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Final Analysis

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Version: As Passed by the General Assembly

Primary Sponsors: Reps. G. Manning and Howse

Effective date: September 18, 2020; appropriations effective June 19, 2020

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UPDATED VERSION*

SUMMARY

- Requires state employee health care benefit plans, the Medicaid program, and Medicaid managed care organizations to cover certain tobacco cessation medications and services.
- Requires the Ohio Department of Health (ODH) to establish a grant program for the provision of group-based prenatal health care services to pregnant Medicaid recipients residing in areas with high preterm birth rates.
- Appropriates $5 million in FY 2021 for the grant program.
- Permits the Ohio Department of Medicaid (ODM) to establish a dental program under which pregnant Medicaid recipients may receive two dental cleanings a year.
- Requires ODH to develop educational materials concerning lead-based paint and distribute them to families who participate in its Help Me Grow Program and reside in homes built before 1979.
- Increases ODM appropriations by a total of $279.6 million in FY 2020 to reflect the temporary federal medical assistance percentage increase by the federal Families First Coronavirus Response Act.

* This version updates the effective date.

DETAILED ANALYSIS

Tobacco cessation services and medications

The act requires the Medicaid program and Medicaid managed care organizations to cover certain tobacco cessation medications and services.[1] It also requires health care benefits provided to state employees to include coverage of those same medications and services.[2]

Types of services and medications

The following types of medications and services must be covered:[3]

- Any tobacco cessation medication approved by the U.S. Food and Drug Administration (FDA); and
- Any tobacco cessation service recommended by the U.S. Preventative Services Task Force.

The act permits the Medicaid program, Medicaid managed care organizations, and state employee health care benefit plans to also cover other tobacco cessation medications and services the act does not require them to cover. (The coverage would be in addition to that required by the act.) It further specifies that the Medicaid program, Medicaid managed care organizations, and state employee health care benefit plans may exclude coverage for any cessation medications and services not otherwise required by the act.[4]

Conditions on coverage

The act prohibits the following conditions from being imposed on the tobacco cessation medications and services for which it requires coverage:[5]

- Counseling requirements for tobacco cessation medication;
- Cost-sharing requirements such as deductibles, coinsurance, and copayments;
- Limits on the duration of services, including annual or lifetime limits on the number of covered attempts to quit using tobacco; and
- In general, prior authorization requirements, step therapy protocols, or any other utilization management requirements.

Prior authorization requirements and limits may, however, be imposed (1) when treatment exceeds the duration recommended in the U.S. Public Health Service's Clinical

[1] R.C. 5164.10 and 5167.12.

[2] R.C. 124.825.

[3] R.C. 124.825(B) and 5164.10(A).

[4] R.C. 124.825(D) and 5164.17.

[5] R.C. 124.825(C) and 5164.10(B).

Practice Guidelines on Treating Tobacco Use and Dependence and (2) when services are associated with more than two attempts to quit using tobacco in a 12-month period.[6]

Rulemaking

The Director of Health must adopt rules establishing standards and procedures for approving covered tobacco cessation medications and services. The rules must be updated whenever the FDA approves new tobacco cessation medications, the U.S. Public Health Service issues new treatment guidance, or the U.S. Preventative Services Task Force recommends new cessation services.[7]

Marketing the coverage

Each insurance company or health plan providing health care benefits to state employees must market the coverage to them. Likewise, the Ohio Department of Medicaid (ODM) must market the coverage to Medicaid recipients.[8]

Group-based prenatal health care services

The act requires the Ohio Department of Health (ODH) to establish a grant program to address the provision of prenatal health care services to pregnant women on a group basis, and appropriates $5 million for it in FY 2021 (see below). The program's aim is to increase the number of pregnant women who begin prenatal care early in their pregnancies and to reduce the number of infants born preterm. Under the program, grants will be awarded to entities such as health care facilities and medical practices, including those operated by physicians, physician assistants, and advanced practice registered nurses, that meet eligibility requirements and can provide group-based prenatal care and services.[9]

Eligibility

To be eligible to participate in the program, an entity must demonstrate that it can meet the following requirements:[10]

- Has space to host groups of at least 12 pregnant women;
- Has adequate in-kind resources, including existing medical staff, to provide necessary prenatal health care services on both an individual and group basis;
- Provides prenatal care based on the Centering Pregnancy Model of Care as developed by the Centering Healthcare Institute, or another model acceptable to ODH;

[6] R.C. 124.825(C)(4) and 5164.10(B)(4).

[7] R.C. 124.825(E).

[8] R.C. 124.825(F) and 5164.10(D).

[9] R.C. 3701.615(B) and (C)(1).

[10] R.C. 3701.615(C)(2).

- Integrates health assessments, education, and support into a unified program in which pregnant women at similar stages of pregnancy meet, learn care skills, and participate in group discussions; and
- Meets any other eligibility requirements established by ODH.

Priority

When distributing funds under the program, ODH must give priority to entities that provide care to pregnant Medicaid recipients and operate in areas with high preterm birth rates, including rural areas and Cuyahoga, Franklin, Hamilton, and Summit counties.[11]

Funding

The act appropriates $5 million in FY 2021 in GRF appropriation item 440474, Infant Vitality (within ODH's budget). It requires $500,000 of that amount to be used for planning grants and $4.5 million to be used for the group prenatal health care services grants.[12]

Dental health education

A participating entity may employ or contract with licensed dental hygienists to educate pregnant women about the importance of prenatal and postnatal dental care.[13]

Rulemaking

ODH may adopt rules as necessary to implement the program. The rules must be adopted in accordance with the Administrative Procedure Act.[14]

Prenatal dental cleanings

The act permits ODM to establish a program to provide dental services to pregnant Medicaid recipients.[15] If the program is established:

- Pregnant Medicaid recipients are eligible to receive two dental cleanings per year;
- ODM must give priority to recipients residing in the areas with high preterm birth rates; and
- ODM must market the program to Medicaid recipients.

Reimbursement rates

The act also requires ODM to establish reimbursement rates for entities that educate Medicaid recipients about the importance of prenatal and postnatal dental care as part of

[11] R.C. 3701.615(D).

[12] Section 4.

[13] R.C. 3701.615(E).

[14] R.C 3701.615(F).

[15] Section 3. Pursuant to R.C. 103.131, this section of the act is codified as R.C. 5162.73.

ODH's group-based prenatal health care services grant program. The act provides that, in the case of an entity that develops and distributes educational materials as part of the grant program, ODM must reimburse the entity for all or part of those costs.[16]

Lead-based paint educational materials

Under the act, ODH must develop educational materials describing the health risks of lead-based paint and the measures that may be taken to reduce those risks. As part of ODH's Help Me Grow Program, copies of the materials must be distributed during home visits to eligible families residing in houses, apartments, or other residences built before 1979. If the date on which a family's residence was built is unknown to the family or home visiting services provider, the family must receive a copy of the educational materials. The act also requires the educational materials developed by ODH to be culturally and linguistically appropriate for the families that receive them during home visits.[17]

Temporary FMAP increase associated with pandemic

The act makes two changes to ODM's budget in FY 2020 to reflect the temporary increase in the federal medical assistance percentage (FMAP): (1) increases GRF appropriation item 651525, Medicaid Health Care Services, by $102.6 million total ($533.7 million decrease in state share and $636.3 million increase in federal share) and (2) increases Federal Fund 3F00 appropriation item 651623, Medicaid Services – Federal, by $177.0 million. The act also makes a technical correction to the DPF Fund Group total in both FY 2020 and FY 2021.[18]

Background

On March 18, 2020, President Trump signed into law H.R. 6021, the Families First Coronavirus Response Act (FFCRA).[19] Section 6008 of the FFCRA provides a temporary 6.2 percentage point increase to each qualifying state's FMAP (for certain Medicaid expenditures) effective January 1, 2020, and extending through the last day of the calendar quarter in which the public health emergency declared by the U.S. Secretary of Health and Human Services for COVID-19, including any extensions, terminates.[20] The FMAP is computed from a formula that takes into account the average per capita income for each state relative to the national average.

To qualify for the temporary increase, a state must (1) maintain eligibility standards or procedures that are no more restrictive than those in place on January 1, 2020, (2) not charge

[16] Section 3. Pursuant to R.C. 103.131, this section of the act is codified as R.C. 5162.73.

[17] R.C. 3701.614.

[18] Section 6.

[19] Pub. L. 116-127.

[20] U.S. Centers for Medicare and Medicaid, *Families First Coronavirus Response Act – Increased FMAP FAQs*, available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf.

premiums that exceed those in place on January 1, 2020, (3) provide testing, services, and treatments including vaccines, specialized equipment, and therapies related to COVID-19 without cost sharing requirements, (4) provide continuous coverage to individuals enrolled in the program during the emergency period,[21] and (5) not require local political subdivisions to pay a greater portion of the nonfederal share of expenditures than was required on March 11, 2020.[22]

HISTORY

Action	Date
Introduced	05-16-19
Reported, H. Health	06-11-19
Reported, H. Finance	06-19-19
Passed House (93-0)	06-20-19
Reported, S. Health, Human Services & Medicaid	06-09-20
Passed Senate (32-0)	06-10-20
House concurred in Senate amendments (93-0)	06-11-20

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[21] States cannot terminate Medicaid coverage for individuals enrolled in the program during the emergency period unless the individual voluntarily terminates eligibility or is no longer a state resident.

[22] U.S. Centers for Medicare and Medicaid, *Families First Coronavirus Response Act – Increased FMAP FAQs*, available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf.