Ohio Legislative Service Commission

Bill Analysis

Bob Bennett

H.B. 251

131st General Assembly
(As Introduced)

Reps. Sprague and Driehaus, Antonio, Bishoff, Green, Lepore-Hagan, Reineke, Rezabek, Rogers

BILL SUMMARY

- Establishes the Medicaid Coverage of Community Behavioral Health Services Study Group to study the issue of revising the Medicaid program's coverage of community behavioral health (CBH) services.
- Requires the group to complete a report of its study and recommendations not later than nine months after the bill's effective date.
- Requires the Ohio Department of Medicaid (ODM) to submit to the Joint Medicaid Oversight Committee (JMOC) written notice of any proposed revisions to the Medicaid program's coverage of CBH services before implementing the revisions.
- Prohibits ODM from implementing the revisions unless JMOC approves, or fails to either approve or reject, the revisions within three months after receiving ODM's notice.
- Eliminates a prohibition against including in the care management system alcohol, drug addiction, and mental health services for which the nonfederal share of the cost is provided by a board of alcohol, drug addiction, and mental health services (ADAMHS board) or a state agency other than ODM.
- Prohibits CBH services from being added to the care management system until at least one year and nine months after the bill's effective date and permits ODM to begin to add them after that if JMOC, before that date, approves, or fails to either approve or reject, adding the services.
- Establishes a phase-in order for adding CBH services to the care management system and authorizes JMOC to approve a different order.

- Prohibits ODM, after implementing a phase, from implementing a subsequent phase unless JMOC, within one month after receiving an ODM report about the preceding phase, approves, or fails to either approve or reject, the implementation of the next phase.

- Makes each Medicaid managed care organization (MCO) responsible for CBH services included in the continuum of care established by ADAMHS boards.

- Requires the portion of the premiums paid to Medicaid MCOs that represents the costs of CBH services to be based on at least the Medicaid payment rates for the services in effect on June 30, 2016, under the fee-for-service system.

- Prohibits a Medicaid MCO from establishing prior authorization requirements for CBH services.

- Prohibits a Medicaid MCO from placing certain limits on access to CBH services, including limiting the access of children in the child welfare system to CBH services in a manner that is more restrictive than the access the children have to the services under the child welfare system.

- Prohibits a Medicaid MCO from including specialty pharmacies in its provider network.

- Prohibits a Medicaid MCO from refusing to permit a qualified and willing provider of CBH services to join the Medicaid MCO's provider network.

- Requires ODM to (1) pay a provider of CBH services a specified amount if a Medicaid MCO fails to pay a claim in full within 45 days after payment is due and (2) collect from the Medicaid MCO the amount ODM pays the provider.

CONTENT AND OPERATION

Medicaid Coverage of Community Behavioral Health Services Study Group

The bill establishes the Medicaid Coverage of Community Behavioral Health Services Study Group.[1] The group is to study the issue of revising the Medicaid program's coverage of community behavioral health (CBH) services.

Membership

The following are to serve on the group:

[1] Section 3.

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

(2) The Director of Mental Health and Addiction Services or the Director's designee;

(3) One representative of each of the following: the Ohio Association of Health Plans, the Ohio Council of Behavioral Health and Family Services Providers, the Public Children Services Association of Ohio, the Ohio Association of Child Caring Agencies, the Ohio Association of County Behavioral Health Authorities, the National Alliance on Mental Illness of Ohio, the Ohio Citizen Advocates for Addiction Recovery, and the Ohio Alliance of Recovery Providers;

(4) Three consumers of CBH services;

(5) Three family members of consumers of CBH services.

The Medicaid Director is required to appoint the members representing the groups specified above, the consumers, and the family members of consumers. The appointments must be made not later than three months after the bill's effective date.

The group's members are to serve without compensation, except to the extent that serving on the group is part of their regular employment duties. The members are not to receive reimbursement for their expenses in serving as part of the group.

Administrative matters

The bill requires the Medicaid Director to serve as the group's chairperson. The Ohio Department of Medicaid (ODM) must provide necessary support services for the group.

Focus of study

In studying the issue of revising the Medicaid program's coverage of CBH services, the group is to study and develop recommendations for all of the following:

(1) Standardizing the admittance criteria for providers of drug addiction services;

(2) Having Medicaid pay for CBH services on the basis of a recipient's episode of needed services in a manner that emphasizes payment for long-term, low intensity maintenance services that help keep people stable or in recovery;

(3) Disaggregating community psychiatric supportive treatment, case management, and health home services;

(4) Redefining the terms "pharmacologic management services" and "medical/somatic services" in order to align the service coding for the services with national standards and to create discrete payment rates;

(5) Ensuring Medicaid coverage of assertive community treatment services, intensive home-based treatment services, high fidelity wrap around services, peer services, supportive employment services, and substance use disorder residential services and implementing a standardized assessment tool to access these services;

(6) Delegating CBH services to specialty plans offered by Medicaid managed care organizations (MCOs);

(7) Having Medicaid MCOs (a) delegate care coordination to providers of CBH services or networks of such providers and (b) oversee the delegated care coordination;

(8) Having ODM contract with a Medicaid MCO that specializes in behavioral health services to provide (a) comprehensive services to Medicaid recipients with an intense need for CBH services and (b) noncomprehensive services to Medicaid recipients with a nonintense need for CBH services;

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

Report

The bill requires the group to complete a report of its study and recommendations not later than nine months after the bill's effective date. The group is to submit the report to the Governor, General Assembly, and Joint Medicaid Oversight Committee (JMOC). The group is to cease to exist on submission of the report.

Revisions to Medicaid's coverage of community behavioral health services

ODM is required by the bill to submit to JMOC written notice of any proposed revisions to the Medicaid program's coverage of CBH services before implementing the revisions.[2] JMOC must hold at least one public hearing regarding the proposed revisions.[3] ODM is prohibited from implementing the revisions unless JMOC approves, or fails to either approve or reject, the revisions not later than three months after receiving ODM's notice. The notice requirement and implementation prohibition do not apply, however, to revisions that must be made to (1) avoid a loss in federal Medicaid funds or (2) add CBH services to the Medicaid managed care system pursuant to the

[2] R.C. 5164.151.

[3] R.C. 103.416 (primary) and 103.41.

bill. (See "**Adding community behavioral health services to Medicaid managed care**" below.)

Adding community behavioral health services to Medicaid managed care

The bill eliminates the prohibition in current law against including in the care management system (i.e., Medicaid managed care) alcohol, drug addiction, and mental health services for which the nonfederal share of the cost is provided by a board of alcohol, drug addiction, and mental health services (ADAMHS board) or a state agency other than ODM.[4] However, the bill prohibits CBH services from being added to the care management system until at least one year and nine months after the bill's effective date. ODM is permitted to begin to add those services after that date if JMOC, within that period, approves, or fails to either approve or reject, adding those services.[5]

Adding the services in phases

If ODM adds CBH services to the care management system, it is to add the services in phases. The bill establishes the phase-in order but authorizes JMOC to approve a different order.[6] The following is the bill's phase-in order:

(1) Community mental health services for adults with severe and persistent mental illness may be added first.

(2) Community mental health services for other adults may be added second.

(3) Community alcohol and drug addiction services for adults may be added third.

(4) Community mental health services for children with serious emotional disorders may be added fourth.

(5) Community mental health services for children who do not have serious emotional disorders but have been adjudicated abused, neglected, dependent, delinquent, or unruly or have multiple needs and receive or are eligible to receive services from multiple state or local government agencies may be added fifth.

(6) Community mental health services for other children may be added sixth.

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[4] R.C. 5167.03.

[5] R.C. 5167.04(A).

[6] R.C. 103.417 (primary) and 103.41.

(7) Community alcohol and drug addiction services for children may be added seventh.[7]

ODM is required to submit to JMOC a written report for each of the phases. A report for each phase is due not later than 120 days after the first day of the phase's implementation and must summarize how well the phase worked during its first 90 days. JMOC must hold a public hearing regarding each report. ODM is prohibited from implementing any subsequent phase unless JMOC, not later than one month after receiving ODM's report for the phase, approves, or fails to either approve or reject, the implementation of the next phase.[8]

Medicaid MCOs' responsibilities, requirements, and prohibitions

If ODM adds CBH services to the care management system, each Medicaid MCO is to be responsible for providing or arranging for the provision of (on behalf of Medicaid recipients enrolled in the Medicaid MCO) all CBH services included in the continuum of care that continuing law requires ADAMHS boards to establish. This responsibility is to be assumed in accordance with the order in which CBH services are added to the care management system. Also, the portion of the premiums paid to Medicaid MCOs that represents the costs of the services is to be based on at least the Medicaid payment rates for the services in effect on June 30, 2016, under the fee-for-service system.[9]

A Medicaid MCO assuming responsibility for CBH services added to the care management system is prohibited from doing any of the following:

(1) Establishing prior authorization requirements for CBH services;

(2) Limiting the number of treatment visits a Medicaid recipient enrolled in the Medicaid MCO may have with a provider of CBH services or otherwise placing arbitrary limits on other treatment units of CBH services;

(3) Limiting the access of children who have been adjudicated abused, neglected, dependent, delinquent, or unruly to CBH services in a manner that is more restrictive than the access the children have to CBH services under the child welfare system;

(4) Including specialty pharmacies in the Medicaid MCO's provider network;

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[7] R.C. 5167.04(B).

[8] R.C. 5167.04(C) and 103.417.

[9] R.C. 5167.04(D)(1) and (2).

(5) Refusing to permit a qualified and willing provider of CBH services (other than specialty pharmacies) to join the Medicaid MCO's provider network.[10]

If a Medicaid MCO, not later than 45 days after a payment is due for a claim for a CBH service provided to a Medicaid recipient enrolled in the Medicaid MCO, fails to pay the claim in full, ODM must do both of the following:

(1) Pay the provider the balance due plus (a) 10% if ODM makes the payment not more than 60 days after the Medicaid MCO's deadline for paying the claim, (b) 20% if ODM makes the payment more than 60 days but not more than 75 days after the deadline, or (c) 30% if ODM makes the payment more than 75 days after the deadline;

(2) Collect from the Medicaid MCO the amount ODM pays the provider in a manner ODM determines is best, which may include reducing premiums ODM pays the Medicaid MCO.[11]

HISTORY

ACTION	DATE
Introduced	06-08-15

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[10] R.C. 5167.04(D)(3).

[11] R.C. 5167.04(D)(4).