Ohio Legislative Service Commission

Bill Analysis

Erika Padgett
Bob Bennett
Nicholas A. Keller
Lisa Musielewicz

H.B. 157

131st General Assembly
(As Introduced)

Reps. Butler and T. Johnson, Becker, Boose, Brenner, Brinkman, Conditt, DeVitis, Henne, Hood, Huffman, Maag, McColley, Perales, Retherford, Rezabek, Roegner, Romanchuk, Sprague, Terhar, Thompson, Vitale, Young, Zeltwanger

TABLE OF CONTENTS

BILL SUMMARY

Medical Injury Compensation System

(R.C. Chapter 3965., with conforming changes throughout the bill)

Liability coverage

- Requires every medical, dental, optometric, or chiropractic provider to obtain liability insurance, allows an interested party to enjoin further operation of a provider who fails to obtain liability insurance, and specifies other penalties for failing to obtain insurance.

- Includes all of the following as providers required to obtain liability insurance: dentists, chiropractors, emergency medical technicians–basic, emergency medical technician–intermediate, emergency medical technician-paramedic, hospitals, licensed practical nurses, optometrists, pharmacists, physicians, physician assistants, physical therapists, podiatrists, registered nurses, and registered facilities (in a drafting error, this should probably be "residential facilities").

- Makes these providers and their employees immune from civil liability for malpractice for claims that do not involve intentional misconduct (the provider acted with deliberate intent to cause another individual to suffer an injury or death) or a provider who does not have liability insurance.

- Prohibits a provider who does not have liability insurance from claiming the common law defenses of assumption of the risk or contributory negligence.

- Requires each provider who obtains liability insurance to post conspicuously in the provider's place of business a notice provided by the liability insurer of the fact that the provider has paid the premium due.

Claims

- Creates the Medical Injury Compensation System as the exclusive remedy to resolve medical, dental, optometric, or chiropractic malpractice claims brought against providers who are required to obtain liability insurance under the bill, and any derivative claims (see **COMMENT,** below).

- Does not include in the System claims that involve intentional misconduct or a provider who does not have liability insurance.

- Creates the Medical Injury Compensation Center, led by the Administrator of Medical Injury Compensation, to administer and process claims, and specifies requirements for its operation.

- Requires a malpractice claim by an individual or a derivative claim by an individual's dependent to be filed with the Center within six months after the date of the injury or death or the discovery of an injury.

- Requires the Center to employ a pool of reviewing health care providers who spend at least 50% of their practice time in a clinical setting and allows the Administrator to remove a reviewing health care provider from the pool if the Administrator determines that decisions of the provider are not accurate or impartial.

- Prohibits an individual from waiving the individual's rights under the System and prohibits a provider from directly charging an individual for a portion of the provider's liability insurance premium.

- Allows the Administrator to file a lien on a provider's real or tangible personal property if an individual files a claim against the provider under the System, it is determined that the individual is entitled to compensation, and the provider does not carry liability insurance as required.

- Requires that the Medical Injury Compensation Law be liberally construed in favor of claimants.

- Creates the offense of "medical injury compensation fraud," which is similar to workers' compensation fraud, and makes the offense a first degree misdemeanor, but escalates the penalties based upon the value of the goods, services, property, or money stolen.

Referral and determination

- Requires the Administrator to assign each claim to a reviewing health care provider who is employed by the Center and engaged in the type of practice that is the primary subject of the claim.

- Allows a reviewing health care provider to refer a claim to the Administrator for reassignment if the reviewing provider determines that the primary issue of a claim involves an area of practice in which the reviewing provider is not engaged or if the reviewing provider is unable to make a determination with respect to an issue that is not the primary issue of the claim.

- Allows a reviewing health care provider or a medical injury compensation panel (see "**Medical Injury Compensation Panel**," below) to require a claimant to submit to a medical examination.

- Requires the reviewing health care provider to determine in each claim whether clear and convincing evidence exists that a provider did not breach the applicable standard of care.

- Requires the claimant to be awarded compensation if a reviewing health care provider determines that clear and convincing evidence does not exist that a provider listed in a claim did not breach the applicable standard of care.

- Requires, if a claim is determined to be compensable, an actuary be assigned to the claim by the Administrator to determine the amount of compensation to be awarded for the claim.

- Requires compensation awarded to be reduced by a compensation modifier calculated under the bill and specifies factors that the actuary must consider in determining the compensation amount.

- Prohibits punitive damages from being awarded in a claim filed under the System.

- Prescribes standards for an individual to give expert testimony in a claim under the System that are similar to the current law requirements for expert testimony in malpractice claims.

- Creates a procedure that is similar to current law regarding malpractice claims, to dismiss a claim against a provider for noninvolvement.

Apportionment of claims

- Requires a reviewing health care provider to determine the percentage of compensatory conduct attributable to each provider listed in a claim.

- Requires the liability insurer of a provider to whom compensatory conduct is attributed to pay compensation in the amount determined to be compensable.

- Allows a liability insurer that has paid more than that liability insurer's proportionate share of the common liability in a claim to seek contribution in a separate court action against another liability insurer that insures a provider to whom compensatory conduct is attributed, similar to current law joint and several liability.

- Generally stays the payment of claims until appeals have been exhausted.

Administration

- Requires administrative costs of the Administrator and the Center to be assessed to providers in the state in a fair and equitable manner, among providers subject to the System based upon the number of patients seen by each of those providers.

- Prohibits an employee of the Center from having an interest in an insurer that provides coverage to a provider under the System.

- Requires the Administrator to create an online gateway that attorneys may use to file claims, provide documents, and otherwise communicate with the Center.

- Creates the Medical Injury Compensation Center Operating Fund in the state treasury.

- Prohibits injunctions that suspend or restrain an order of the Administrator, the Center, a reviewing health care provider, or a Medical Injury Compensation Panel required to be made under the System.

Medical Injury Compensation Panel

(R.C. Chapter 3967., with conforming changes throughout the bill)

- Requires the Administrator to appoint a medical injury compensation panel (MICP) for purposes of hearing an appeal of a claim filed under the System in the same manner as reviewing health care providers are appointed.

- Prohibits a member of a MICP from having an interest in an insurer that provides coverage under the Medical Injury Compensation System.

- Allows a claimant or a provider's liability insurer to appeal an order issued by a reviewing health care provider to an MICP.

- Allows a claimant or a provider's liability insurer to appeal an order issued by an MICP, other than a decision as to the extent of a disability, to a court of common pleas.

- Requires the Administrator to establish a voluntary alternative dispute resolution process for claims within a MICP's jurisdiction.

Health Care Professional Standards Board

(R.C. Chapter 4746., with conforming changes throughout the bill)

- Creates the Health Care Professional Standards Board (HCPSB) to discipline medical, dental, optometric, and chiropractic providers who are required to obtain liability insurance under the bill relating to malpractice.

- Requires the HCPSB to investigate each claim filed with the System alleging malpractice to determine if an act or omission by the named provider constitutes gross negligence or whether the provider has engaged in a pattern of negligent behavior.

- Requires the appropriate regulatory authority (State Medical Board, State Dental Board, State Nursing Board, State Board of Optometry, State Chiropractic Board, State Board of Pharmacy, Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board, and the State Board of Emergency Medical, Fire, and Transportation Services) to suspend any investigation, and prohibits the authority from taking any disciplinary action, relating to that claim, until the HCPSB has concluded its investigation.

- Allows the HCPSB, upon making an adverse determination against a provider, to issue a public reprimand to the provider, or to suspend or revoke the provider's license.

- Allows the HCPSB to require an appropriate regulatory authority to impose discipline in lieu of the HCPSB taking action against the provider.

- Requires the HCPSB to provide hearings for providers who contest adverse determinations.

- Requires the HCPSB to create and maintain a database of all claims and any reports or complaints about which the HCPSB receives notice and to use the database to set standards for process improvements throughout the health care industry.

Office of Medical Purchasing

(R.C. 195.01 to 195.06 and 5166.50)

- Creates the Office of Medical Purchasing in the Department of Administrative Services.

- Requires the Office to seek to enter into a pact with other states and Canadian provinces to negotiate discounted prices for drugs and medical equipment with the suppliers of those items.

- If a pact is entered into:

  --Requires the Office to collaborate with other pact members to ensure that the negotiated prices are the lowest that can be attained and do not exceed those negotiated by Canadian provinces that are not pact members;

  --Requires a person or government entity that receives state or county money to purchase drugs or to purchase, lease, or use medical equipment to do so only from suppliers that have agreed to provide those items at the negotiated prices;

  --Requires that if such a person or government entity reimburses another person or government entity for the drugs or medical equipment (rather than procuring one or both directly), it must do so only if those expenses are incurred as a result of a relationship with a supplier described above; and

  --Permits an insurer or third-party administrator to purchase drugs or to purchase, lease, or use medical equipment from a supplier described above.

- Specifies that implementation of the provisions described above are subject to the U.S. Secretary of Health and Human Services entering into an enforceable agreement with the Medicaid Director (see "**Enforceable agreement with federal government,**" below).

Hospital referrals for nonemergency medical conditions

(R.C. 3727.61, 4731.74, and 5166.50)

- Requires each operator of an emergency department (ED), including a hospital's ED or a facility operated as a freestanding ED, to (1) designate a space within or adjacent to the ED where services may be provided (24 hours a day, 7 days a week) to patients who have nonemergency conditions or (2) authorize a federally qualified health center (FQHC) to operate within or adjacent to the ED on that same basis.

- Requires the State Medical Board to specify a list of nonemergency medical conditions that are not "emergency conditions" under federal Emergency Medical Treatment and Labor Act (EMTALA) regulations and, for each condition on the list, identify the symptoms associated with the condition.

- Except when immediate emergency care is needed or an individual is unable to respond or lacks a representative, requires a qualified ED staff member to request

from each individual who seeks treatment at the ED (or the individual's representative) a description of the individual's symptoms.

- Requires that if an individual's symptoms are associated with a nonemergency medical condition, the qualified ED staff member must refer the individual to receive services at the designated space or FQHC.

- Permits the ED staff member who makes such a referral to assign another facility employee or volunteer to escort the individual to the designated space or FQHC.

- Specifies that there is a rebuttable presumption that such a referral is not negligent.

- Requires each ED operator to implement the bill's provisions in such a manner that an individual is not required to duplicate any application or other administrative procedures relative to the receipt of services when (1) such a referral is made or (2) subsequent to the referral, it is determined that the individual needs emergency medical care and must return to the ED.

- Prohibits a service provided to a Medicaid recipient in a designated space or FQHC to be billed as an emergency service if, at the time the service was provided, the individual had a nonemergency condition.

- Prohibits charges for treatment of a nonemergency condition in the ED to exceed the usual and customary charges for that treatment had it been provided in the designated space or FQHC.

- Specifies that implementation of the provisions described above are subject to the U.S. Secretary of Health and Human Services entering into an enforceable agreement with the Medicaid Director (see "**Enforceable agreement with federal government,**" below).

Nonemergency service conditioned on paying out-of-pocket charge

(R.C. 4743.08 and 5166.50)

- Requires, unless an emergency exists, that a health care provider do the following before dispensing a prescription drug or providing a medical product or service to the patient: (1) provide to the patient or the patient's representative certain cost information, including the provider's usual and customary charge, the amount to be paid through health insurance or Medicaid, and the patient's out-of-pocket charges, and (2) obtain that person's consent to the out-of-pocket charges.

- Requires the Director of Health to specify in rules which situations constitute emergencies.

- Permits health care providers to create forms to fulfill the cost information requirement described above.

- Specifies that implementation of the provisions described above are subject to the U.S. Secretary of Health and Human Services entering into an enforceable agreement with the Medicaid Director (see "**Enforceable agreement with federal government,**" below).

Advertisement of charges

(R.C. 4743.09)

- Permits a health care provider to advertise the provider's usual and customary charge for any product, procedure, or service the provider provides, performs, or renders.

- Specifies that any contractual provision that prohibits such advertising is void.

Limit on payment for hospital outpatient services

(R.C. 5164.78 (primary), 5164.01, 5166.50, 5167.01, and 5167.33)

- Prohibits the Medicaid fee-for-service payment rate for an outpatient service provided by a hospital, hospital-owned provider, or institutional provider from exceeding by more than 10% a noninstitutional provider's Medicaid fee-for-service payment rate for the service if a noninstitutional provider also may provide the service.

- Requires the Ohio Department of Medicaid (ODM) to penalize a Medicaid managed care organization that pays a rate for a hospital outpatient service that is more than 10% higher than the rate it pays for the same service provided by a noninstitutional provider.

- Provides that these provisions are not to be implemented if the United States Secretary of Health and Human Services (HHS Secretary) refuses to enter into an enforceable agreement regarding many of the bill's Medicaid provisions (see "**Enforceable agreement with federal government,**" below).

Billing by hospital emergency department for nonemergency

(R.C. 5164.83)

- Prohibits a hospital emergency department's diagnosis and treatment of a Medicaid recipient for a nonemergency medical condition from being billed to Medicaid as an

emergency room visit claim if the nonemergency medical condition is discovered pursuant to the bill's provision requiring a hospital emergency department to request a description of an individual's symptoms before providing treatment (see "**Hospital referrals for nonemergency medical conditions,**" above).

- Provides that the prohibition does not apply if (1) the Medicaid recipient is referred to a location within or adjacent to the hospital to receive services for a nonemergency medical condition and (2) a determination is made, while the recipient receives the services, that the recipient has an emergency medical condition, the recipient returns to the hospital emergency department for treatment, and the hospital emergency department treats the condition.

Nursing facility value-based purchasing payment

(R.C. 5165.24 (primary), 5165.15, and 5165.23; Section 8)

Requires ODM to reduce a portion of nursing facilities' Medicaid rates by 2% for fiscal year 2016, 4% for fiscal year 2017, and 6% for each subsequent fiscal year.

Requires ODM to use the funds made available by the reductions to pay nursing facilities a value-based purchasing payment based on their ranking regarding quality indicators.

Establishes quality indicators regarding the following: hours of direct care provided by nurse aides and nurses, number of nurse aides from whom long-stay residents receive direct care, pressure ulcers, antipsychotic medication, avoidable inpatient hospital admissions, use of the Preferences for Everyday Living Inventory, and use of the Electronic Medication Administration Record System.

Billing other states for nursing facility services

(R.C. 5165.98 and 5166.50)

- Requires ODM to seek to have another state pay for nursing facility services provided under the Medicaid program to a recipient who has resided in Ohio for less than one year.

- Provides that this requirement does not apply if the HHS Secretary refuses to enter into an enforceable agreement regarding many of the bill's Medicaid provisions (see "**Enforceable agreement with federal government,**" below).

Healthy Ohio Program

(R.C. 5166.52 to 5166.5210 (primary), 5166.50, and 5167.03)

- Requires the Medicaid Director to establish the Healthy Ohio Program (HOP) unless the HHS Secretary refuses to enter into an enforceable agreement regarding many of the bill's Medicaid provisions (see "**Enforceable agreement with federal government,**" below).

- Provides that, under HOP, certain Medicaid recipients, in lieu of Medicaid coverage through the Medicaid fee-for-service or managed care system, are required to enroll in a comprehensive health plan offered by a managed care organization under contract with ODM.

- Requires an individual, other than a ward of the state, to participate in HOP as a condition of Medicaid eligibility if the individual qualifies for Medicaid on the basis of (1) being included in the category identified by ODM as covered families and children or (2) another provision of the bill that provides, under certain circumstances, for Medicaid to cover individuals (or a prioritized portion of individuals) who meet all of the following criteria: are under age 65, are not pregnant, are not entitled to or enrolled in Medicare Part A, are not entitled to Medicare Part B, are not otherwise eligible for Medicaid, and have family countable incomes equal to at least 50 but not more than 100% of the federal poverty line (see "**Use of certain Medicaid funds and Medicaid Donations Fund,**" below).

- Requires that an account, to be known as a Buckeye account, be established for each HOP participant and that the account consist of Medicaid funds and contributions made by the individual and contributions made on the individual's behalf.

- Requires a health plan in which a HOP participant enrolls to (1) cover certain services, (2) pay the Medicare rate for a health professional service that is covered by the health plan and Medicare, (3) require copayments for services as long as there are funds in the core portion of the participant's Buckeye account (the portion of the account consisting of contributions made by or on behalf of the participant and amounts awarded to the account for achieving health care goals and satisfying health care benchmarks), (4) not begin to pay for services until the noncore portion of the participant's Buckeye account is zero, and (5) have a $300,000 annual payout limit and $1 million lifetime payment limit.

- Prohibits a Buckeye account from having more than $10,000.

- Requires, with certain exceptions, that $1,000 of Medicaid funds be deposited annually into an adult HOP participant's Buckeye account and $500 of Medicaid funds be deposited annually into a minor HOP participant's Buckeye account.

- Requires, with certain exceptions, that a HOP participant annually contribute to the participant's Buckeye account at least the greater of $1 or the lesser of (1) 2% of the participant's annual countable family income and (2) $99 if the participant is an adult nonsmoker, $49 if the participant is a minor nonsmoker, and $149 if the participant is a smoker of any age.

- Permits, with certain limitations, the following to make contributions to a HOP participant's Buckeye account on the participant's behalf: the participant's parent or caretaker relative (if the participant is a minor), the participant's employer, a not-for-profit organization, and the managed care organization that offers the health plan in which the participant enrolls.

- Prohibits an individual from beginning to participate in HOP until an initial contribution is made to the individual's Buckeye account unless the individual is exempt from the requirement to make contributions.

- Provides for all or part of the amount remaining in a HOP participant's Buckeye account at the end of a year to carry forward in the account for the next year and for the amount that the participant must contribute to the account that next year be reduced by the amount that carries forward.

- Specifies what a Buckeye account may be used for.

- Requires ODM to provide for a HOP participant to receive monthly statements showing the current amount in the participant's Buckeye account and the previous month's expenditures from the account and permits ODM to arrange for statements to be provided in an electronic format.

- Requires a managed care organization that offers the health plan in which a HOP participant enrolls to issue a debit swipe card to be used to pay only for (1) the costs of covered health care services provided to the participant as long as there are funds in the noncore portion of the participant's Buckeye account, (2) copayments, and (3) the costs of noncovered, medically necessary health care services, including dental and vision services.

- Requires that (1) the noncore portion of a HOP participant's Buckeye account be used to pay for covered health care services, (2) the core portion be used to pay for copayments and noncovered, medically necessary services, and (3) deductions be made from the participant's debit swipe card accordingly.

- Requires that a HOP participant's debit swipe card (1) verify the participant's eligibility for HOP, (2) determine whether a service the participant seeks is covered, (3) determine whether the provider from which the participant seeks the service is a participating provider, and (4) be linked to the participant's Buckeye account in a manner that enables the participant to know at the point of service what will be deducted from the noncore and core portions and how much will remain in each portion after the deduction.

- Requires the ODM Director to establish a system under which amounts are awarded to a HOP participant's Buckeye account if the participant (1) provides for the participant's contributions to the account to be made electronically, (2) achieves health care goals to be specified in rules, and (3) satisfies health care benchmarks set by one or more primary care physicians.

- Suspends a HOP participant's participation in HOP if the participant exhausts the annual payout limit and ends the suspension on the first day of the following year.

- Terminates a HOP participant's participation in HOP if (1) a monthly installment payment for the participant's contributions to his or her Buckeye account is 60 days late, (2) the participant, or if the participant is a minor, the participant's parent or caretaker relative, fails to submit documentation needed for a Medicaid eligibility redetermination before the 61st day after the documentation is requested, (3) the participant becomes eligible for Medicaid under a category not required to participate in HOP, (4) the participant becomes a ward of the state, (5) the participant ceases to be eligible for Medicaid, (6) the participant exhausts the lifetime payout limit, or (7) the participant, or if the participant is a minor, the participant's parent or caretaker relative requests that the participant's participation be terminated.

- Provides that a former HOP participant must wait at least 12 months before resuming participation in HOP if the former participant's participation was terminated because of a late installment payment or eligibility redetermination documentation.

- Requires that a HOP participant's contributions to his or her Buckeye account be returned to the participant when the participant ceases to participate in HOP unless the amount in the account is transferred to a bridge account.

- Transfers to a bridge account the entire amount remaining in a HOP participant's Buckeye account if the participant ceases to qualify for Medicaid due to increased family countable income and the participant purchases a health insurance policy or obtains health care coverage under an eligible employer-sponsored health plan.

- Provides that the amount transferred to a bridge account may be used only for (1) a former HOP participant's costs in purchasing a health insurance policy and paying for out-of-pocket expenses under the policy for covered health care services and prescription drugs and (2) a former participant's out-of-pocket expenses for health care services and prescription drugs covered by an eligible employer-sponsored health plan.

- Closes a bridge account once the amount transferred to it is exhausted.

- Requires the ODM Director to provide for a former HOP participant to be able to access the amount transferred to a bridge account with the former participant's HOP debit swipe card (to the extent possible) or another debit swipe card issued to the former participant.

- Requires that a HOP participant be transferred to a catastrophic health care plan to be established in rules if the participant exhausts the annual or lifetime payout limits.

- Requires county departments of job and family services to offer to refer to a workforce development agency each HOP participant who is an adult and either unemployed or employed for less than an average of 20 hours per week.

- Permits a HOP participant to refuse to accept the referral and to participate in workforce development activities without any effect on the participant's eligibility for, or participation in, HOP.

Regional hospital network as a Medicaid managed care organization

(R.C. 5167.04 (primary), 5166.50, 5167.03, and 5167.10)

- Authorizes a regional network consisting of hospitals to serve as a Medicaid managed care organization if it accepts a capitated payment from ODM that is not more than 90% of the lowest capitated payment made to a Medicaid managed care organization that is a health insuring corporation.

- Provides that this provision is subject to the HHS Secretary entering into an enforceable agreement regarding many of the bill's Medicaid provisions (see "**Enforceable agreement with federal government,**" below).

Hospital value-based purchasing programs

(R.C. 5167.16 (primary), 5166.50, and 5167.01)

- Requires that an ODM contract with a Medicaid managed care organization require the organization to implement a hospital value-based purchasing program that is largely identical to the Medicare program's hospital value-based purchasing program, unless the HHS Secretary refuses to enter into an enforceable agreement regarding many of the bill's Medicaid provisions (see "**Enforceable agreement with federal government,**" below).

- Requires a Medicaid managed care organization to make incentive payments under the program to participating hospitals based only on their successes in meeting the clinical process of care measures used for the Medicare program's hospital value-based purchasing program.

- Requires that the total amount that a Medicaid managed care organization makes available for the incentive payments for a year equal the total amount of the savings achieved for that year due to reductions the organization must make under the program to participating hospitals' base operating DRG payments.

Medicaid managed care performance payment program

(R.C. 5167.30)

- Revises the Medicaid managed care performance payment program by (1) requiring, instead of permitting, ODM to make payments to Medicaid managed care organizations under the program, (2) specifying the amounts that are to be withheld from the organizations' premiums, and (3) requiring ODM to establish the amount of each performance payment in an equitable manner that results in the total amount withheld from the premiums being spent on the performance payments.

Medicaid managed care organizations' shared saving bonus

(R.C. 5167.32 (primary) and 5166.50)

- Requires ODM to pay a shared saving bonus to a Medicaid managed care organization if its three-year average per recipient capitated payment rate is less than the three-year average per recipient cost to the Medicaid programs in Illinois, Indiana, Michigan, Ohio, Pennsylvania, and West Virginia for the populations served by the Ohio Medicaid managed care program.

- Specifies that the amount of a Medicaid managed care organization's shared saving bonus is to equal the amount that is 20% of the difference between the organization's

three-year average per recipient capitated payment rate and three-year average per recipient cost determined for the states specified above.

- Requires ODM to terminate a Medicaid managed care organization's contract if it does not qualify for the shared saving bonus and to contract with another managed care organization.

- Makes these provisions subject to the HHS Secretary entering into an enforceable agreement regarding many of the bill's Medicaid provisions (see "**Enforceable agreement with federal government,**" below).

Use of certain Medicaid funds and Medicaid Donations Fund

(R.C. 5166.53 (primary), 5162.63, 5166.01, and 5166.50)

- Requires the ODM Director to seek grants and donations to help fund certain Medicaid payments, services, and coverage.

- Creates the Medicaid Donations Fund into which the grants and donations are to be deposited.

- Requires the ODM Director, for fiscal year 2018 and each fiscal year thereafter, to (1) adjust the total amount of the Medicaid program's fiscal year 2016 actual expenditures by the cumulative rate of core inflation for the period beginning July 1, 2016, and ending the last day of the most recent month for which the rate of core inflation is known preceding the first month of the fiscal year for which the determination is being made and (2) subtract, from that adjusted amount, the total amount of the Medicaid program's estimated expenditures for the fiscal year immediately preceding the fiscal year for which the determination is being made.

- Requires the ODM Director to use the amount determined above for a fiscal year and the amount in the Medication Donations Fund to fund, to the extent possible, the following Medicaid payments, services, and coverage, unless the HHS Secretary refuses to enter into an enforceable agreement regarding many of the bill's Medicaid provisions (see "**Enforceable agreement with federal government,**" below):

    - Payments to disproportionate share hospitals in the amount of the difference between (1) the amount the hospital would have received under the Hospital Care Assurance Program if not for Patient Protection and Affordable Care Act and (2) the amount the hospital is paid under the Hospital Care Assurance Program.

- Home and community-based services provided under Medicaid waiver programs administered by the Ohio Department of Developmental Disabilities (ODODD).

- Community behavioral health services.

- Maintenance therapies for chronic conditions to be specified in rules provided to individuals who have one or more of the chronic conditions, are not entitled to or enrolled in Medicare Part A, are not enrolled in Medicare Part B, and are not otherwise eligible for Medicaid.

- Medicaid coverage of (1) veterans who do not otherwise qualify for Medicaid and are either ineligible for medical benefits from the U.S. Department of Veterans Affairs or reside more than 100 miles away from a Veterans Affairs medical facility, (2) individuals who are considered to have serious mental illnesses under a federal Medicaid regulation and do not otherwise qualify for Medicaid, (3) individuals who would qualify for Medicaid if the income eligibility threshold for parents and caretaker relatives were 100%, rather than 90%, of the federal poverty line, and (4) subject to funding priorities, individuals who are under age 65, are not pregnant, are not entitled to or enrolled in Medicare Part A, not enrolled in Medicare Part B, not otherwise eligible for Medicaid, and have family countable incomes equal to at least 50% but not more than 100% of the federal poverty line.

- Requires the Medicaid Director, if the Director determines that the amount available for Medicaid to cover the last group discussed above is insufficient for a fiscal year, to limit coverage of the group by giving first priority to individuals with incomes between 90% and 100% of the federal poverty line, second priority to individuals with incomes between 80% and 90% of the federal poverty line, third priority for individuals with incomes between 70% and 80% of the federal poverty line, fourth priority for individuals with incomes between 60% and 70% of the federal poverty line, and fifth priority to individuals with incomes between 50% and 60% of the federal poverty line.

Enforceable agreement with federal government

(R.C. 5166.50 (primary) and 5166.01)

- Requires the ODM Director to request that the HHS Secretary enter into an enforceable agreement that provides for many of the health and Medicaid provisions described above to be implemented without loss of federal funds and for the federal government to pay the state a penalty for failure to comply in full with the agreement.

Medicaid managed care service coordination pilot program

(Section 10)

- Requires ODM to establish a two-year pilot program under which one or more Medicaid managed care organizations help coordinate the following services that Medicaid recipients who enroll in the organizations receive: (1) the health care services that the organizations provide to, or arrange for, the recipients, (2) addiction services, (3) mental health services, (4) support services for children, including child care and publicly funded child care, (5) services made available by ODODD and county boards of developmental disabilities for individuals with mental retardation and other developmental disabilities, (6) services made available by the Ohio Department of Aging (ODA) for individuals age 60 or older, (7) housing services, (8) workforce development activities, (9) food assistance, including the Supplemental Nutrition Assistance Program and the WIC program, and (10) ex-offender reentry services.

- Requires all of the following to assist ODM in establishing the pilot program: (1) ODA, (2) ODODD, (3) the Development Services Agency, (4) the Department of Health, (5) the Department of Job and Family Services, (6) the Department of Mental Health and Addiction Services, and (7) the Department of Rehabilitation and Correction.

- Requires ODM to select the Medicaid managed care organizations that are to participate in the pilot program through a request for proposals process.

- Requires ODM to provide for a Medicaid managed care organization participating in the pilot program to receive a bonus payment if the organization succeeds in coordinating the services listed above in an efficient and effective manner that prevents Medicaid and other programs from incurring costs that would have been incurred if not for the coordination.

- Provides that a service is to be coordinated with the other services for a Medicaid recipient only to the extent, if any, that the recipient is eligible for and receiving the service and specifies that this provision of the bill is not to be construed as making an individual eligible for a service the individual is not otherwise eligible to receive.

- Requires all persons and government entities overseeing or operating a program offering any of the services to be coordinated, or providing the services, to cooperate with the Medicaid managed care organizations participating in the pilot program.

- Requires ODM, not later than 90 days after the pilot program ends, to complete a report regarding the pilot program, to specify in the report the pilot program's

successes and problems, and to include recommendations for resolving the problems.

Nonstandard Multiple Employer Welfare Arrangement Program

(R.C. 1739.30 to 1739.33; Sections 3 to 6; and R.C. 1739.01(B), not in the bill)

- Requires the Department of Insurance (ODI) to operate a nonstandard multiple employer welfare arrangement (MEWA) program to enable certain employer groups to form self-insured MEWAs that do not fit into the existing MEWA Law standards.

  Requires program participants to (1) have a projected enrollment of at least 2 and no more than 500 individuals and (2) have ODI and arrangement representation on the participant's board of directors.

- Sunsets the program after five years and prohibits a MEWA from participating in the program for longer than five years.

- Requires program participants to reimburse health care providers using reference-based pricing.

- Requires ODI to provide reinsurance coverage for program participants.

- Requires ODI to guarantee the liabilities of program participants and caps the amount that can be paid out on such liabilities to be no more than the surplus amount required for MEWAs under Ohio's standard MEWA Law.

- Requires a program participant to maintain a surplus amount determined by a specified calculation involving the number of years the member participates in the program.

- Specifies that the insurance guarantees provided to program participants under the bill do not preclude a participant from obtaining stop-loss insurance coverage (an insurance policy purchased by a MEWA under which it receives reimbursement for benefits it pays in excess of a preset deductible or limit) as required under continuing law.

- Creates the Nonstandard Multiple Employer Welfare Arrangement Reinsurance Fund to reduce the cost of purchasing stop-loss insurance coverage, which is to consist of fees collected by ODI from insurers providing stop-loss insurance coverage to program participants, as well as other transfers to the Fund.

- Creates the Nonstandard Multiple Employer Welfare Arrangement Guarantee Fund consisting of fees collected by ODI from program participants, to be used to guarantee the liabilities of program participants.

- Specifies that all cash credited to the Nonstandard Multiple Employer Welfare Arrangement Reinsurance Fund and the Nonstandard Multiple Employer Welfare Arrangement Guarantee Fund will be transferred to the GRF and the funds abolished five years after the bill's effective date.

- Requires the Superintendent of Insurance to adopt rules to implement the program.

COMMENT

The bill's Medical Injury Compensation System and corresponding procedure for resolving malpractice claims may raise questions under Ohio's constitutional prohibition on limiting damages recoverable in wrongful death awards,[1] the Right to Remedy Clause of Ohio's Constitution,[2] and the due process clauses of the U.S and Ohio constitutions.[3]

HISTORY

ACTION	DATE
Introduced	04-15-15

H0157-I-131.docx/ejs

[1] Ohio Constitution Article I, Section 19a.

[2] Ohio Constitution Article I, Section 16.

[3] U.S. Constitution, Amend XIV and Ohio Constitution Article I, Section 16.