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Representative Sears

Cosponsors: Representatives Adams, J., Adams, R., Balderson, Boose, Burke, Combs, Grossman, Huffman, Jones, Jordan, McGregor, Stebelton, Wachtmann

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A BILL

To amend section 5111.083 and to enact sections 5111.035, 5111.092, 5111.093, 5111.141, 5111.142, and 5111.165 of the Revised Code to modify the Medicaid program. 1 2 3 4

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That section 5111.083 be amended and sections 5111.035, 5111.092, 5111.093, 5111.141, 5111.142, and 5111.165 of the Revised Code be enacted to read as follows: 5 6 7

Sec. 5111.035. (A) Each medicaid provider selected by the department of job and family services shall give bond with surety to the department, in the amount the department determines and to the satisfaction of the department, for the faithful adherence by the provider to the requirements of section 5111.03 of the Revised Code. 8 9 10 11 12 13

(B) The department shall determine which providers are subject to division (A) of this section, but at a minimum shall apply the bond requirement to each provider who has been investigated for any criminal offense of fraud, as defined in 14 15 16 17

Chapter 2913. of the Revised Code. The department shall set the amount of the bond at a level that reflects, as determined by the director of job and family services, the level of risk of fraud by the provider.

Sec. 5111.083. (A) As used in this section, "licensed health professional authorized to prescribe drugs" has the same meaning as in section 4729.01 of the Revised Code.

(B) The director of job and family services ~~may~~ shall establish an e-prescribing system for the medicaid program under which a medicaid provider who is a licensed health professional authorized to prescribe drugs shall use an electronic system to prescribe a drug for a medicaid recipient when required to do so by division (C) of this section. The e-prescribing system shall eliminate the need for such medicaid providers to make prescriptions for medicaid recipients by handwriting or telephone. The e-prescribing system also shall provide such medicaid providers with an up-to-date, clinically relevant drug information database and a system of electronically monitoring medicaid recipients' medical history, drug regimen compliance, and fraud and abuse.

(C) ~~If the director establishes~~ In establishing an e-prescribing system under division (B) of this section, the director shall do all of the following:

(1) Require that a medicaid provider who is a licensed health professional authorized to prescribe drugs use the e-prescribing system during a fiscal year if the medicaid provider was one of the ten medicaid providers who, during the calendar year that precedes that fiscal year, issued the most prescriptions for medicaid recipients receiving hospital services;

(2) Before the beginning of each fiscal year, determine the ten medicaid providers that issued the most prescriptions for

medicaid recipients receiving hospital services during the calendar year that precedes the upcoming fiscal year and notify those medicaid providers that they must use the e-prescribing system for the upcoming fiscal year; 49 50 51 52

(3) Seek the most federal financial participation available for the development and implementation of the e-prescribing system. 53 54 55

Sec. 5111.092. (A) Not later than January 1, 2010, and each year thereafter, the department of job and family services shall prepare a report on the department's efforts to minimize fraud, waste, and abuse in the medicaid program. In preparing the report, the department shall collaborate with other medicaid program fraud, waste, and abuse personnel from all of the following: 56 57 58 59 60 61

(1) The medicaid fraud control unit of the office of the attorney general; 62 63

(2) The fraud and investigative audit group of the auditor of state; 64 65

(3) State agencies with which the department contracts under section 5111.91 of the Revised Code to administer one or more components of the medicaid program or one or more aspects of a component; 66 67 68 69

(4) County departments of job and family services. 70

(B) Each report shall include at least both of the following with regard to minimizing fraud, waste, and abuse in the medicaid program: 71 72 73

(1) Goals and objectives that are mutually agreed upon by the department and the entities with which it collaborates under division (A) of this section; 74 75 76

(2) Performance measures for monitoring all state and local activities. 77 78

(C) Each report shall be made available on the department's web site. Copies of the report shall be made available to the public on request. 79 80 81

Sec. 5111.093. (A) As used in this section, "local medicaid administrative agency" means all of the following: 82 83

(1) A county department of job and family services; 84

(2) A county board of mental retardation and developmental disabilities; 85 86

(3) A board of alcohol, drug addiction, and mental health services; 87 88

(4) A PASSPORT administrative agency; 89

(5) A board of education of a city, local, or exempted village school district; 90 91

(6) The governing authority of a community school established under Chapter 3314. of the Revised Code. 92 93

(B) Each local medicaid administrative agency shall report annually to the department of job and family services and office of budget and management all of the following information regarding the previous calendar year: 94 95 96 97

(1) The total amount of local government funds the local medicaid administrative agency expended for the medicaid program; 98 99

(2) The portion of the total reported under division (B)(1) of this section that represents funds raised by local property tax levies; 100 101 102

(3) The local medicaid administrative agency's total administrative costs for the medicaid program; 103 104

(4) The local medicaid administrative agency's administrative costs for the medicaid program for which the agency receives no federal financial participation; 105 106 107

(5) The total amount of state funds provided to the local medicaid administrative agency for the medicaid program. 108 109

Sec. 5111.141. (A) The department of job and family services shall implement a disease management component of the medicaid program. Medicaid recipients participating in the care management system established under section 5111.16 of the Revised Code shall be excluded from the disease management component. The department may implement the disease management component as part of the alternative care management program established under section 5111.165 of the Revised Code. 110 111 112 113 114 115 116 117

(B) The disease management component shall consist of a system of coordinated health care interventions and patient communications for groups of medicaid recipients who have medical conditions for which the department determines patient self-care efforts are significant. The disease management component shall do all of the following: 118 119 120 121 122 123

(1) Support physicians, the professional relationship between patients and their medical caregivers, and patients' plans of care; 124 125 126

(2) Emphasize prevention of exacerbations and complications of medical conditions using evidence-based practice guidelines and patient empowerment strategies; 127 128 129

(3) Evaluate clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health. 130 131

(C) To the extent the department considers appropriate, contracts that the department enters into with other state agencies under section 5111.91 of the Revised Code shall provide for the other state agencies to include the disease management component in the component of the medicaid program that the other state agency administers pursuant to the contract. 132 133 134 135 136 137

Sec. 5111.142. (A) The department of job and family services shall conduct a review of case management services provided under the fee-for-service component of the medicaid program. In conducting the review, the department shall identify which groups of medicaid recipients not participating in the care management system established under section 5111.16 of the Revised Code or enrolled in a medicaid waiver component as defined in section 5111.85 of the Revised Code do not receive case management services and which groups of such medicaid recipients receive case management services as part of two or more components of the medicaid program or from two or more providers. 138 139 140 141 142 143 144 145 146 147 148

After completing the review, the department shall implement a case management component of the medicaid program. The department shall model the case management component on the former enhanced care management program that the department created as part of the care management system established under section 5111.16 of the Revised Code. The department shall make adjustments to the former enhanced care management program as are necessary to accomodate the groups the case management component is to serve. 149 150 151 152 153 154 155 156

(B) At a minimum, the case management component shall serve medicaid recipients who are members of the groups identified in the review conducted under this section and have been diagnosed by a physician as having any of the following medical conditions: 157 158 159 160

(1) A high-risk pregnancy; 161

(2) Diabetes; 162

(3) Asthma; 163

(4) Lung disease; 164

(5) Congestive heart failure; 165

(6) Coronary artery disease; 166

(7) Hypertension; 167

(8) Hyperlipidemia; 168

(9) Infection with the human immunodeficiency virus; 169

(10) Acquired immunodeficiency syndrome; 170

(11) Chronic obstructive pulmonary disease. 171

Sec. 5111.165. (A) The department of job and family services shall develop and implement an alternative care management program for medicaid recipients that is separate from the care management program established under section 5111.16 of the Revised Code. The purpose of the program shall be to test and evaluate multiple alternative care management models for providing health care services to medicaid recipients designated under this section as participants in the program. 172 173 174 175 176 177 178 179

(B) The program shall be implemented not later than October 1, 2009, or, if by that date the department has not received any necessary federal approval to implement the program, as soon as practicable after receiving the approval. From among the medicaid recipients who are not participants in the care management system established under section 5111.16 of the Revised Code, the department shall designate the medicaid recipients who are required to participate in the alternative care management program established under this section. 180 181 182 183 184 185 186 187 188

(C) The department shall ensure that each alternative care management model included in the program is operated in at least three counties. The department shall select the counties in which each model is to be operated. The department may extend the operation of a model into other counties if the department determines that such an expansion is necessary to evaluate the effectiveness of the model. 189 190 191 192 193 194 195

The department may periodically alter the requirements, design, or eligible participants in the program in order to test 196 197

and evaluate the effectiveness of varying care management models for providing medicaid services, except that each model included in the program shall be in effect for a period sufficient in length to evaluate the effectiveness of the model. 198 199 200 201

(D) The department shall conduct an evaluation of each alternative care management model included in the program. As part of the evaluation, the department shall maintain statistics on physician expenditures, hospital expenditures, preventable hospitalizations, costs for each participant, effectiveness, and health outcomes for participants. 202 203 204 205 206 207

(E) The department shall adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement this section. The rules shall specify standards and procedures to be used in designating participants of the program. 208 209 210 211

Section 2. That existing section 5111.083 of the Revised Code is hereby repealed. 212 213

Section 3. THIRD PARTY LIABILITY - PILOT PROGRAM 214

(A) As used in this section: 215

(1) "Medicaid program" means the medical assistance program established under Chapter 5111. of the Revised Code. 216 217

(2) "Third party" has the same meaning as in section 5101.571 of the Revised Code. 218 219

(B)(1) Except as provided in division (C) of this section and using technology designed to identify all persons liable to pay a claim for a medical item or service, the Director of Job and Family Services shall establish and administer a pilot program for the purpose of identifying third parties that are liable for paying all or a portion of a claim for a medical item or service provided to a Medicaid recipient before the claim is submitted to, 220 221 222 223 224 225 226

or paid by, the Medicaid program. The Director shall determine the duration of the pilot program, except that the Director shall not terminate the program less than eighteen months after it is established. 227 228 229 230

(2) In administering the pilot program, the Director shall, subject to division (B)(3) of this section, ensure that all aspects of the program comply with Ohio and federal law, including the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, as amended, and regulations promulgated by the United States Department of Health and Human Services to implement the Act. 231 232 233 234 235 236 237

(3) The Director's duty to ensure compliance with the laws described in division (B)(2) of this section does not prohibit either of the following: 238 239 240

(a) A third party from providing information to the Department of Job and Family Services or disclosing or making use of information as permitted under section 5101.572 of the Revised Code or when required by any other provision of Ohio or federal law; 241 242 243 244 245

(b) The Department from using information provided by a third party as permitted in section 5101.572 of the Revised Code or when required by any other provision of Ohio or federal law. 246 247 248

(C)(1) The Director may enter into a contract with any person under which the person serves as the administrator of the pilot program. Before entering into a contract for a pilot program administrator, the Department shall issue a request for proposals from persons seeking to be considered. The Department shall develop a process to be used in issuing the request for proposals, receiving responses to the request, and evaluating the responses on a competitive basis. In accordance with that process, the Department shall select the person to be awarded the contract. 249 250 251 252 253 254 255 256 257

(2) The Director may delegate to the person awarded the contract any of the Director's powers or duties specified in this section. The terms of the contract shall specify the extent to which the powers or duties are delegated to the pilot program administrator. 258 259 260 261 262

(3) In exercising powers or performing duties delegated under the contract, the pilot program administrator is subject to the same provisions of this section that grant the powers or duties to the Director, as well as any limitations or restrictions that are applicable to or associated with those powers or duties. 263 264 265 266 267

(4) The terms of a contract for a pilot program administrator shall include a provision that specifies that the Director or any agent of the Director is not liable for the failure of the administrator to comply with a term of the contract, including any term that specifies the administrator's duty to ensure compliance with the laws described in division (B)(1) of this section. 268 269 270 271 272 273

(D) Twelve months after the pilot program is established, the Director shall evaluate the program's effectiveness. As part of this evaluation, the Director shall determine both of the following: 274 275 276 277

(1) For the twelve months immediately preceding the establishment of the pilot program, all of the following: 278 279

(a) The amount of money paid for each Medicaid claim in which no third party liability was indicated by the Medicaid recipient but for which at least one third party was liable to pay all or a portion of the claim, and the amount attributable to each liable party; 280 281 282 283 284

(b) The portions of the amounts attributable to each liable third party, described in division (D)(1)(a) of this section, that were recovered by the Director or a person with which the Director has contracted to manage the recovery of money due from liable 285 286 287 288

third parties; 289

(c) The portions of the amounts attributable to each liable third party, described in division (D)(1)(a) of this section, that would have been identified by the technology used by the pilot program had the technology been used in those twelve months. 290 291 292 293

(2) For the first twelve months of the pilot program, both of the following: 294 295

(a) The items described in divisions (D)(1)(a) and (b) of this section; 296 297

(b) The portions of the amounts attributable to each liable third party, described in division (D)(1)(a) of this section, that were identified by the technology used by the pilot program. 298 299 300

(E) Not later than three months after the evaluation required by division (D) of this section is initiated, the Director shall prepare and submit to the Governor, the Speaker and Minority Leader of the House of Representatives, and the President and Minority Leader of the Senate a report that summarizes the results of the Director's evaluation of the pilot program. At a minimum, the report shall summarize and compare the determinations made under division (D) of this section, conclude whether the program achieved savings for the Medicaid program, and make a recommendation as to whether the pilot program should be extended or be made permanent. 301 302 303 304 305 306 307 308 309 310 311

(F) The Director may adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement this section. 312 313

Section 4. (A) As used in this section, "community behavioral health services" means both of the following: 314 315

(1) Community mental health services certified by the Director of Mental Health under section 5119.611 of the Revised Code; 316 317 318

(2) Services provided by an alcohol and drug addiction program certified by the Department of Alcohol and Drug Addiction Services under section 3793.06 of the Revised Code. 319 320 321

(B) There is hereby created the Medicaid Community Behavioral Health Administration Examination Group. The Examination Group shall consist of all of the following: 322 323 324

(1) The Director of Mental Health or the Director's designee; 325

(2) The Director of Alcohol and Drug Addiction Services or the Director's designee; 326 327

(3) The Director of Job and Family Services or the Director's designee; 328 329

(4) Two members of the House of Representatives from different political parties appointed by the Speaker of the House of Representatives; 330 331 332

(5) Two members of the Senate from different political parties appointed by the President of the Senate. 333 334

(C) The Directors of Mental Health and Alcohol and Drug Addiction Services, or their designees, shall serve as co-chairpersons of the Examination Group. The Departments of Mental Health and Alcohol and Drug Addiction Services shall provide administrative services to the Examination Group. 335 336 337 338 339

(D) Members of the Examination Group shall serve without compensation, except to the extent that serving as members is considered part of their regular employment duties. 340 341 342

(E) The Examination Group shall study the administration and management of Medicaid-covered community behavioral health services. Not later than one year after the effective date of this act, the Examination Group shall submit a report regarding its study to the Governor and, in accordance with section 101.68 of the Revised Code, the General Assembly. The report shall include 343 344 345 346 347 348

all of the following: 349

(1) Recommendations for system changes needed for the effective administration and management of Medicaid-covered community behavioral health services. The recommendations shall focus on increasing efficiencies, transparency, and accountability in order to improve the delivery of community behavioral health services. 350 351 352 353 354 355

(2) An evaluation of merging the Departments of Mental Health and Alcohol and Drug Addiction Services or of other options to improve the organizational structure used to provide Medicaid-covered community behavioral health services; 356 357 358 359

(3) An examination of the best practices for providing Medicaid-covered community behavioral health services, using as a reference other state's best practices for providing such services; 360 361 362 363

(4) An analysis of using a case management program for Medicaid-covered community behavioral health services. 364 365

(F) The Examination Group shall cease to exist on submission of its report. 366 367