
DEPARTMENT OF MEDICAID

Suspension of provider agreements and payments

- Generally conforms the terms and procedures for suspending a Medicaid provider agreement because of a disqualifying indictment to those for suspending a provider agreement because of a credible allegation of fraud.
- Requires, with certain exceptions, that the provider agreement of a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID) be suspended when a disqualifying indictment is issued against the provider or the provider's officer, authorized agent, associate, manager, or employee.
- Requires, with certain exceptions, that the provider agreement of an independent provider be suspended when an indictment charges the provider with a felony or misdemeanor regarding furnishing or billing for Medicaid services or performing related management or administrative services.
- Requires that all Medicaid payments for services rendered be suspended, regardless of the date of service, when the provider agreement is suspended because of a credible allegation of fraud or disqualifying indictment.
- Permits the Department of Medicaid to suspend, without prior notice, a provider agreement and all Medicaid payments to the provider if there is evidence that the provider presents a danger of immediate and serious harm to the health, safety, or welfare of Medicaid recipients.

Rates for hospital inpatient services (VETOED)

- Would have required that an urban hospital's Medicaid base rate for inpatient services provided during FY 2020 be at least the average of the base rates for hospitals in the same peer group region if the urban hospital's FY 2019 base rate was less than \$4,000 (VETOED).

Rates for nursing facility services (PARTIALLY VETOED)

- Provides for a nursing facility's Medicaid payment rate to be \$115 per day for services provided to low resource utilization residents regardless of whether the nursing facility cooperates with the Long-Term Care Ombudsman Program.
- Revises the law governing the quality payments that nursing facilities earn under Medicaid for satisfying quality indicators.
- Provides for nursing facilities to earn a quality incentive payment under Medicaid beginning with the second half of FY 2020.
- Repeals a provision that would have adjusted nursing facilities' rates for tax costs and a \$16.44 add-on by an amount equal to the difference between the Medicare skilled nursing facility market basket index and a budget reduction adjustment factor.

- Would have delayed the repeal until July 1, 2021 (VETOED).
- Provides for the budget reduction adjustment factor to be, for the second half of FY 2020, 2.4%.
- Provides for the budget reduction adjustment factor to be, for FY 2021, equal to the Medicare skilled nursing facility market basket for federal FY 2020.

Rate for Vagus Nerve Stimulation (VETOED)

- Would have required that the Medicaid payment rate for Vagus Nerve Stimulation during FY 2020 and FY 2021 equal 75% of the Medicare rate for the service (VETOED).

Rates for personal care waiver services (VETOED)

- Would have required that the Medicaid rates for personal care waiver services be increased annually, beginning with FY 2022, by the difference between the Medicare skilled nursing facility market basket index and a budget reduction adjustment factor (VETOED).

Rates for aide and nursing services

- Repeals a law that required the Department to (1) reduce the Medicaid rates for aide and nursing services on October 1, 2011, and (2) adjust the Medicaid rates for those services not sooner than July 1, 2012.

Rates for community behavioral health services

- Permits the Department to establish Medicaid rates for community behavioral health services provided during FYs 2020 and 2021 that exceed the Medicare rates.

Home-delivered meals under Medicaid waivers (VETOED)

- Would have required each home and community-based services Medicaid waiver program that covers home-delivered meals to provide for (1) the meals to be delivered in a format and frequency consistent with individuals' needs and (2) the delivery person to meet face-to-face with the meal recipients (VETOED).
- Would have established the payment rates for home-delivered meals provided under the MyCare Ohio and Ohio Home Care waiver programs during FYs 2020 and 2021 (VETOED).

MyCare Ohio standardized claim form (PARTIALLY VETOED)

- Requires the Medicaid Director to develop a standardized claim form to be used under the Integrated Care Delivery System (MyCare Ohio) and standardized claim codes to be used on the form.
- Requires MyCare Ohio providers to use the standardized claim form and codes.
- Would have required the Department to pay a clean claim within 30 days and would have imposed 1% interest per month on that claim if not paid within 35 days (VETOED).

Medicaid managed care

Monitoring of behavioral health services

- Repeals on July 1, 2020, the requirement that the Joint Medicaid Oversight Committee periodically monitor the Department's inclusion of behavioral health services in the Medicaid managed care system.

Recoupment of payments

- Requires a Medicaid managed care organization (MCO) to give a provider all of the details of a recoupment of an overpayment.
- Requires the Department to assess the efforts of Medicaid MCOs to recoup overpayments and to include in contracts with Medicaid MCOs reasonable terms establishing limits on the recoupments.

Medicaid prompt payment waiver

- Repeals a requirement that the Medicaid Director apply for a waiver from the federal Medicaid prompt payment requirements to instead require health insuring corporations to submit claims in accordance with requirements established by the Department of Insurance.

Area agencies on aging

- Requires the Department, if it adds to Medicaid managed care during FYs 2020 and 2021 more Medicaid recipients who are aged, blind, disabled, or also enrolled in Medicare, to take certain actions regarding the duties of area agencies on aging relative to home and community-based waiver services.

Integrated Care Delivery System performance payments

- For FYs 2020 and 2021, requires the Department to continue to (1) make performance payments to Medicaid MCOs that provide care to participants of MyCare Ohio and (2) withhold a percentage of their premium payments for the purpose of providing the performance payments.

Performance metrics

- Requires the Department to establish performance metrics to evaluate Medicaid MCOs' performance, post the metrics on its website, and update them quarterly with any changes.

Employment program measure

- Requires the Department, as part of the re-procurement process for new Medicaid MCO contracts, to include in the measures used to determine which MCOs will be awarded contracts measures related to the abilities and commitment of MCOs to operate employment programs for Medicaid recipients.

Prescribed drugs

- Permits, instead of requiring, the Department to include prescribed drugs in the Medicaid managed care system.

State pharmacy benefit manager (PARTIALLY VETOED)

Procurement

- Requires the Director to select and contract with a state pharmacy benefit manager (PBM) to administer prescribed drug benefits under the care management system and to be responsible for processing all pharmacy claims under the care management system.

Disclosures

- Requires entities seeking to become the state PBM to disclose specified information.

Contract amendment

- Would have required the Department to review the contract every six months and make recommended changes and to reprocur the master state PBM contract every four years (VETOED).

Affiliated companies

- Would have permitted the affiliated companies of the state PBM to conduct state PBM business in their own names with Medicaid MCOs (VETOED).

Provisional state PBM

- Requires the Director to select a provisional state PBM by July 1, 2020.
- Specifies that the provisional state PBM will be fully implemented as the state PBM upon its demonstrated ability to fulfill the state PBM's duties, as evidenced through a readiness review process established by the Director.
- Requires the Director to notify the Joint Medicaid Oversight Committee if selection of the provisional state PBM cannot occur by the required date.

Medicaid MCOs and the state PBM

- Requires Medicaid MCOs to use the state PBM pursuant to the terms of the master contract between the Department and the state PBM.
- Would have tasked the contracted state PBM with serving as the single PBM used by Medicaid MCOs under the care management system (VETOED).
- Would have required the master contract to specify that all pharmacy claims information shared between the parties is confidential and proprietary (VETOED).
- Would have clarified that, despite the act's PBM provisions, a Medicaid MCO can contract directly with a pharmacy regarding the practice of pharmacy (VETOED).

State PBM compensation

- Requires all payments between the Department, Medicaid MCOs, and the state PBM to comply with state and federal law and any other agreement reached between the Department and the federal government.
- Would have required the Director to determine the payment to the state PBM, with payments for claims adjudication being made to the state PBM from a Medicaid MCO and payments for other administrative services being made to the state PBM directly from the Department (VETOED).
- Would have required the Director to establish a dispensing fee to be paid for the state PBM for each prescribed drug dispensed under the care management system (VETOED).

Prescribed drug formulary

- Would have required the state PBM, in consultation with the Director, to establish a Medicaid prescribed drug formulary, and would have specified that the formulary was not effective until approved by the Director (VETOED).
- Would have prohibited the state PBM from making a payment for a prescribed drug exceeding the drug's formulary per-unit prize (VETOED).

State PBM quarterly reports

- Requires the state PBM to report specified information to the Director quarterly.
- Permits the Director to ask for additional information as necessary.

Medicaid Director quarterly reports

- Would have required the Director to make findings based on the state PBM quarterly reports and submit a report to the General Assembly within 60 days after receiving the quarterly report (VETOED).
- Would have required the Director to be available to testify, on request, before either chamber of the General Assembly or the Joint Medicaid Oversight Committee (VETOED).

Civil penalty

- Prohibits a person from violating the terms of the master PBM contract or the act's requirements pertaining to the state PBM.

Pharmacy appeals process

- Requires the Director to establish an appeals process by which pharmacies can appeal to the Department any disputes relating to the maximum allowable cost for a prescribed drug set by the state PBM.
- Requires all pharmacies participating in the care management system to use the pharmacy appeals process.

Rulemaking

- Would have required the Director to adopt rules as necessary to implement the act's state PBM provisions, including specifically enumerated provisions (VETOED).

Payment and cost disclosures

- Requires the state PBM to disclose to the Department upon request all of the PBM's prescription drugs payment sources.
- Requires Medicaid MCOs to disclose to the Department their administrative costs associated with providing pharmacy services under the care management system.

Prescribed drug claims processing pilot

- Requires the Department to administer a pilot program for the pre-audit processing of prescribed drug claims made by qualifying pharmacies in 16 southeastern Ohio counties to Medicaid MCOs and their pharmacy benefit managers.
- Requires the Department to submit a report by September 1, 2021, to the Governor, the Senate President, the Speaker of the House, and the chairperson of the Joint Medicaid Oversight Committee.

Vetoed Medicaid managed care provisions (VETOED)

- Would have permitted a Medicaid MCO to submit a request to the State Board of Pharmacy for information in its drug database about all Medicaid recipients enrolled in a plan offered by the MCO, and would have required the Board to provide the information in a single electronic file or format (VETOED).
- Would have required the Department to establish a waiver under which Medicaid MCO plans could cover any service or product that would have a beneficial effect on enrollees' health and would likely reduce the plan's costs (VETOED).
- Would have required the Department to establish the Shared Savings Bonus Program, under which a Medicaid MCO would earn a bonus if its three-year average per recipient capitated payment rate was less than the three-year average per recipient cost of certain other states' Medicaid programs (VETOED).
- Would have required the Department to establish the Quality Incentive Program, under which the Department would randomly assign certain Medicaid recipients to Medicaid MCOs based on points earned for meeting health and quality metrics (VETOED).
- Would have permitted regional hospital networks to become Medicaid MCOs if they accepted a capitated payment that was not more than 90% of the lowest capitated payment made to a Medicaid MCO that is a health insuring corporation (VETOED).
- Would have required each Medicaid MCO to establish a program to incentivize enrollees to obtain covered health care from high quality and efficient providers (VETOED).

- Would have required a Medicaid MCO, if it established a rate for a service that was greater than the fee-for-service rate, to require providers of the service to enter into value-based contracts as a condition of joining the MCO's provider panel (VETOED).
- Would have prohibited a Medicaid MCO from permitting a provider to be part of the MCO's provider panel unless the provider assured the MCO that it would comply with a requirement regarding cost estimates (VETOED).
- Would have required a hospital, with certain exceptions, to accept as payment in full from a Medicaid MCO an amount equal to 90% of the fee-for-service rate for a nonemergency service provided to a Medicaid recipient, if the hospital did not have a contract with the MCO and the MCO referred the recipient to the hospital (VETOED).
- Would have required the Department to evaluate and benchmark the financial health of Medicaid MCOs (VETOED).
- Would have required the Department to obtain approval from the Joint Medicaid Oversight Committee and the Controlling Board before adjusting the capitation rates paid to Medicaid MCOs under certain circumstances (VETOED).
- Would have required the Department to complete a procurement process for Medicaid MCOs by July 1, 2020 (VETOED).

Prescribed drug spending growth

- Requires the Director, by July 1, 2020, to establish an annual benchmark for prescribed drug spending growth under Medicaid.
- Requires the Director, for each year that the Director projects that Medicaid drug spending will exceed the benchmark, to identify specific drugs that significantly contribute to exceeding the benchmark and publish a list of them.
- Requires the Director to enter into a supplemental rebate agreement or renegotiate an existing supplemental rebate agreement for identified drugs, if appropriate, and establishes criteria for these renegotiations.
- Permits the Director to consider removing an identified drug from the Medicaid preferred drug list and imposing a prior authorization requirement on the drug if a supplemental rebate agreement is not established or renegotiated.

Review of prescribed drug reform savings

- Requires the Department, before January 1, 2021, to conduct a review of all savings to the state from the act's prescribed drug reforms.
- Requires the Department to complete a report outlining its findings within 60 days after its review and to submit it to the Governor and the General Assembly.
- Requires the Department to testify about its findings before the Joint Medicaid Oversight Committee and, on request, before the General Assembly.

Pharmacy supplemental dispensing fee (PARTIALLY VETOED)

- Requires the Department to adopt rules to provide to retail pharmacies a supplemental dispensing fee that includes at least three payment levels.
- Would have required the Department to adopt the rules by January 1, 2020 (VETOED).
- Would have prohibited the supplemental dispensing fee from causing a reduction in other payments made to the pharmacy (VETOED).
- Requires the Director to adjust the supplemental dispensing fee if federal Medicaid law reduces the amount of federal funds the Department receives for the fee.

Social determinants of health

- Requires the Medicaid Director to implement within the Medicaid program strategies that affect social determinants of health.

Evaluations of expansion group's employment success

- Requires the Department to periodically evaluate the success that the expansion eligibility group has with (1) obtaining employer-sponsored health insurance, (2) improving health conditions that would otherwise prevent or inhibit stable employment, and (3) improving the conditions of employment.
- Requires the Department to complete a report for each evaluation.

Automatic designation of representative (VETOED)

- Would have automatically designated a facility participating in the Assisted Living Program as the primary authorized representative for a Medicaid applicant who resides in the facility, for purposes of allowing disclosure of information by a county department of job and family services (VETOED).

Care Innovation and Community Improvement Program

- Requires the Medicaid Director to continue the Care Innovation and Community Improvement Program for the FY 2020-FY 2021 biennium.

Rural healthcare workforce training and retention (VETOED)

- Would have required the Medicaid Director to create the Rural Healthcare Workforce Training and Retention Program for FYs 2020 and 2021, under which nonprofit hospital agencies and public hospital agencies could have earned supplemental Medicaid payments for graduate medical education costs (VETOED).

Children's hospitals study committee

- Requires the Department of Medicaid to establish a committee to study and develop performance indicators for children's hospitals.

Hospital Care Assurance Program, franchise permit fee

- Continues, for two additional years, the Hospital Care Assurance Program and the franchise permit fee imposed on hospitals under Medicaid.

Health information exchanges

- Eliminates all provisions regarding approved health information exchanges in statutes governing protected health information, including provisions that required the Medicaid Director to adopt rules regarding the exchanges.

Health Care/Medicaid Support and Recoveries Fund

- Requires that money credited to the Health Care/Medicaid Support and Recoveries Fund additionally be used for (1) programs that serve youth involved with multiple government agencies and (2) innovative programs that promote access to health care or help achieve long-term cost savings.

Abolished funds

- Abolishes the Integrated Care Delivery Systems Fund.
- Abolishes the Managed Care Performance Payment Fund.
- Abolishes the Medicaid Administrative Reimbursement Fund.
- Abolishes the Medicaid School Program Administrative Fund.

Extended authority regarding employees

- Extends through July 1, 2021, the Medicaid Director's authority to establish, change, and abolish positions for the Department and to assign, reassign, classify, reclassify, transfer, reduce, promote, or demote employees who are not subject to collective bargaining.

Updating references

- Updates references to the former U.S. Health Care Financing Administration with references to the U.S. Centers for Medicare and Medicaid Services.

Suspension of provider agreements and payments

(R.C. 5164.36, primary; R.C. 173.391 and 5164.37, repealed)

Suspensions because of disqualifying indictments

The act makes the terms and procedures for suspending a Medicaid provider agreement because of certain types of indictments, which it refers to as disqualifying indictments, generally the same as those for suspending a provider agreement because of a credible allegation of fraud. The act also makes the following revisions to the law governing the suspension of provider agreements because of a disqualifying indictment:

- Under prior law, the Department of Medicaid was required to suspend a provider agreement of a noninstitutional provider, other than an independent provider, if the provider or its owner, officer, authorized agent, associate, manager, or employee was indicted for an act that would be a felony or misdemeanor under Ohio law and the act related to or resulted from furnishing or billing for Medicaid services or participating in the performance of management or administrative services relating to furnishing Medicaid services. The act is generally the same except that (a) the provider agreement of an independent provider or an institutional provider also is to be suspended in this situation (unless, in the case of an institutional provider, the owner is indicted) and (b) the indictment may be for an act that would be a felony or misdemeanor under the laws of the jurisdiction within which the act occurred rather than only under Ohio law. An independent provider is a person who has a provider agreement to provide home and community-based services as an independent provider in a Medicaid waiver program that the Department administers. Hospitals, nursing facilities, and ICF/IIDs are institutional providers.
- Prior law required the Department to *terminate* Medicaid payments to a provider when the provider agreement was suspended because of a disqualifying indictment. The termination applied only to payments for Medicaid services rendered *after* the date the Department sent notice of the suspension. Claims for payment for Medicaid services rendered before that date could be subject to prepayment review procedures under which the Department reviewed claims to determine whether they were supported by sufficient documentation, in compliance with state and federal law, and otherwise complete. Under the act, the Department must suspend, rather than terminate, the Medicaid payments, and the suspension applies to payments for all services regardless of the date the services are rendered.

The following table compares the provisions of law in effect before the act and law in effect after the act regarding the suspension of Medicaid provider agreements because of disqualifying indictments.

Law in effect before the act	Law in effect after the act
Medicaid providers subject to suspension	
<p>Noninstitutional providers when the Department received notice and a copy of an indictment that charged any of the following with committing certain acts:</p> <ol style="list-style-type: none"> 1. The provider; 2. The provider's owner, officer, authorized agent, associate, manager, or employee. (<i>R.C. 5164.37(C).</i>) 	<p>Any provider, when the Department determines that an indictment has been issued that charges any of the following with committing certain acts:</p> <ol style="list-style-type: none"> 1. The provider; 2. The provider's officer, authorized agent, associate, manager, or employee;

Law in effect before the act	Law in effect after the act
	3. If the provider is a noninstitutional provider, the provider's owner. <i>(R.C. 5164.36(A)(5) and (6) and (B)(1).)</i>
Indictments that require suspension	
<p>1. Except for an independent provider, an act that would be a felony or misdemeanor under Ohio law that related to or resulted from furnishing or billing for Medicaid services or participating in management or administrative services related to furnishing Medicaid services;</p> <p>2. For an independent provider, an offense that continuing law specifies is cause to deny or terminate a provider agreement. <i>(R.C. 5164.37(E).)</i></p>	<p>1. Regardless of whether the provider is an independent provider, an act that would be a felony or misdemeanor under Ohio law or the law where the act occurred and that relates to or results from the furnishing or billing for Medicaid services or management or administrative services relating to furnishing Medicaid services;</p> <p>2. Same. <i>(R.C. 5164.36(A)(2), (3), and (4).)</i></p>
Stopping Medicaid payments	
<p>The Department was required to terminate Medicaid payments to a suspended provider for Medicaid services rendered after the date when the Department sent the provider notice of the suspension. Claims for services rendered before the notice was sent could be subject to prepayment review procedures. <i>(R.C. 5164.37(C) and (D)(2).)</i></p>	<p>The Department must suspend all Medicaid payments to a suspended provider for services rendered, regardless of the date of service. <i>(R.C. 5164.37(B)(2).)</i></p>
Exceptions	
<p>No suspension or payment termination if:</p> <p>1. The provider or owner submits written evidence that the provider or owner did not directly or indirectly sanction the act that resulted in the indictment;</p> <p>2. Circumstances that may be specified in rules apply. <i>(R.C. 5164.37(D)(1) and (H).)</i></p>	<p>Same. <i>(R.C. 5164.36(C) and (I).)</i></p>

Law in effect before the act	Law in effect after the act
When suspension is lifted	
<p>1. The proceedings in <i>the criminal case</i> were completed through dismissal of the indictment, conviction, entry of a guilty plea, or finding of not guilty;</p> <p>2. If the Department commences a process to terminate the suspended provider agreement, the termination process is concluded. (R.C. 5164.37(C).)</p>	<p>1. The proceedings in <i>any related case</i> are completed through dismissal of the indictment, conviction, entry of a guilty plea, or finding of not guilty;</p> <p>2. Same. (R.C. 5164.36(B)(3).)</p>
Restricted Medicaid activities	
<p>A provider, owner, officer, authorized agent, associate, manager, or employee could not do any of the following during the suspension:</p> <p>1. Own or provide Medicaid services to any other Medicaid provider or risk contractor;</p> <p>2. Arrange for, render, or order Medicaid services;</p> <p>3. Receive direct payments under Medicaid or indirect payments of Medicaid funds in the form of a salary, shared fees, contracts, kickbacks, or rebates from or through any other Medicaid provider or risk contractor. (R.C. 5164.37(C).)</p>	<p>A provider; officer, authorized agent, associate, manager, or employee (if suspension results from an action taken by that person); or owner (if the provider is a noninstitutional provider and the suspension results from an action of the owner) cannot do any of the following during the suspension:</p> <p>1. Own services provided, or provide services, to any other Medicaid provider or risk contractor;</p> <p>2. Arrange for, render to, or order services (a) to any other Medicaid provider or risk contractor or (b) for Medicaid recipients;</p> <p>3. Same. (R.C. 5164.36(B)(4).)</p>

Law in effect before the act	Law in effect after the act
Notice of suspension	
<p>The Department had to send notice of a provider agreement suspension to the provider or owner not later than five days after suspending the provider agreement. <i>(R.C. 5164.37(F).)</i></p>	<p>The Department must send notice of a provider agreement suspension to the provider or, if the provider is a noninstitutional provider, the owner:</p> <ol style="list-style-type: none"> 1. Not later than five days after the suspension unless a law enforcement agency makes a written request to temporarily delay the notice; 2. If such a request is made, not later than 30 days after the suspension. A law enforcement agency may request up to two renewed delays, but the notice must be issued not more than 90 days after the suspension. <i>(R.C. 5164.36(D) and (E).)</i>
Content of suspension notice	
<p>A notice of a provider agreement suspension had to:</p> <ol style="list-style-type: none"> 1. Describe the indictment that was the cause of the suspension, without necessarily disclosing specific information concerning any ongoing civil or criminal investigation; 2. State how long the suspension will continue; 3. Inform the provider or owner of the opportunity to request a reconsideration. <i>(R.C. 5164.37(F).)</i> 	<p>A notice of a provider agreement suspension must:</p> <ol style="list-style-type: none"> 1. Describe the conduct leading to the suspension (without disclosing information concerning an ongoing investigation), the type of Medicaid claims or business units affected by the suspension, and that payments are being suspended; 2. Same; 3. Same. <i>(R.C. 5164.36(F).)</i>

Law in effect before the act	Law in effect after the act
Reconsideration	
<p>A suspended provider or owner could request a reconsideration within 30 days of receiving the suspension notice. The reconsideration was not subject to an adjudication hearing under the Administrative Procedure Act. The provider or owner could submit to the Department written information about whether (1) the suspension determination was based on a mistake of fact, (2) the indictment resulted from an offense for which the Department was authorized to suspend provider agreements, or (3) the provider or owner could demonstrate that they did not directly or indirectly sanction the action of its authorized agent, associate, manager, or employee that resulted in the indictment. The Department had to review the information and documents. After the reviews, the information, the suspension could be affirmed, reversed, or modified, in whole or in part. The review and notification of its results had to be completed not later than 45 days after the information and documents are received. (R.C. 5164.37(G).)</p>	<p>Same, except an owner may request a reconsideration only if the provider is a noninstitutional provider. (R.C. 5164.36(G) and (H).)</p>

Suspensions because of credible allegations of fraud

(R.C. 5164.36)

Prior law required the Department to *terminate* Medicaid payments to a provider when the provider agreement was suspended because of a credible allegation of fraud for which an investigation was pending under the Medicaid program. The termination applied only to payments for Medicaid services rendered after the date the Department sent the provider notice of the suspension. Claims for payment for Medicaid services rendered before that date could be subject to prepayment review procedures under which the Department reviewed claims to determine whether they were supported by sufficient documentation, were in compliance with state and federal statutes and rules, and were otherwise complete. Under the act, the Department must suspend, rather than terminate, the Medicaid payments, and the suspension applies to payments for all services regardless of the date the services are rendered.

Summary suspensions, danger of immediate and serious harm

(R.C. 5164.37 and 5164.38)

The act permits the Department to suspend, without prior notice, a Medicaid provider agreement if there is evidence that the provider presents a danger of immediate and serious harm to the health, safety, or welfare of Medicaid recipients. When the Department suspends a provider agreement for this reason, it must:

- Suspend all Medicaid payments to the provider for services rendered, regardless of the date that the services were rendered;
- Not later than five days after suspending the provider agreement, notify the provider of the suspension; and
- Not later than ten business days after suspending the provider agreement, notify the provider that the Department intends to terminate the provider agreement.

The notice that the Department sends regarding the intention to terminate a provider agreement must include the allegation that the provider presents a danger of immediate and serious harm to the health, safety, or welfare of Medicaid recipients. It may also include other grounds for terminating the provider agreement. When terminating the provider agreement, continuing law that requires the Department to issue an order pursuant to adjudication conducted in accordance with the Administrative Procedure Act (R.C. Chapter 119) applies.

The suspension of a provider agreement and Medicaid payments is to cease at the earliest of:

- The Department's failure to provide within the required time a notice regarding the suspension or intent to terminate the provider agreement;
- The Department rescinds its notice to terminate the provider agreement;
- The Department issues an order regarding the termination of the provider agreement pursuant to an adjudication.

The act states that this provision does not limit the Department's authority to suspend or terminate a provider agreement or Medicaid payments under any other provision of the Revised Code.

Continuing law provides that the Department is not required to issue an order pursuant to an adjudication when it refuses to enter into or revalidate a Medicaid provider agreement or suspends or terminates a provider agreement if the provider agreement and Medicaid payments are suspended because of a credible allegation of fraud or disqualifying indictment. The act provides that an adjudication order also is not required if the provider agreement and Medicaid payments are suspended because the provider presents a danger of immediate and serious harm to the health, safety, or welfare of Medicaid recipients.

Rates for hospital inpatient services (VETOED)

(Section 333.170)

The Governor vetoed a provision that would have required that an urban hospital's Medicaid base rate for inpatient services provided during FY 2020 be no less than the average of the Medicaid base rates in effect on July 1, 2019, for inpatient services provided by other urban hospitals that are located in the same peer group region, if the hospital's Medicaid base rate in effect June 30, 2019, for inpatient services was not more than \$4,000.

Rates for nursing facility services

Low resource utilization residents

(R.C. 5165.152)

The act revises the Medicaid payment rate for nursing facility services provided to low resource utilization residents. A low resource utilization resident is a Medicaid recipient residing in a nursing facility who, when calculating the facility's Medicaid rate, is placed in either of the two lowest resource utilization groups (excluding any resource utilization group that is a default group used for residents with incomplete assessment data).

Under prior law, the rate was the following:

- \$115 per day if the Department was satisfied that the facility cooperated with the Long-Term Care Ombudsman Program in efforts to help its low resource utilization residents receive the services that are most appropriate for their level of care needs;
- \$91.70 per day if the Department was not satisfied.

The act provides for the rate to be \$115 per day regardless of whether the facility cooperates with the Long-Term Care Ombudsman Program.

Quality payment rates

(R.C. 5165.25)

The act revises the law governing the quality payments that nursing facilities earn under Medicaid for satisfying quality indicators, as follows:

- Eliminates as a quality indicator a nursing facility's use of the nursing home version of the Preferences for Everyday Living Inventory for all of its residents;
- Establishes as a quality indicator a nursing facility's obtaining at least a target score on the Department of Aging's resident satisfaction survey (for even-numbered state fiscal years) or the family satisfaction survey (for odd-numbered state fiscal years);
- Requires the Department to specify the target score for the satisfaction surveys;
- Eliminates a requirement that the Department, when determining the percentages of a nursing facility's short-stay residents who newly received an antipsychotic medication and long-stay residents who newly or otherwise received an antipsychotic medication, exclude residents who received the medication in conjunction with hospice care;

- Provides for a nursing facility that undergoes a change of operator to receive, for the state fiscal year following the one during which the change of operator occurs, the mean quality payment regardless of whether the change of operator occurred before or during the last quarter of a calendar year.

Quality incentive payments

(R.C. 5165.26, primary and 5165.15)

Addition of quality incentive payment

The act adds a quality incentive payment to nursing facilities' Medicaid payment rates beginning with the second half of FY 2020. A nursing facility's quality incentive payment is to be based on the score it receives for meeting certain quality metrics regarding its residents who have resided in the facility for at least 100 days (i.e., long-stay residents).

Score on quality metrics

With certain adjustments, a nursing facility's score for a state fiscal year is to be the sum of the total number of points that the U.S. Centers for Medicare and Medicaid Services (CMS) assigned to the facility under its nursing facility five-star quality rating system for the following quality metrics:

- The percentage of the nursing facility's long-stay residents at high risk for pressure ulcers who had pressure ulcers during the calendar year preceding the calendar in which the fiscal year begins (i.e., the measurement period);
- The percentage of the facility's long-stay residents who had a urinary tract infection during the measurement period;
- The percentage of the facility's long-stay residents whose ability to move independently worsened during the measurement period;
- The percentage of the facility's long-stay residents who had a catheter inserted and left in their bladder during the measurement period.

In determining a nursing facility's score for a fiscal year, the Department must make the following adjustments to the number of points that CMS assigned to the facility for each quality metric:

- Unless CMS assigned the nursing facility the lowest percentile for the quality metric, divide the number of the facility's points for the quality metric by 20;
- If CMS assigned the nursing facility the lowest percentile for the quality metric, reduce the facility's points for the quality metric to zero.

A nursing facility's score is to be zero for a fiscal year if it is not to receive a quality incentive payment for that fiscal year because it does not satisfy the licensed occupancy condition.

Quality incentive conditioned on licensed occupancy (PARTIALLY VETOED)

A nursing facility is not to receive a quality incentive payment for a fiscal year, other than the second half of FY 2020, if its licensed occupancy percentage is less than 80%. However, this disqualification does not apply to a nursing facility for a fiscal year if it has a score for meeting the quality metrics for the fiscal year of at least 15 points. The Governor vetoed a second exception to the disqualification. If not for the veto, a nursing facility would have been exempt for a fiscal year if, less than four years before the first day of the fiscal year, it had undergone a renovation during which it temporarily removed one more of its licensed beds from service. The Governor also vetoed part of a third exception to the disqualification. If not for the veto, a nursing facility would have been exempt from the disqualification for a fiscal year if it had been initially certified for participation in Medicaid less than four years before the first day of the fiscal year. As a result of the partial veto, a nursing facility is exempt for a fiscal year if it was initially certified for participation in Medicaid. Because the initial certification would not have to have occurred within four years and all nursing facilities must obtain Medicaid certification to participate in Medicaid, it appears that all nursing facilities are exempt from the disqualification and therefore do not have to meet the licensed occupancy percentage requirement to receive a quality incentive payment.

A nursing facility's licensed occupancy percentage for a fiscal year is to be determined as follows:

- Multiply the facility's licensed occupancy on the last day of the measurement period by the number of days in that measurement period;
- Divide the number of the facility's inpatient days for the measurement period by the product determined under the first step.

Quality incentive payment amount

A nursing facility's per Medicaid day quality incentive payment rate for a fiscal year is to be determined as follows:

1. Determine the sum of the scores on the quality metrics for all nursing facilities.
2. Determine the average score by dividing the sum determined under (1) by the number of nursing facilities for which a score was determined.
3. Determine the following:
 - For the second half of FY 2020, the sum of the total number of Medicaid days for the second half of calendar year 2018 for all nursing facilities for which a score was determined.
 - For all of FY 2021 and each fiscal year thereafter, the sum of the total number of Medicaid days for the measurement period for all nursing facilities for which a score was determined.
4. Multiply the average score determined under (2) by the sum determined under (3).

5. Determine the value per quality point by dividing the total amount to be spent on quality incentive payments for the fiscal year by the product determined under (4).

6. Multiply the value per quality point by the nursing facility's score on the quality metrics.

Total amount spent on quality incentive payments (PARTIALLY VETOED)

The act specifies the total amount that is to be spent on quality incentive payments for each fiscal year.

For the second half of FY 2020, the amount is to be the sum of the following for all nursing facilities:

1. The amount that is 2.4% of the portions of each nursing facility's Medicaid payment rate regarding its ancillary and support, capital, direct care, and tax costs, the critical access incentive payment, and the \$16.44 add-on (i.e., the base rate) on January 1, 2020;

2. Multiply the amount determined under (1) by the number of each nursing facility's Medicaid days for the second half of calendar year 2018.

For all of FY 2021 and each fiscal year thereafter, the amount is to be determined pursuant to a two-step process. The Governor partially vetoed the first step. If not for the veto, the first step would have been to determine the following for each nursing facility, including those that are not to receive a quality incentive payment because they do not meet the licensed occupancy condition:

1. Determine the amount that is 2.4% of each nursing facility's base rate on the first day of the fiscal year;

2. Add the amount determined under (1) to the facility's base rate for nursing facility services provided on the first day of the fiscal year;

3. Multiply the sum determined under (2) by the Medicare skilled nursing facility market basket index for federal fiscal year 2020;

4. Add amounts determined under (1) and (3);

5. Multiply the sum determined under (4) by the number of each nursing facility's Medicaid days for the measurement period.

As a result of the veto, the first step is to determine the following for each nursing facility:

1. Determine the amount that is 2.4% of each nursing facility's base rate on the first day of the fiscal year;

2. Multiply the amount determined under (1) by the number of the nursing facility's Medicaid days for the measurement period.

The second step is to determine the sum of the amounts determined under the first step for all nursing facilities.

Budget reduction adjustment factor (PARTIALLY VETOED)

(R.C. 5165.15, 5165.21, and 5165.361; Sections 333.270, 812.10, and 812.12)

For FYs 2018 and 2019, the formula for determining the Medicaid rates for nursing facility services contained a \$16.44 add-on, which became part of the formula on July 1, 2016. Prior law provided that, in FY 2020 and thereafter (other than the first fiscal year in a rebasing cycle), the add-on was instead to be the sum of the following:

1. The amount of the add-on for the preceding fiscal year;
2. The difference between (a) the Medicare skilled nursing facility market basket index determined for the federal fiscal year that began during the state fiscal year preceding the one for which the rate is being determined and (b) the budget reduction adjustment factor for the fiscal year for which the rate is being determined.

The act provides for the add-on to continue to be \$16.44. The Governor vetoed a provision that would have delayed the elimination of the adjustment until FY 2022.

Continuing law provides that, beginning with FY 2020 (other than the first fiscal year in a rebasing cycle), the formula includes the difference between the Medicare skilled nursing facility market basket index and the budget reduction adjustment factor as part of the manner in which the rates for ancillary and support costs, capital costs, and direct care costs are determined. Under prior law eliminated by the act, this was also to be applied as part of the process of determining rates for tax costs beginning with FY 2020. The Governor vetoed a provision that would have delayed the elimination until FY 2022.

The act provides that the budget reduction adjustment factor for the second half of FY 2020 is to be 2.4%. For FY 2021, it is to be an amount equal to the Medicare skilled nursing facility market basket index determined for all of federal fiscal year 2020.

Rate for Vagus Nerve Stimulation (VETOED)

(Section 333.185)

The Governor vetoed a provision that would have required that the Medicaid payment rate for the Vagus Nerve Stimulation (VNS) service provided under the outpatient hospital benefit during FY 2020 and FY 2021 equal 75% of the Medicare payment rate for the service in effect on the date that the service would have been provided.

The vetoed provision would also have required that the Medicaid payment rates for other Medicaid services selected by the Medicaid Director be less than the amount of the rates for those services in effect on June 30, 2019, so that the cost of the rate for the VNS service would not increase Medicaid expenditures. The Director would have been prohibited from selecting for rate reduction any Medicaid service for which the rate is determined in accordance with state statutes.

Rates for personal care waiver services (VETOED)

(R.C. 5166.09, primary and 5166.01)

The Governor vetoed a provision that would have required that the Medicaid rate for personal care services provided under a Medicaid waiver that covers home and community-based services as an alternative to nursing facility services be increased each state fiscal year beginning with FY 2022. The amount of the increase would have been the difference between:

1. The Medicare skilled nursing facility market basket index determined for the federal fiscal year that begins during the state fiscal year immediately preceding the state fiscal year for which the determination is being made; and

2. The budget reduction adjustment factor for the state fiscal year for which the determination is being made.

The budget reduction adjustment factor for a state fiscal year would have had to be the same as the budget reduction adjustment factor used for that state fiscal year in determining the Medicaid rates for nursing facility services. (See “**Rates for nursing facility services**” above.)

Rates for aide and nursing services

(R.C. 5164.77, repealed)

The act repeals a law that required the Department to (1) reduce the Medicaid rates for aide and nursing services on October 1, 2011, and (2) adjust the Medicaid rates for those services not sooner than July 1, 2012, in a manner that reflects, at a minimum, labor market data, education and licensure status, home health agency and independent provider status, and length of service visit.

Rates for community behavioral health services

(Section 333.180)

The act permits the Department to establish Medicaid payment rates for community behavioral health services provided during FY 2020 and FY 2021 that exceed the authorized rates paid for the services under Medicare. This does not apply, however, to such services provided by hospitals on an inpatient basis, nursing facilities, or ICF/IIDs.

Home-delivered meals under Medicaid waivers (VETOED)

(R.C. 5166.04; Section 333.160)

The Governor vetoed a provision that would have required a Medicaid waiver that covers home-delivered meals to provide for the format in which the meals are delivered to an individual and the frequency of the deliveries to be consistent with the individual’s needs, as specified in the individual’s written plan of care or individual service plan. Such a waiver also would have had to prohibit an individual who delivers the meals from leaving the meals with the individual to whom they are delivered unless the individuals meet face-to-face at the time of the delivery.

The Governor also vetoed a provision that would set the payment rates for home-delivered meals provided under the MyCare Ohio and Ohio Home Care waivers during FYs 2020 and 2021 at the following amounts:

- For each meal delivered daily on a per-meal delivery basis by a volunteer or employee of the provider, \$7.19;
- For each meal delivered in a chilled or frozen format on a weekly delivery basis by a volunteer or employee of the provider, \$6.99;
- For each meal delivered in a chilled or frozen format on a weekly basis by a common carrier used by the provider, \$6.50.

MyCare Ohio standardized claim form (PARTIALLY VETOED)

(R.C. 5164.912)

The act requires the Medicaid Director to develop a standardized claim form that must be used by medical providers providing health care services under the Integrated Care Delivery System (known as MyCare Ohio). The required form must be selected from universally accepted claim forms used in the United States.

The Director also must create standardized claim codes to be used on the claim form. The act requires Medicaid providers providing Medicaid services to use the appropriate standardized claim form and codes.

The Governor vetoed a provision that would have required the Department to pay within 30 days any clean claim. A clean claim is one that is properly submitted using the appropriate standardized claim form and claim codes and is for Medicaid services that are allowable under the MyCare program. If the Department failed to pay the clean claim within 35 calendar days, the Department would have had to pay interest on the claim of 1% per month, calculated from the expiration of the 35-day period.

Medicaid managed care

Monitoring of behavioral health services

(R.C. 103.416; Section 125.10)

Effective July 1, 2020, the act repeals a requirement that the Joint Medicaid Oversight Committee periodically monitor the Department's inclusion of alcohol, drug addiction, and mental health services in the Medicaid managed care system.

Recoupment of payments

(R.C. 5167.22, primary, 5167.01, and 5167.221)

The act requires a Medicaid MCO, when it seeks to recoup an overpayment made to a provider, to give the provider all details of the recoupment, including:

- The name, address, and Medicaid identification number of the Medicaid recipient to whom the agency provided the services;

- The dates that the services were provided;
- The reason for the recoupment;
- The method by which the provider may contest the proposed recoupment.

The Department must assess Medicaid MCOs' efforts to recoup overpayments made to providers who are network providers and providers who are not network providers. The assessments must examine the amount of time recoupment efforts take, starting from the time providers receive final payment and ending when the recoupment effort is completed. Each Medicaid MCO must submit to the Department information that the Department needs to perform the assessments. The Department must specify what information is needed.

Following the assessments, the Department must include in contracts with Medicaid MCOs terms the Department determines are reasonable to establish limits on Medicaid MCOs' recoupment efforts. The terms must include exceptions for cases of fraud and other types of deception.

Medicaid prompt payment waiver

(R.C. 5167.25, repealed, with conforming changes in R.C. 3901.3814)

The act repeals a requirement that the Medicaid Director apply to CMS for a waiver from the federal Medicaid prompt payment requirements that would have instead required health insuring corporations to submit claims in accordance with requirements established by the Department of Insurance.

Area agencies on aging

(Section 333.190)

The act requires the Department, if it expands the inclusion of the aged, blind, and disabled Medicaid eligibility group or Medicaid recipients who are also eligible for Medicare in the Medicaid managed care system during the FY 2020-FY 2021 biennium, to do both of the following for the remainder of the biennium:

- Require area agencies on aging to be the coordinators of home and community-based waiver services that the recipients receive, and permit Medicaid MCOs to delegate to the agencies full-care coordination functions for those and other health care services;
- In selecting Medicaid MCOs, give preference to organizations that will enter into subcapitation arrangements with area agencies on aging under which the agencies perform, in addition to other functions, network management and payment functions for services that those recipients receive.

Integrated Care Delivery System performance payments

(Section 333.60)

The Department is authorized under continuing law to implement a demonstration project to test and evaluate the integration of care received by individuals dually eligible for

Medicaid and Medicare. In statute the project is called the Integrated Care Delivery System. It may be better known as MyCare Ohio.

The act continues for FYs 2020 and 2021 a requirement that the Department make performance payments to Medicaid MCOs that provide care under the Integrated Care Delivery System. The Department has been required to provide the performance payments since FY 2014.⁷⁸

If participants receive care through Medicaid MCOs under the system, the Department must both:

- Develop quality measures designed specifically to determine the effectiveness of the health care and other services provided to participants by Medicaid MCOs; and
- Determine an amount to be withheld from the Medicaid premium payments paid to Medicaid MCOs for participants.

For purposes of determining the amount to be withheld from premium payments, the Department must establish a percentage amount and apply the same percentage to all Medicaid MCOs providing care to participants of the Integrated Care Delivery System. Each organization must agree to the withholding as a condition of receiving or maintaining its Medicaid provider agreement. The act provides that a Medicaid managed care organization providing care under the system is not subject to withholdings under the Medicaid Managed Care Performance Payment Program for premium payments attributed to participants of the system during FYs 2020 and 2021.

Performance metrics

(R.C. 5167.103)

The act requires the Department to establish performance metrics to evaluate and compare how Medicaid MCOs perform under their MCO contracts with the Department. The performance metrics can include financial incentives and penalties. These metrics are in addition to the managed care performance program under continuing law unchanged by the act, under which the Department provides payments to Medicaid MCOs that meet certain performance standards. The Department must post the metrics on its website and update its website quarterly to reflect any changes it makes to the metrics.

Employment program measure

(Section 333.197)

The act requires the Department, as part of the re-procurement process for new Medicaid MCO contracts, to include, in the measures to determine which MCOs will be awarded contracts, measures related to their abilities and commitment to establish and operate employment programs for Medicaid recipients enrolled in their plans.

⁷⁸ Section 323.300 of H.B. 59 of the 130th General Assembly.

Prescribed drugs

(R.C. 5167.05 and 5167.12)

The act provides that the Department is permitted, instead of required, to include prescribed drugs in the Medicaid managed care system. Under prior law, the Department had to require Medicaid MCOs to cover prescribed drugs.

State pharmacy benefit manager (PARTIALLY VETOED)

(R.C. 5167.24)

Procurement (PARTIALLY VETOED)

The act establishes a state pharmacy benefit manager (PBM) under the Medicaid care management system. A PBM is an entity that contracts with pharmacies on behalf of a health insurer, including a state agency or MCO. The act provides that the state PBM is a pharmacy benefit manager for purposes of Ohio's third party administrator law, therefore, the state PBM is subject to that law. The Director, through a procurement process, must select a state PBM to be responsible for processing all pharmacy claims administration for Medicaid MCOs under the care management system (so long as the Department includes prescribed drugs in that system). The Department is responsible for enforcing the contract after the procurement process.

As part of the procurement process, the Director must:

- Accept applications;
- Establish eligibility criteria for the state PBM;
- Select and contract with a single state PBM; and
- Develop a master contract to be used when the Director contracts with the state PBM, which must prohibit the state PBM from requiring a Medicaid recipient to obtain a specialty drug from a specialty pharmacy owned or otherwise associated with the state PBM.

The Governor vetoed a requirement that the Director reprocure the state PBM contract every four years.

Disclosures (PARTIALLY VETOED)

As part of the procurement process, a prospective state PBM must disclose to the Director all of the following:

- Any activity, policy, practice, contract, or arrangement of the state PBM that may present any conflict of interest with the PBM's relationship with or obligation to the Department or a Medicaid MCO;
- All common ownership, members of a board of directors, managers, or other control of the PBM (or any of the PBM's affiliated companies) with (1) a Medicaid MCO and its affiliated companies, (2) an entity that contracts on behalf of a pharmacy or any pharmacy services administration organization and its affiliated companies, (3) a drug

wholesaler or distributor and its affiliated companies, (4) a third-party payer and its affiliated companies, or (5) a pharmacy and its affiliated companies;

- Any direct or indirect fees, charges, or any kind of assessments imposed by the PBM on pharmacies licensed in Ohio with which it shares common ownership, management, or control, or that are owned, managed, or controlled by any of its affiliated companies;
- Any direct or indirect fees, charges, or any kind of assessments imposed by the PBM on pharmacies licensed in Ohio. (The Governor vetoed a requirement that the state PBM list separately the fees and assessments charged to Ohio pharmacies that operate 11 or fewer locations and those charged to Ohio pharmacies that operate more than 11 locations.)
- Any financial terms and arrangements between the PBM and a prescription drug manufacturer or labeler, including formulary management, drug substitution programs, educational support claims processing, or data sales fees.

For purposes of these provisions, an affiliated company is an entity (including a third-party payer or specialty pharmacy) with common ownership, members of a board of directors, or managers, or that is a parent company, subsidiary company, jointly held company, or holding company with respect to the other entity.

Contract amendment (VETOED)

The Governor vetoed a provision that would have required the Medicaid Director to review the state PBM contract every six months and make the recommended changes.

Affiliated companies (VETOED)

The Governor vetoed a provision that would have permitted the affiliated companies of the state PBM to conduct PBM business in their own names with Medicaid MCOs.

Provisional state PBM

The act requires the Director to select a provisional state PBM by July 1, 2020. The provisional state PBM will be fully implemented as the state PBM upon its demonstrated ability to fulfill the obligations of the state PBM, as illustrated through a readiness review process established by the Director. An entity failing to complete the readiness review process will be deemed as not having met the criteria of the review process. The act prohibits the provisional state PBM from entering into contracts with the Department or Medicaid MCOs as the state PBM before it has satisfactorily completed the readiness review process.

If the Director determines that, for reasons beyond his or her control, selection of a provisional state PBM cannot occur before July 1, 2020, the Director must notify the Joint Medicaid Oversight Committee of (1) the reasons for the delay and (2) the steps that the Director is taking to complete the selection as expeditiously as possible.

Medicaid MCOs and the state PBM (PARTIALLY VETOED)

(R.C. 5167.241(A) and (C))

The act requires Medicaid MCOs to use the state PBM pursuant to the terms of the master contract between the Department and the state PBM.

The Governor vetoed provisions that would have required:

- The state PBM to be responsible for processing all pharmacy claims under the care management system;
- All contracts between the state PBM and a MCO to specify that all pharmacy claims information shared between the parties is confidential and proprietary.

The Governor also vetoed a provision that would have permitted a Medicaid MCO, despite the act's state PBM provisions, to contract directly with a pharmacy regarding the practice of pharmacy, which includes interpreting prescriptions, dispensing drugs, counseling individuals about their drugs, performing drug regimen reviews or utilization reviews, advising an individual regarding the individual's drug therapy, acting under a consult agreement with a physician, or administering immunizations or drugs as authorized by Ohio law.⁷⁹

State PBM compensation (PARTIALLY VETOED)

(R.C. 5167.241(B))

All payments between the Department, Medicaid MCOs, and the state PBM must comply with state and federal law (which includes federal statutes as well as CMS regulations) and any other agreement reached between the Department and CMS. The Director can change a payment arrangement in order to comply with state or federal law or any agreement between the Department and CMS.

The Governor vetoed provisions that would have required the Director to do both of the following regarding the state PBM's compensation:

- Determine the rate the state PBM is paid for its services. All payments relating to claims adjudication would have had to be made to the state PBM from a Medicaid MCO. All payments relating to other administrative matters (such as formulary management and prescribed drug supplemental rebate negotiation) would have had to be made to the state PBM directly by the Department.
- Establish a dispensing fee to be paid to the state PBM for each drug it dispenses under the care management system.

⁷⁹ R.C. 4729.01, not in the act.

Prescribed drug formulary (VETOED)

(R.C. 5167.242)

The Governor vetoed provisions that would have required the state PBM, in consultation with the Director, to develop a Medicaid prescribed drug formulary for the care management system. At minimum, the formulary would have had to list prescribed drugs and specify the per unit price for each drug. The formulary price would have been the total price ceiling for the prescribed drug including any supplemental rebates or discounts received for the drug. The state PBM would have been prohibited from making any payment for a formulary drug in an amount in excess of the per unit price as listed in the formulary.

The Medicaid prescribed drug formulary would not have been effective until approved by the Director. The state PBM would have been required to immediately disclose in writing to the Director any changes to the formulary, and the Director could disapprove any changes. In developing the formulary, the state PBM would have been required to negotiate prices for and price prescribed drugs at the lowest price that also maximizes the health of Medicaid recipients and promotes the efficiency of Medicaid.

State PBM quarterly reports

(R.C. 5167.243)

The state PBM must provide to the Director a written quarterly report containing the following information from the preceding quarter:

- The prices the state PBM negotiated for prescribed drugs under the care management system, including any rebates received from the drug manufacturer;
- The prices the state PBM paid to pharmacies for prescribed drugs;
- Any rebate amounts the state PBM passed on to individual pharmacies;
- The percentage of savings in drug prices that were passed on to care management system participants;
- Any activity, policy, practice, contract, or arrangement of the state PBM that may present any conflict of interest with its relationship with or obligation to the Departments or Medicaid MCO;
- All common ownership, members of a board of directors, managers, or other control of the PBM (or any of the PBM's affiliated companies) with (1) a Medicaid MCO and its affiliated companies, (2) an entity that contracts on behalf of a pharmacy or any pharmacy services administration organization and its affiliated companies, (3) a drug wholesaler or distributor and its affiliated companies, (4) a third-party payer and its affiliated companies, (5) a pharmacy and its affiliated companies;
- Any direct or indirect fees, charges, or any kind of assessments imposed by the PBM on pharmacies licensed in Ohio with which the PBM shares common ownership, management, or control, or that are owned, managed, or controlled by any of the PBM's affiliated companies;

- Any direct or indirect fees, charges, or any kind of assessments imposed by the PBM on pharmacies licensed in Ohio;
- Any financial terms and arrangements between the PBM and a prescription drug manufacturer or labeler, including formulary management, drug substitution programs, educational support claims processing, or data sales fees.
- Any other information required by the Director.

The act permits the Director to ask the state PBM to provide additional information as necessary. It also requires the Department to modify the reporting requirements under its Medicaid managed care organization contracts at the time of contract execution, renewal, or modification as necessary to comply with the act's reporting requirements.

Medicaid Director quarterly reports (VETOED)

(R.C. 5162.137)

The Governor vetoed provisions that would have required the Director to make findings based on the state PBM's quarterly reports and complete a report detailing the findings within 60 days after receiving the quarterly report. The Director would have been required to submit the report to the General Assembly and, on request, testify about the findings before either chamber of the General Assembly or the Joint Medicaid Oversight Committee. While testifying, the Director would have been required to keep confidential any document marked as "confidential" or "proprietary" and redact any information as necessary before it becomes public, except that the Director could have shared the document or information with other state agencies or entities.

Civil penalty

(R.C. 5167.244)

The act prohibits any person from violating the terms of the master PBM contract or its requirements pertaining to the state PBM compensation and Medicaid MCOs and the state PBM. Violations are subject to a civil penalty in an amount to be determined by the Director.

Pharmacy appeals process

(R.C. 5167.245)

The Director must establish an appeals process by which pharmacies can appeal to the Department (as opposed to the state PBM) any disputes relating to the maximum allowable cost set by the state PBM for a prescribed drug. All pharmacies participating in the care management system must use the appeals process to resolve any disputes relating to the maximum allowable cost.

Rulemaking (VETOED)

(R.C. 5167.246)

The Governor vetoed provisions that would have required the Director to adopt rules as necessary to implement the act's PBM provisions, including:

- Specifying the information that the state PBM must disclose to the Director;
- Establishing the amount of civil penalties for violations of these provisions;
- Adjusting capitation payments to Medicaid MCOs as necessary, as a result of the state PBM processing all pharmacy claims;
- Prohibiting the state PBM from requiring an enrollee to obtain a specialty drug from a specialty pharmacy owned or otherwise associated with the state PBM;
- Defining “specialty drug” and “specialty pharmacy”;
- Establishing a dispensing fee to be paid to the state PBM for claims adjudication;
- Specifying procedures for conducting appeals (see above).

Payment and cost disclosures

(R.C. 5167.122)

The state PBM to, on request from the Department, must disclose to the Department all sources of payment the PBM receives for prescribed drugs, including any benefits such as drug rebates, discounts, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other payments related to services provided for the Medicaid MCO.

Additionally, Medicaid MCOs must disclose to the Department, in the format specified by the Department, the MCO’s administrative costs associated with providing pharmacy services under the care management system.

Prescribed drug claims processing pilot

(Section 333.290)

The act requires the Department to administer a 16-county pilot program for the pre-audit processing of prescribed drug claims submitted to Medicaid MCOs or their pharmacy benefit managers, by a qualifying pharmacy. The Department must ensure that the pilot program is operational beginning January 1, 2020.

Qualifying pharmacies

In order for a pharmacy to submit a claim under the pilot program, both of the following must apply to the claim:

1. The claim must relate to a prescription filled in Adams, Athens, Belmont, Gallia, Guernsey, Harrison, Morgan, Muskingum, Noble, Perry, Pike, Ross, Scioto, Tuscarawas, Vinton, or Washington County.

2. The pharmacy submitting the claim must serve a significant share of Medicaid enrollees in the county who are enrolled in Medicaid MCO plans, as determined by the Director.

The act specifies that a pharmacy’s participation in the pilot program is voluntary.

Department duties

Under the pilot program, the Department must:

- Approve individuals or entities to serve as claims processors;
- Ensure that claims are adjudicated by approved claims processors and that information relating to each claim is submitted to the Department for evaluation and review;
- Authorize approved claims processors to accept and adjudicate claims from the payment amounts submitted by patients;
- Utilize a coordination of benefits process to determine the respective payment responsibilities of different payors.

If a claims processor is unable to provide claims data to the Department, the participating pharmacy must, to the extent permissible under state and federal law, cooperate with the Department in providing any information missing from the claim.

Conclusion date, report

The pilot program is temporary; the Department must conclude it on December 31, 2020. At the conclusion of the program, the Department must evaluate and review the following data relating to each prescribed drug claim made under the program:

- The usual and customary drug cost;
- The contracted drug ingredient cost;
- The dispensing fee;
- Any applicable taxes.

The Department must prepare a report relating to the pilot program by September 1, 2021. The Department must submit the report to the Governor, the Senate President, the Speaker of the House, and the chairperson of the Joint Medicaid Oversight Committee. The report must outline both:

1. The costs, savings, trends, and utilization rates realized under the pilot program; and
2. Any policy recommendations, including whether to reinstate the program, and if further implementation will decrease prescribed drug costs and spending levels.

Vetoed Medicaid managed care provisions (VETOED)

(R.C. 4729.80, 4729.801, 5162.138, 5162.139, 5166.01, 5166.43, 5166.50, 5167.10, 5167.105, 5167.106, 5167.107, 5167.20, 5167.29, 5167.35, and 5167.36; Sections 333.65, 333.195, and 333.230)

The Governor vetoed a number of provisions regarding Medicaid managed care. The vetoed provisions would have done the following:

- Permitted a Medicaid MCO to submit a request to the State Board of Pharmacy for information in its drug database (the Ohio Automated Rx Reporting System or OARRS)

about all Medicaid recipients enrolled in a plan offered by the MCO, and required the Board to provide the information in a single electronic file or format.

- Required the Department to establish a waiver under which Medicaid MCO plans could cover any service or product that would have a beneficial effect on the health of Medicaid recipients enrolled in the plans and, because of the beneficial effect, would likely have reduced the per recipient per month costs under the plan by the end of the first three years that the service or product was covered.
- Required the Department to do all of the following if the U.S. Secretary of Health and Human Services agreed to enter into an enforceable agreement that safeguarded the state's receipt of federal Medicaid funds:
 - Establish the Shared Savings Bonus Program, under which a Medicaid MCO would have earned a bonus if its three-year average per recipient capitated payment rate was less than the three-year average per recipient cost of certain other states' Medicaid programs.
 - Establish the Quality Incentive Program, under which the Department would have randomly assigned certain Medicaid recipients to Medicaid MCOs based on points earned for meeting health and quality metrics.
 - Permit regional hospital networks to become Medicaid MCOs if they accepted a capitated payment that was not more than 90% of the lowest capitated payment made to a Medicaid MCO that is a health insuring corporation.
- Required each Medicaid MCO to establish a program that incentivized enrollees to obtain covered health care from high quality and efficient providers.
- Required a Medicaid MCO, if it established a rate for a service that was greater than the fee-for-service rate, to require providers of the service to enter into value-based contracts as a condition of joining the MCO's provider panel.
- Prohibited a Medicaid MCO from permitting a provider to be part of the MCO's provider panel unless the provider assured the MCO that it would comply with a requirement regarding cost estimates.
- Required a hospital, with certain exceptions, to accept as payment in full from a Medicaid MCO an amount equal to 90% of the fee-for-service rate for a non-emergency service provided to a Medicaid recipient, if the hospital did not have a contract with the MCO and the MCO referred the recipient to the hospital.
- Required the Department, by January 1, 2020, to (1) evaluate and benchmark the financial health of Medicaid MCOs against other MCOs providing services under the Medicaid programs of other states in the Midwest, (2) publish its findings on its website, (3) submit the findings to the Joint Medicaid Oversight Committee, and (4) adopt rules addressing the financial health of Medicaid MCOs in the state.

A detailed description of these vetoed provisions is available on pages 307 to 315, 318, 320, and 351 to 352 of LSC's analysis of H.B. 166, As Passed by the House. The analysis is available online at <https://www.lsc.ohio.gov/documents/budget/133/MainOperating/HP/BillAnalysis/h0166-ph-133.pdf>.

The Governor also vetoed a provision that would have required the Department, before adjusting the capitation rates paid to Medicaid MCOs under certain circumstances, to obtain the approval of the Joint Medicaid Oversight Committee and then obtain approval for the appropriations needed for the adjustment from the Controlling Board. The requirement would have applied if (1) the adjustment would increase the capitation rate for a period of time to an amount exceeding the amount the capitation rate otherwise would be for that period, according to the Medicaid MCO contracts in effect at the time the adjustment would be applied and (2) the total cost to the Medicaid program would exceed \$50 million. The requirement would have been in addition to a requirement under continuing law to obtain federal approval for changes to Medicaid.

Additionally, the Governor also vetoed a provision that would have required the Department to complete a procurement process for Medicaid MCOs by July 1, 2020.

Clarification and simplification of statutes

(R.C. 5167.01, primary; R.C. 3701.612, 4729.80, 5166.01, 5167.03, 5167.04, 5167.05, 5167.051, 5167.10, 5167.101, 5167.102, 5167.11, 5167.12, 5167.13, 5167.14, 5167.17, 5167.171, 5167.172, 5167.173, 5167.18, 5167.20, 5167.201, 5167.22, 5167.23, 5167.26, 5167.41, and 5168.75)

The act clarifies and simplifies statutes governing the Medicaid managed care system. For the sake of clarity, the act provides for Medicaid recipients to enroll in "Medicaid MCO plans" rather than in Medicaid managed care organizations. For the sake of simplicity, the act requires Medicaid MCOs to comply with various requirements rather than, as under prior law, requiring the contracts that the Department enters into with Medicaid MCOs to include the requirements. Also, the act uses the term "enrollee," which is defined as a Medicaid recipient who participates in the Medicaid managed care system and enrolls in a Medicaid MCO plan.

Prescribed drug spending growth

(R.C. 5164.7515)

The act requires the Director, by July 1, 2020, to establish an annual benchmark for prescribed drug spending growth under Medicaid. If the Director determines that Medicaid prescribed drug spending in a given year is projected to exceed the benchmark, the Director must identify specific prescribed drugs that significantly contribute to exceeding the benchmark. The Director must publish a list of the identified prescribed drugs.

Identified drugs

For each drug identified by the Director, the Director must determine if there is a current supplemental rebate for that drug between the drug's manufacturer and the Department, or its designee. If there is, the Director can choose to renegotiate the rebate

agreement. If there is not a current supplemental rebate for the drug, the Director must evaluate whether to pursue one with the drug manufacturer. In making this evaluation, the Director can consider:

- The drug's actual cost to the state;
- Whether the manufacturer is providing significant discounts or rebates for other prescribed drugs under Medicaid; and
- Any other information the Director considers relevant.

Renegotiation of rebate agreement

If the Director determines that an existing prescribed drug supplemental rebate agreement should be renegotiated, the Director must establish a target rebate amount for the renegotiation, considering any of the following:

- Public information relevant to pricing the drug;
- Department information that is relevant to pricing the drug;
- Information relating to value-based pricing of the drug for Medicaid recipients;
- The seriousness and prevalence of the conditions for which the drug is prescribed;
- The drug's volume of use among Medicaid recipients;
- The drug's effectiveness in treating conditions for which it is prescribed or improving a patient's health, quality of life, or overall health outcomes;
- The likelihood that the drug will reduce the need for other medical care, including hospitalization;
- The drug's average wholesale price, wholesale acquisition cost, and retail price, and its cost under the Medicaid program, not including any rebates received for it;
- In the case of generic drugs, the number of manufacturers that produce the drug;
- Whether there are pharmaceutical equivalents to the drug; and
- Any other information the Director considers relevant.

In renegotiating a supplemental rebate agreement, the Director must seek to negotiate the Director's target rebate amount. The act prohibits the Director from entering into a rebate agreement for less than 60% of the target.

Removal from preferred drug list

If a supplemental rebate is not established or renegotiated for an identified prescribed drug, the Director can consider removing the drug from the Medicaid preferred drug list and imposing a prior authorization requirement on the drug, in accordance with continuing Medicaid law unchanged by the act.

Review of prescribed drug reform savings

(Section 333.240)

The act requires the Department, by January 1, 2021, to conduct a review of all savings to the state from the act's prescribed drug reforms. The Department must complete a report outlining its findings 60 days after its review and submit it to the Governor and the General Assembly. The Department must testify about its findings before the Joint Medicaid Oversight Committee, and, on request of the Senate President, the Speaker of the House, or both, before the General Assembly.

Pharmacy supplemental dispensing fee (PARTIALLY VETOED)

(Section 333.280)

The act requires the Department to adopt rules to provide a supplemental dispensing fee under the care management system to retail pharmacies. The supplemental dispensing fee must have at least three different payment levels. The Director must adjust the supplemental dispensing fee if federal Medicaid law reduces the amount of federal funds the Department receives for the fee.

The Governor vetoed provisions that would have:

- Required the rules establishing the supplemental dispensing fee to be adopted by January 1, 2020;
- Required the supplemental dispensing fee to be based on (1) the ratio of Medicaid prescriptions a pharmacy location filled compared to the total prescriptions the location filled (based on the "Survey of the Average Cost of Dispensing a Medicaid Prescription in the State of Ohio" prepared for the Department) and (2) the number of retail pharmacy locations participating in the care management system in the area (as determined and periodically reviewed by the Department). Pharmacy locations with a high ratio of Medicaid prescriptions and a low number of other pharmacy locations would have received a higher dispensing fee amount.
- Prohibited the supplemental dispensing fee from causing a reduction in other payments made to the pharmacy for providing prescription drugs under the care management system.

Social determinants of health

(R.C. 5162.72)

The act requires the Medicaid Director to implement strategies that address social determinants of health, including employment, housing, transportation, food, interpersonal safety, and toxic stress.

Evaluations of expansion group's employment success

(R.C. 5162.1310)

The act requires the Department to periodically evaluate the success that members of the expansion eligibility group (also known as Group VIII) have with (1) obtaining employer-sponsored health insurance coverage, (2) improving health conditions that would otherwise prevent or inhibit stable employment, and (3) improving the conditions of their employment, including duration and hours of employment. Medicaid MCOs are required to collect and submit to the Department relevant data about members of the expansion eligibility group who are enrolled in the MCOs' plans. The Department is permitted to request that a Medicaid MCO collect and submit to the Department additional data the Department needs for its evaluation.

The Department must complete a report for each of the evaluations. The Medicaid Director must submit the reports to the General Assembly and Joint Medicaid Oversight Committee.

Automatic designation of representative (VETOED)

(R.C. 5160.01 and 5160.48)

The Governor vetoed a provision that would have designated a facility participating in the Assisted Living Program as the primary authorized representative when a resident of the facility applied for Medicaid. Under law unchanged by the act, the Department and county departments of job and family services are authorized to disclose information regarding a medical assistance applicant or recipient to the person's authorized representative.

The vetoed provision would have specified that, for an applicant who resides in a nursing facility or residential care facility that participates in the Assisted Living Program, a county department of job and family services must automatically designate the facility as the applicant's primary authorized representative at the time of the application for medical assistance. The facility would have been considered an authorized representative for purposes of the continuing law discussed above, and accordingly, the county department could communicate with the facility regarding the application.

Care Innovation and Community Improvement Program

(Section 333.220)

The act requires the Medicaid Director to continue the Care Innovation and Community Improvement Program for the FY 2020-FY 2021 biennium. The Director was originally required to establish it for the FY 2018-FY 2019 biennium.⁸⁰

Any nonprofit hospital agency affiliated with a state university and any public hospital agency may volunteer to participate if the hospital has a Medicaid provider agreement. The nonprofit and public hospital agencies that participate are responsible for the state share of the

⁸⁰ Section 333.320 of H.B. 49 of the 132nd General Assembly.

program's costs and must make or request the appropriate government entity to make intergovernmental transfers to pay for the costs. The Director must establish a schedule for making the transfers.

Each participating hospital agency must undertake at least one of the following tasks in accordance with strategies, and for the purpose of meeting goals, the Director is to establish:

- Sustain and expand community-based patient centered medical home models;
- Expand access to community-based dental services;
- Improve the quality of community care by creating and sharing best practice models for emergency department diversions, care coordination at discharge and during transitions of care, and other matters related to community care;
- Align community health improvement strategies and goals with the State Health Improvement Plan and local health improvement plans;
- Expand access to ambulatory drug detoxification and withdrawal management services;
- Train medical professionals on evidence-based protocols for opioid prescribing and drug addiction risk assessments;
- In collaboration with other nonprofit and public hospital agencies that also do this task, create and implement a plan to assist rural areas to (a) expand access to cost-effective detoxification, withdrawal management, and prevention services for opioid addiction and (b) disseminate evidence-based protocols for opioid prescribing and drug addiction risk assessment.

If a hospital agency chooses the task to expand access to ambulatory drug detoxification and withdrawal management services, or the task to create and implement a plan to assist rural areas, it must give priority to the areas of the community it serves with the greatest concentration of opioid overdoses and deaths.

Regardless of the task chosen, a hospital agency must submit annual reports to the Joint Medicaid Oversight Committee summarizing its work and progress in meeting the program's goals.

Each participating hospital agency is to receive supplemental Medicaid payments for physician and other professional services that are covered by Medicaid and provided to Medicaid recipients. The payments must equal the difference between the Medicaid rate and average commercial rates for the services. The Director may terminate, or adjust the amount of, the payments if funding for the program is inadequate.

The Director must establish a process to evaluate the work done under the program by nonprofit and public hospital agencies and their progress in meeting the program's goals. The process must be established by January 1, 2020. The Director may terminate a hospital agency's participation if the Director determines that it is not performing at least one of the tasks discussed above or making progress in meeting the program's goals.

All intergovernmental transfers made under the program must be deposited into the existing Care Innovation and Community Improvement Program Fund. Money in the fund and the corresponding federal funds must continue to be used to make the supplemental payments to hospital agencies under the program.

Rural healthcare workforce training and retention (VETOED)

(Section 333.227)

The Governor vetoed a provision that would have required the Medicaid Director to create the Rural Healthcare Workforce Training and Retention Program for FYs 2020 and 2021. Any nonprofit hospital agency affiliated with a state university and any public hospital agency could have volunteered to participate if the hospital has a Medicaid provider agreement and an approved graduate medical education program.

Nonprofit and public hospital agencies that participated in the program would have been responsible for the state share of the program's costs and required to make or request the appropriate government entity to make intergovernmental transfers to pay for the costs. The Director would have been required to establish a schedule for making the transfers.

Each participating hospital agency would have been required to do all of the following tasks in accordance with strategies, and for the purpose of meeting goals, that the Director would have been required to establish:

- Increase residency positions in primary, specialty, or dental care as identified by the Director;
- Create incentives to increase recruitment and retention of graduates of Ohio residency and fellowship programs in primary, specialty, or dental care as identified by the Director;
- Increase training opportunities for physician assistants, psychologists, and advanced practice registered nurses in primary care, alcohol and drug treatment, or mental health, as appropriate for their scope of practice;
- Report to the Director about how the above tasks would address the workforce needs of critical access hospitals and rural hospitals (i.e., hospitals that are Medicare certified or accredited by a federally approved national accrediting organization, registered with the Department of Health, and located in a county that has a population of less than 125,000);
- Create opportunities for persons to receive training in serving medically underserved populations, providing team-based care, and undergoing clinical rotations in federally qualified health centers, facilities operated by community addiction services providers and community mental health services providers, critical access hospitals, and rural hospitals.

The Medicaid Director would have been required to consult with the Director of Health and Director of Mental Health and Addiction Services to ensure that the program's strategies and goals were consistent with the state's healthcare workforce objectives.

Participating hospital agencies would have received supplemental Medicaid payments at least once during FY 2020 and at least once again during FY 2021 for graduate medical education costs that were apportioned to the provision of hospital inpatient services included in the Medicaid managed care system. The supplemental payments would have equaled the difference between (1) Medicaid payments for direct and indirect graduate medical education and (2) the Medicaid payment based in part on Medicare direct and indirect graduate medical education reimbursement principles.

The Director would have been required to consult with participating hospital agencies to create a centralized database that tracked (1) how they encouraged physicians in residency programs to practice medical specialties for which there is a need in this state and (2) physicians' decisions to practice medicine in this state, the locations at which they practiced, and whether they became or obtained employment with Medicaid providers.

The Rural Healthcare Workforce Training and Retention Program Fund would have been created in the state treasury. All intergovernmental transfers under the program were to be deposited into the fund. Money in the fund and the corresponding federal match were to be used to make supplemental Medicaid payments under the program.

Children's hospitals study committee

(Section 333.67)

The act requires the Department to establish a committee to study and develop performance indicators for children's hospitals. The Medicaid Director must appoint the committee's members. The committee must prepare and submit to the Department a report of its findings and recommendations. The act does not specify a timeline by which members must be appointed or the report must be submitted.

Hospital Care Assurance Program, franchise permit fee

(Sections 601.22 and 601.23, amending Sections 125.10 and 125.11 of H.B. 59 of the 130th G.A.)

The act continues the Hospital Care Assurance Program (HCAP) for two additional years. The program was scheduled to end October 16, 2019, but under the act is to continue until October 16, 2021. Under HCAP, hospitals are annually assessed an amount based on their total facility costs, and government hospitals make annual intergovernmental transfers. The Department distributes to hospitals money generated by the assessments and intergovernmental transfers along with federal matching funds. A hospital compensated under the program must provide (without charge) basic, medically necessary, hospital-level services to Ohio residents who are not recipients of Medicare or Medicaid and whose income does not exceed the federal poverty line.

The act also continues for two additional years another assessment imposed on hospitals; that assessment is to end on October 1, 2021, rather than October 1, 2019. The assessment is in addition to HCAP, but like that program, it raises money to help pay for the Medicaid program. To distinguish the assessment from HCAP, the assessment is sometimes called a hospital franchise permit fee.

Health information exchanges

(R.C. 3798.01 and 3798.07; R.C. 3798.06, 3798.08, 3798.14, 3798.15, and 3798.16, all repealed)

The act eliminates all provisions regarding approved health information exchanges from statutes governing protected health information.⁸¹ Prior law defined “approved health information exchange” as a health information exchange that had been approved by the Medicaid Director or that had been certified by the Office of the National Coordinator for Health Information Technology. A health information exchange is any person or government entity that provides a technical infrastructure to connect computer systems or other electronic devices used by covered entities to facilitate the secure transmission of health information.⁸²

Specifically, the act repeals statutes that:

- Required the Medicaid Director to adopt rules establishing (a) standards and processes for approving health information exchanges, (b) processes for the Director to investigate and resolve concerns and complaints regarding approved health information exchanges, and (c) processes and content for agreements under which covered entities participated in approved health information exchanges (participation agreements);
- Permitted a covered entity to disclose an individual’s protected health information to a health information exchange without a valid authorization if (a) the exchange was an approved health information exchange, (b) the covered entity was a party to a valid participation agreement with the exchange, (c) the disclosure was consistent with all procedures established by the exchange, and (d) the covered entity, before making the disclosure, furnished written notice to the individual or the individual’s personal representative;
- Gave covered entities and approved health information exchanges immunity from civil and criminal liability for actions authorized by the statutes governing approved health information exchanges.

⁸¹ “Protected health information” is defined in a federal regulation generally as individually identifiable health information that is transmitted by or maintained in electronic media or any other form or medium. (45 C.F.R. 160.103.) “Individually identifiable health information” is defined in the same federal regulation as health information, including demographic information collected from an individual, that (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse, (2) relates to (a) the past, present, or future physical or mental health or condition of an individual, (b) the provision of health care to an individual, or (c) the past, present, or future payment for the provision of health care to an individual, and (3) identifies the individual or reasonably could be used to identify the individual.

⁸² “Covered entity” is defined in federal regulations as a health plan, health care clearinghouse, or health care provider that transmits any health information in electronic form in connection with a transaction covered by federal rules governing the privacy of personal health information (the HIPAA Privacy Rule). (45 C.F.R. 160.103.)

The act also eliminates a requirement that a covered entity, when it disclosed an individual's protected health information to a health information exchange, restrict disclosure in a manner consistent with a written request from the individual or the individual's personal representative concerning specific categories of protected health information to the extent the rules required the covered entity to comply with such a request. The Director's duty to adopt those rules is eliminated as part of the act's repeals.

Health Care/Medicaid Support and Recoveries Fund

(R.C. 5162.52)

The act establishes two additional purposes for which the Department is to use money credited to the Health Care/Medicaid Support and Recoveries Fund: (1) programs that serve youth involved with multiple government agencies and (2) innovative programs that the Department has the statutory authority to implement and that promote access to health care or help achieve long-term cost savings to the state.

Under continuing law, the Department must use money credited to the fund to pay for Medicaid services and costs associated with the administration of Medicaid.

Abolished funds

Integrated Care Delivery Systems Fund

(R.C. 5162.58, repealed; R.C. 5162.01)

The act abolishes the Integrated Care Delivery Systems Fund, which was part of the state treasury. Under prior law, a portion of the amounts that the Integrated Care Delivery System (MyCare Ohio) saved the Medicare program had to be deposited into the fund, if an agreement with the federal government provided for the state to receive those amounts. The Department was required to use money to further develop integrated delivery systems and improved care coordination for individuals eligible for both Medicare and Medicaid (dual eligible individuals).

Managed Care Performance Payment Fund

(R.C. 5162.60, repealed)

The act abolishes the Managed Care Performance Payment Fund. The fund, which was part of the state treasury, consisted of:

- Amounts transferred to it for the Managed Care Performance Payment Program;
- All fines collected from Medicaid MCOs for failure to meet performance standards or other requirements specified in provider agreements with the Department or rules adopted by the Medicaid Director;
- All of the fund's investment earnings.

Prior law required that the fund be used to do the following:

- Make performance payments to Medicaid MCOs under the Managed Care Performance Payment Program;

- Meet obligations specified in Medicaid provider agreements;
- Pay for Medicaid services provided by Medicaid MCOs;
- Reimburse a Medicaid MCO that had paid a fine for failure to meet performance standards or other requirements if the organization came into compliance.

Medicaid Administrative Reimbursement Fund

(R.C. 5162.62, repealed)

The act abolishes the Medicaid Administrative Reimbursement Fund. The balance of this fund was transferred to a different fund in FY 2018, and it had a zero cash balance.

Medicaid School Program Administrative Fund

(R.C. 5162.64, repealed)

The act repeals the law that established the Medicaid School Program Administrative Fund. Prior law required that money be used to pay for the school component of Medicaid, including refunding a Medicaid school provider any overpayment the provider made to Medicaid. Although the fund was authorized in 2013, it was never created.

Extended authority regarding employees

(Section 333.20)

The act extends until July 1, 2021, the Medicaid Director's authority to establish, change, and abolish positions for the Department, and to assign, reassign, classify, reclassify, transfer, reduce, promote, or demote employees who are not subject to the state's public employees collective bargaining law.

The Director has had this authority since July 1, 2013. It was last scheduled to expire July 1, 2019.⁸³

The authority includes assigning or reassigning an exempt employee to a bargaining unit classification if the Director determines that the bargaining unit classification is the proper classification for that employee.⁸⁴ The Director's actions must comply with a federal regulation establishing standards for a merit system of personnel administration. If an employee in the E-1 pay range is assigned, reassigned, classified, reclassified, transferred, reduced, or demoted to a position in a lower classification, the Director, or for a transfer outside the Department, the Director of Administrative Services, must assign the employee to the appropriate classification

⁸³ Section 323.10.30 of H.B. 59 of the 130th General Assembly, Section 327.20 of H.B. 64 of the 131st General Assembly, and Section 333.20 of H.B. 49 of the 132nd General Assembly.

⁸⁴ An exempt employee is a permanent full-time or permanent part-time employee paid directly by warrant of the Director of Budget and Management whose position is included in the job classification plan established by the Director of Administrative Services, but who is not subject to the collective bargaining law. (R.C. 124.152, not in the act.)

and place the employee in Step X. The employee is not to receive any increase in compensation until the maximum rate of pay for that classification exceeds the employee's compensation. Actions either Director takes under this provision are not subject to appeal to the State Personnel Board of Review.

Updating references

(R.C. 3901.381, 5168.03, 5168.05, 5168.06, and 5168.08)

The act updates Revised Code references to the former U.S. Health Care Financing Administration with references to the U.S. Centers for Medicare and Medicaid Services. The federal government announced this name change in 2001.