Ohio Legislative Service Commission

Bill Analysis

Laura Gengo

H.B. 240

128th General Assembly
(As Introduced)

Reps. Sears, J. Adams, R. Adams, Balderson, Boose, Burke, Combs, Grossman, Huffman, Jones, Jordan, McGregor, Stebelton, Wachtmann

BILL SUMMARY

- Requires the Ohio Department of Job and Family Services (ODJFS), in preparing an annual report regarding its efforts to minimize Medicaid fraud, waste, and abuse, to collaborate with personnel from other state and local government entities and to include in the report (1) goals and objectives to minimize fraud, waste, and abuse that are mutually agreed upon by ODJFS and the collaborating entities and (2) performance measures for monitoring all state and local activities related to minimizing fraud, waste, and abuse.

- Requires local agencies that administer components of the Medicaid program to report Medicaid expenditure information annually to ODJFS and the Office of Budget and Management.

- Requires the ODJFS Director to establish 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, or paid by, the Medicaid program.

- Requires an ODJFS-selected Medicaid provider to give bond with surety to ODJFS for the faithful adherence to prohibitions against obtaining or attempting to obtain payments under the Medicaid program to which the provider is not entitled or providing false information regarding a Medicaid payment.

- Provides that the ODJFS Director is required, rather than permitted, to establish an e-prescribing system for the Medicaid program.

- Requires ODJFS to implement a disease management program for Medicaid consisting of a system of coordinated health care interventions and patient

communications for groups of Medicaid recipients who have medical conditions for which ODJFS determines patient self-care efforts are significant.

- Requires ODJFS to (1) conduct a review of case management services provided under the fee-for-service component of the Medicaid program, (2) identify which groups of Medicaid recipients receive no case management services and which groups receive case management services as part of two or more parts of the Medicaid program or from two or more providers, and (3) after completing the case management review, implement a case management component for the Medicaid program that serves at least those Medicaid recipients who are members of the groups ODJFS identifies in its case management review and have been diagnosed by a physician as having certain medical conditions.

- Requires ODJFS to develop and implement an Alternative Care Management Program for Medicaid recipients to test and evaluate multiple alternative care management models for providing health care services to Medicaid recipients.

- Creates the Medicaid Community Behavioral Health Administration Examination Group to study the administration and management of Medicaid-covered community behavioral health services.

TABLE OF CONTENTS

CONTENT AND OPERATION

Medicaid fraud, waste, and abuse report

(R.C. 5111.092)

Current law enacted by Am. Sub. H.B. 1 of the 128th General Assembly (the main operating budget for fiscal years 2010-2011) requires the Ohio Department of Job and

Family Services (ODJFS) to prepare an annual report on its efforts to minimize fraud, waste, and abuse in the Medicaid program. The first report is due not later than January 1, 2010. The reports must be made available on ODJFS's web site and ODJFS must submit a copy of each report to the Governor and General Assembly. Copies are to be made available to the public on request.

The bill was introduced before the enactment of H.B. 1 and includes a provision similar to, but more detailed than, this H.B. 1 provision.[1] As under H.B. 1, ODJFS is required by the bill to prepare an annual report regarding its efforts to minimize fraud, waste, and abuse in the Medicaid program. The first report is due not later than January 1, 2010, and each report must be made available on ODJFS's web site and to the public on request. Unlike H.B. 1, though, the bill requires ODJFS, in preparing the report, to collaborate with other Medicaid program fraud, waste, and abuse personnel from (1) the Attorney General's Medicaid Fraud Control Unit, (2) the Auditor of State's Fraud and Investigative Audit Group, (3) state agencies with which ODJFS contracts to administer one or more components of the Medicaid program or aspects of such components, and (4) county departments of job and family services. Also unlike H.B. 1, the bill requires that each report include (1) goals and objectives to minimize fraud, waste, and abuse that are mutually agreed upon by ODJFS and the entities it collaborates with in preparing the report and (2) performance measures for monitoring all state and local activities related to minimizing fraud, waste, and abuse.

Local reports on Medicaid expenditures

(R.C. 5111.093)

The bill requires certain local agencies that administer components of the Medicaid program to report Medicaid expenditure information annually to ODJFS and the Office of Budget and Management. The following agencies are charged with providing the information: county departments of job and family services; county boards of developmental disabilities;[2] community behavioral health boards; PASSPORT administrative agencies; boards of education of city, local, and exempted village school districts; and the governing authorities of community schools. A local agency's annual report must contain the following information regarding the previous calendar year:

---

[1] An amendment could be drafted to coordinate the bill's provision with the law already enacted in Am. Sub. H.B. 1 of the 128th General Assembly. At a minimum, a technical amendment is needed to assign a different section number to the bill's provision, since the H.B. 1 provision was enacted under the same number. Also, the January 1, 2010, due date of the first report will have to be changed (R.C. 5111.092).

[2] The bill was introduced before Sub. S.B. 79 of the 128th General Assembly was enacted. S.B. 79 changed the name of county boards of mental retardation and developmental disabilities to county boards of developmental disabilities. A technical amendment is necessary to update the bill's reference to the name of the county boards.

(1) The total amount of local government funds the local agency expended for the Medicaid program;

(2) The portion of that total amount that represents funds raised by local property tax levies;

(3) The local agency's total administrative costs for the Medicaid program;

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

(5) The total amount of state funds provided to the local agency for the Medicaid program.

Third party liability pilot program

(Section 3)

The bill requires the ODJFS Director, using technology designed to identify all persons liable to pay a claim for a medical item or service, to establish a pilot program for the purpose of identifying third parties[3] 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, or paid by, the Medicaid program. The Director must determine the duration of the pilot program, but the bill prohibits the program from ending less than 18 months after it is established.

In administering the pilot program, the ODJFS Director must ensure that all aspects of the program comply with Ohio and federal law, including the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations promulgated to implement HIPAA. The duty to ensure compliance with these laws, however, does not prohibit (1) a third party from providing information to ODJFS or disclosing or making use of information as permitted under current law governing third party responsibilities (R.C. 5101.572) or when required by any other provision of Ohio or federal law or (2) ODJFS from using information provided by a third party as

[3] Under the bill, a "third party" is (1) a person authorized to engage in the business of sickness and accident insurance, (2) a person or governmental entity providing coverage for medical services or items to individuals on a self-insurance basis, (3) a health insuring corporation, (4) a group health plan, (5) a service benefit plan, (6) a managed care organization, (7) a pharmacy benefit manager, (8) a third party administrator for health insurers, (9) any other person or governmental entity that is, by law, contract, or agreement, responsible for the payment or processing of a claim for a medical item or service for a public assistance recipient or participant. "Third party" does not include the Department of Health's Program for Medically Handicapped Children (*i.e.,* the BCMH Program). (R.C. 5101.571.)

permitted by law governing third parties responsibilities or when required by any other provision of Ohio or federal law.

Contract for pilot program administrator

The ODJFS Director is to either administer the pilot program or contract with a person to administer the pilot program. Before entering into a contract, ODJFS must issue a request for proposals from persons seeking to be considered. ODJFS must develop a process to be used in issuing the request for proposals, receiving responses, and evaluating the responses on a competitive basis. In accordance with that process, ODJFS must select the person to be awarded the contract.

The ODJFS Director is permitted by the bill to delegate to the person awarded the contract any of the Director's powers or duties with respect to the pilot program. The terms of the contract must specify the extent to which the powers or duties are delegated to the administrator. In exercising powers or performing duties delegated under the contract, the administrator is subject to the same provisions of the bill that grant powers or duties to the Director, as well as any limitations or restrictions that are applicable to or associated with those powers or duties.

The terms of the contract must include a provision that specifies that the ODJFS 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 federal and state laws, including HIPAA.

Evaluation

The ODJFS Director is required to evaluate the pilot program's effectiveness 12 months after it is established. As part of this evaluation, the Director must determine two sets of information. First, the evaluation must determine all of the following for the 12 months immediately preceding the pilot program's establishment:

(1) 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;

(2) The portions of the amounts attributable to each liable third party that were recovered by the Director or a person with which the Director has contracted to manage the recovery of money due from liable third parties;

(3) The portions of the amounts attributable to each liable third party that would have been identified by the technology used by the pilot program had the technology been used in those 12 months.

Second, the evaluation must determine both of the following for the first 12 months of the pilot program:

(1) The same three things that the evaluation must determine for the 12 months immediately preceding the pilot program's establishment;

(2) The portions of the amounts attributable to each liable third party that were identified by the technology used by the pilot program.

The bill requires the ODJFS Director, not later than three months after the evaluation is initiated, to 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 evaluation of the pilot program. At a minimum, the report must summarize and compare the Director's determinations regarding third party liability and recovery before and after the pilot program is established, as described above, 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.

Rules

The bill authorizes the ODJFS Director to adopt rules in accordance with the Administrative Procedure Act (R.C. Chapter 119.) as necessary to implement the pilot program.

Surety bond for Medicaid providers

(R.C. 5111.035)

Current law provides for specific civil penalties against a Medicaid provider under contract with the ODJFS who, by deception, obtains or attempts to obtain payments under the Medicaid program to which the provider is not entitled or provides false information regarding a Medicaid payment.[4]

The bill requires each Medicaid provider selected by ODJFS to give bond with surety[5] to ODJFS for the faithful adherence to the prohibitions against obtaining or attempting to obtain payments under the Medicaid program to which the provider is not entitled or providing false information regarding a Medicaid payment. ODJFS is to

[4] R.C. 5111.03.

[5] A "surety" is a person who is primarily liable for paying another's debt or performing another's obligation. Although a surety is similar to an insurer, one difference is that a surety often receives no compensation for assuming liability. (Bryan A. Garner, *Black's Law Dictionary*, 9th ed.)

determine which providers are subject to the bond with surety requirement but, at a minimum, is to apply the requirement to each provider who has been investigated for any criminal offense of fraud. ODJFS is to set the amount of the bond at a level that reflects the level of risk of fraud by the provider.

Medicaid e-prescribing system

(R.C. 5111.083)

Current law permits the ODJFS Director to establish an e-prescribing system for the Medicaid program under which a Medicaid provider who is a licensed health professional authorized to prescribe drugs[6] must use an electronic system to prescribe a drug for a Medicaid recipient under certain circumstances. If the e-prescribing system were to be established, a Medicaid provider would be required to use the system during a fiscal year if the provider was one of the ten providers who, during the calendar year that precedes that fiscal year, issued the most prescriptions for Medicaid recipients receiving hospital services. The ODJFS Director would be required, before the beginning of each fiscal year, to 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 providers that they must use the e-prescribing system for the upcoming fiscal year. The ODJFS Director would also be required to seek the most federal financial participation available for the development and implementation of the e-prescribing system.

Current law requires any such e-prescribing system to eliminate the need for Medicaid providers participating in the system to make prescriptions for Medicaid recipients by handwriting or telephone. The e-prescribing system, if established, also would be required to provide participating 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.

The bill requires, rather than permits, the ODJFS Director to establish such an e-prescribing system for the Medicaid program.

---

[6] The following licensed health professionals are authorized to prescribe drugs: (1) dentists, (2) clinical nurse specialists, certified nurse-midwives, and certified nurse practitioners holding a certificate to prescribe, (3) optometrists licensed to practice under a therapeutic pharmaceutical agents certificate, (4) physicians and podiatrists, and (5) physician assistants who hold a certificate to prescribe. Veterinarians also have authority to prescribe drugs but they do not participate in the Medicaid program. (R.C. 4729.01(I).)

Medicaid disease management program

(R.C. 5111.141)

ODJFS is required by the bill to implement a disease management program for Medicaid consisting of a system of coordinated health care interventions and patient communications for groups of Medicaid recipients who have medical conditions for which ODJFS determines patient self-care efforts are significant. ODJFS may implement the program as part of the Alternative Care Management Program that the bill also requires ODJFS to implement.[7] The bill provides that Medicaid recipients participating in the existing Medicaid care management system[8] are excluded from the program.

The disease management program must do all of the following:

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

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

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

The bill provides that contracts that ODJFS enters into with other state agencies for the other agencies to administer a part of the Medicaid program on ODJFS's behalf must, to the extent ODJFS considers appropriate, provide for the other agencies to include the disease management program in the part of the Medicaid program the other agencies administer.

Medicaid case management services

(R.C. 5111.142)

The bill requires ODJFS to conduct a review of case management services provided under the fee-for-service component of the Medicaid program. ODJFS must identify (1) which groups of Medicaid recipients not participating in the existing Medicaid care management system or enrolled in a Medicaid waiver program do not

---

[7] See "**Alternative Care Management Program**" below.

[8] Continuing law permits ODJFS to do both of the following under the Medicaid care management system: (1) require or permit participants in the system to obtain health care services from providers that ODJFS designates and (2) require or permit participants in the system to obtain health care services through managed care organizations with which ODJFS contracts (R.C. 5111.16).

receive case management services and (2) which groups of such Medicaid recipients receive case management services as part of two or more parts of the Medicaid program or from two or more providers.

After completing the review, ODJFS is to implement a case management component for the Medicaid program. The case management component must be modeled on the former enhanced care management program that ODJFS created as part of the Medicaid care management system. However, ODJFS is to make adjustments as are necessary to accommodate the groups the case management component is to serve.

The case management component is to serve, at a minimum, Medicaid recipients who (1) are members of the groups ODJFS identifies in its review of case management services and (2) have been diagnosed by a physician as having certain medical conditions. The following are the medical conditions: a high-risk pregnancy, diabetes, asthma, lung disease, congestive heart failure, coronary artery disease, hypertension, hyperlipidemia (i.e., high cholesterol), infection with HIV, AIDS, and chronic obstructive pulmonary disease.

Alternative Care Management Program

(R.C. 5111.165)

As a program separate from the existing Medicaid care management system, the bill requires ODJFS to develop and implement an Alternative Care Management Program for Medicaid recipients. The program must be implemented not later than October 1, 2009,[9] or if by that date ODJFS has not received any necessary federal approval, as soon as practicable after receiving approval. ODJFS is to designate the Medicaid recipients who are required to participate in the program, but is not to include any individual participating in the existing Medicaid care management system.

The bill provides that the purpose of the Alternative Care Management Program is to test and evaluate multiple alternative care management models for providing health care services to Medicaid recipients. In implementing the program, ODJFS is to ensure that each model included in the program is operated in at least three counties selected by ODJFS. ODJFS may expand a model program to other counties if ODJFS determines that the expansion is necessary to evaluate the model's effectiveness.

ODJFS is permitted to periodically alter the requirements, design, or eligible participants in the Alternative Care Management Program in order to test and evaluate the effectiveness of varying models. However, each model must be in effect for a period sufficient in length to evaluate the model's effectiveness. In evaluating each

[9] A technical amendment is needed to change the deadline.

model, ODJFS is required to maintain statistics on physician expenditures, hospital expenditures, preventable hospitalizations, costs for each participant, effectiveness, and health outcomes for participants.

ODJFS is to adopt rules under the Administrative Procedure Act (R.C. Chapter 119.) as necessary to implement the Alternative Care Management Program. The rules are to specify standards and procedures for use in designating participants in the program.

Medicaid Community Behavioral Health Administration Examination Group

(Section 4)

The bill creates the Medicaid Community Behavioral Health Administration Examination Group. The Group is to study the administration and management of Medicaid-covered community behavioral health services, which consist of community mental health services certified by the Director of Mental Health and services provided by alcohol and drug addiction programs certified by the Department of Alcohol and Drug Addiction Services.

Members

The Group is to consist of all of the following:

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

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

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

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

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

The Directors of Mental Health and Alcohol and Drug Addiction Services, or their designees, are to serve as co-chairpersons. The Departments of Mental Health and Alcohol and Drug Addiction Services are required to provide administrative services to the Group. Members of the Group are to serve without compensation, except to the extent that serving on the Group is considered part of their regular employment duties.

Report

The Group is required to submit a report regarding its study to the Governor and General Assembly.[10] The report is due not later than one year after the bill's effective date and the Group is to cease to exist on submission of the report. The report is to include all of the following:

(1) Recommendations for system changes needed for the effective administration and management of Medicaid-covered community behavioral health services;[11]

(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;

(3) An examination of the best practices for providing Medicaid-covered community behavioral health services, using as a reference other states' best practices for providing the services;

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

HISTORY

ACTION	DATE
Introduced	06-23-09

h0240-i-128.docx/kl

[10] In submitting the report to the General Assembly, the Group is to provide it to the Senate President, Senate Minority Leader, Speaker of the House of Representatives, House Minority Leader, and the Director of the Legislative Service Commission (R.C. 101.68(B)).

[11] The recommendations must focus on increasing efficiencies, transparency, and accountability to improve the delivery of community behavioral health services.