to community behavioral health services.

(E) The workgroup shall regularly report to the joint medicaid oversight committee about its determinations and assessments under division (D) of this section.

(F) The workgroup shall cease to exist on the date specified by the joint medicaid oversight committee pursuant to section 103.416 of the Revised Code."

In line 87862, after "(A)" insert ""Clean claim" has the same meaning as in 42 C.F.R. 447.45(b).

(B) "Community behavioral health services" has the same meaning as in section 5164.01 of the Revised Code.

(C)"

In line 87864, strike through "(B)" and insert "(D)"

In line 87866, strike through "(C)" and insert "(E)"

In line 87869, strike through "(D)"

In line 87870, after "~~component"~~" insert "(F)"

In line 87872, strike through "(E)" and insert "(G)"

In line 87875, strike through "(F)" and insert "(H)"

In line 87877, strike through "(G)" and insert "(I)"

In line 87879, strike through "(H)" and insert "(J)"

In line 87881, strike through "(I)" and insert "(K)"

In line 87885, strike through "(J)" and insert "(L)"

Delete lines 87915 through 87936 and insert:

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

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

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

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

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

services of both of the following:

(1) That the services are to begin to be included in the care management system beginning on a date specified in the notice, which shall not be sooner than sixty days after the date of the notice;

(2) The procedures for becoming providers under the care management system.

~~(B) All of the following apply to the manner in which division (A) of this section is implemented:~~

~~(1) The department shall begin to include the services in the system not later than January 1, 2018.~~

~~(2) Before January 1, 2018, any proposal by the department to include all or part of the services in all or part of the system is subject to review by the joint medicaid oversight committee under division (B) of section 103.42 of the Revised Code. The department may implement the proposal only if the committee approves the proposal.~~

~~(3) On and after January 1, 2018, any proposal by the department to include all or part of the services in all or part of the system is subject to monitoring by the committee under division (A) or (C) of section 103.42 of the Revised Code, but approval by the committee is no longer required before the proposal may be implemented.~~

Sec. 5167.041. (A) If medicaid-covered community behavioral health services begin to be included in the care management system established under section 5167.03 of the Revised Code, both of the following shall apply:

(1) The department of medicaid shall establish a process

consistent with division (B) of this section to ensure that providers of the services are not put at financial risk as a result of the services being included in the care management system.

(2) Each contract between the department and a medicaid managed care organization shall include all of the following:

(a) A prohibition against the organization doing any of the following:

(i) Requiring that providers submit payment claims to the organization sooner than one year after the date the provider provides the service to a medicaid recipient enrolled in the organization;

(ii) Requiring that prior authorization be obtained for services provided on an outpatient basis;

(iii) Excluding a provider from the organization's provider panel if the provider's certifiable services and supports, as defined in section 5119.01 of the Revised Code, are certified and in good standing under section 5119.36 of the Revised Code.

(b) A provision that permits medicaid recipients to disenroll from one medicaid managed care organization and enroll in another medicaid managed care organization only once a year and only during an annual open enrollment period;

(c) A requirement that the medicaid managed care organization comply with sections 5164.762 and 5164.763 of the Revised Code as if the organization were the department.

(B) The process established under division (A)(1) of this section is subject to the approval of the joint medicaid oversight committee pursuant to section 103.416 of the Revised Code and shall do all of the following:

(1) Authorize a provider of community behavioral health 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;

(2) Require the department to pay the clean claim in full not later than ten days after receiving the provider's notice;

(3) Require the medicaid managed care organization to reimburse the department in full for the payment."

In line 105414, delete "103.42,"

In line 105544, after "5164.753," insert "5164.76,"

In line 105568, after "sections" insert "103.42,"

Delete lines 134533 through 134563

In line 142889, after "amendment" insert ", enactment, or repeal"; delete "section" and insert "sections 103.416, 103.42, 5162.70,"; after "5164.753" insert ", 5164.76, 5164.761, 5164.762, 5164.763, 5164.764, 5167.01, 5167.04, and 5167.041"

Between lines 142901 and 142902, insert:

"**Section 812.___.** The sections that are listed in the left-hand column of the following table combine amendments by this act that are and that are not exempt from the referendum under Ohio Constitution, Article II, sections 1c and 1d and section 1.471 of the Revised Code.

The middle column identifies the amendments to the listed sections that are subject to the referendum under Ohio Constitution, Article II, section 1c and therefore take effect on the ninety-first day after this act is filed with the Secretary of State or, if a later effective date is specified, on that date.

The right-hand column identifies the amendments to the listed

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 becomes law or, if a later effective date is specified, on that date.

Section of law	Amendments subject to the referendum	Amendments exempt from the referendum
103.41	All amendments except for those described in the right-hand column	The amendments in division (A) take effect July 1, 2017
5164.01	The amendments adding definitions for the terms "federal poverty line" and "state plan home and community-based services" in what will be, because of the amendments, divisions (G) and (V)	All amendments except for those described in the middle column take effect July 1, 2017"

The motion was _____ agreed to.

SYNOPSIS

Medicaid coverage of community behavioral health services

R.C. 5164.761 (primary), 103.41, 103.416, 103.42 (repealed), 5162.70, 5164.01, 5164.76, 5164.762, 5164.763, 5164.764, 5167.01, 5167.04, and 5167.041; Sections 333.260 (removed from the bill), 812.20, and 812.___

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

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

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

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

Restricts the Department's authority to make the Medicaid payment rate for such a service provided by an individual without a postgraduate degree less than the rate for the same service provided by an individual with a postgraduate degree.

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

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

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

Requires a Medicaid managed care organization to reimburse the Department for such a payment.

Establishes a seven-year prohibition against the Department making other changes to the Medicaid program's coverage of the services that negatively impact access to providers or the ability of providers to employ and contract with workers.

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

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