

**Testimony of Tracy Williams, Interim Deputy Director
Ohio Department of Job and Family Services
Office of Ohio Health Plans
Joint Committee on Medicaid Technology and Reform
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Chairman Wachtmann and members of the Committee, I am Tracy Williams, Interim Deputy Director of the ODJFS Office of Ohio Health Plans. Today I will provide information for you on the following topics:

1. An update on the implementation of Medicaid managed care;
2. A summary of the recommendations of the Disability Determination Study Council;
3. An update on Medicaid recoveries from third party insurance carriers (also known as Third Party Liability or TPL); and
4. An update on the RFP for development of our Medicaid Information Technology System.

In addition, following my testimony, Bill Larkin, Vice President of Fox Systems will provide you with an overview of their work plan to assess the existing Ohio Medicaid Data Warehouse and whether it should be enhanced or replaced.

1. **Update on the Implementation of Medicaid Managed Care**

In short, ODJFS is on track to meet our legislative deadline to have Ohio's entire CFC population and a sub-group of the ABD population enrolled in Medicaid managed care by the end of calendar year 2006. Here are a few highlights.

Levy franchise fees on managed care plans - Implemented on December 1, 2005

With the enactment of Amended Senate Bill 190, ODJFS implemented the Medicaid managed care plan franchise fee on December 1, 2005, in time to be federally grandfathered into existence until October, 2009. The first fee was collected from the managed care plans in January. These fees and the associated federal share will help to cover the costs of Medicaid managed care expansion in Ohio.

Managed care expansion for Covered Families and Children (CFC)

As of February 1st, there were nearly 644,000 Medicaid consumers enrolled in managed care in 17 counties. ODJFS now has provider agreements with nine managed care plans. Enrollment in the program is mandatory for CFC consumers in 12 urban counties and voluntary in 5 other counties. The most recent expansion was in Franklin County, which was designated for mandatory status in December. As a result of Franklin county's mandatory status, enrollment in the managed care program is expected to exceed 700,000 consumer in April 2006.

The next phase, CFC statewide expansion, is well underway. ODJFS released a Request for Applications (RFA) to expand the program on a regional basis to all 88 counties on November 30, 2005. Applications from eleven managed care plans were submitted to ODJFS by February 7, 2006 and are currently under review. Selected plans are expected to be announced in early March.

When fully implemented at the end of this calendar year, we estimate that 1.3 million Ohio parents and their children will receive their Medicaid services via managed care arrangements.

Managed care expansion for Aged, Blind and Disabled (ABD)

ODJFS staff continue to develop the Medicaid managed care program for elders and people with disabilities. As a reminder, the ABD managed care program established in HB 66 was focused on a specific subset of the Medicaid ABD population. The following groups of Medicaid ABD consumers will be excluded from enrollment in this program:

- Residents of nursing facilities and ICFs/MR;
- Children with disabilities or special needs;
- Medicare “dual eligibles;”
- Consumers enrolled in Medicaid waiver programs; and
- Consumers who have a “spend down” amount before they can obtain a Medicaid card.

ODJFS will release a Request for Applications (RFA) in April 2006 which will begin the competitive procurement process. ODJFS and Mercer (ODJFS’s contracted actuary) are progressing on risk-adjusted capitation rates for the ABD managed care program which are needed to release the RFA.

When fully implemented at the end of this calendar year, ODJFS estimates that 126,000 elderly or disabled Ohioans will receive their Medicaid health care via managed care arrangements.

Prompt Payment Requirements

HB 66 required the Ohio Department of Insurance to begin to monitor the prompt pay performance of Medicaid managed care plans. (Previously, Medicaid plans had been excluded from ODI prompt pay oversight.) Statute requires the Department of Insurance to monitor electronic claims only. ODJFS has a federal requirement to monitor the prompt pay performance of Medicaid managed care plans for all claim types (electronic & paper.)

As further required by HB 66, ODJFS asked CMS if the Department’s existing prompt pay monitoring requirements could be waived in light of the new state law change involving the Department of Insurance. The logic was that a waiver would enable the state agencies to avoid somewhat duplicative oversight functions. CMS responded that it would not be permissible to waive Ohio Medicaid’s prompt pay monitoring process, and indicated that ODJFS would have to continue its current functions in addition to the new involvement of the Department of Insurance. ODJFS has informed both ODI and the managed care plans of this information. We will continue to work with both parties to try to streamline this to the extent possible in light of the federal feedback.

Surety Bond

Pursuant to HB 66, the Ohio Department of Insurance will require any new Medicaid managed care plan that applies after October 1, 2005 to provide insurance in Ohio to have secured a \$3 million surety bond. To my knowledge all existing plans are in compliance with this new requirement.

2. Summary of the Recommendations of the Disability Determination Study Council

Amended Substitute House Bill 66 (Section 206.66.46) required a study of the processes used by governmental entities that administer “programs or services for which disability is an eligibility requirement.” The stated purpose of this study was to examine the feasibility of combining the disability determination functions within a single agency and to examine potential advantages or disadvantages of consolidating these functions.

In compliance with HB 66, ODJFS convened representatives of county departments of job and family services (CDJFS) and the Rehabilitation Services Commission (RSC) to examine these issues. In addition, ODJFS invited representatives of the Disability Medical Assistance Council to participate. This facilitated coordination with their recommendations to improve Medicaid disability determination and thereby reduce the number of people using the state-only funded DMA program as a “waiting room” for Medicaid.

After six meetings and extensive review, the members of the Study Council recommended that Ohio should streamline the administrative processes used to determine the presence of a disability as required by Ohio Medicaid and federal Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI). The Council concluded this could be accomplished without consolidating disability determination functions under a single governmental agency. In fact, the Council found the “total consolidation” option to be more costly than this more incremental streamlining approach.

In summary, the Council recommended utilizing the existing process and infrastructure of the RSC to perform the vast majority of disability determinations for Ohio Medicaid. Under this model, Medicaid applicants would still apply at their county department of job and family services, but would utilize the same form used by RSC and Social Security. Applicants seeking Medicaid enrollment in the ABD category would be required to apply simultaneously for SSI or SSDI through the Rehabilitation Services Commission via one of 57 field offices or on-line via the Internet. By filing what is effectively a dual application, RSC would perform the disability determination process for Medicaid applicants just as they currently perform them for SSI and SSDI applicants. County departments of job & family services would be relieved of most of the administrative and financial burden of scheduling and paying for medical testing for these Medicaid applicants.

Ohio Medicaid could accomplish this change quickly and easily by simply utilizing the same disability determination and medical release of information forms currently used by Social Security. As the single state Medicaid agency, ODJFS would retain the final eligibility determination for Medicaid. If a consumer appealed his or her eligibility denial, the Medicaid-related appeal would be managed by ODJFS. The CDJFS would continue to fund testing that is necessary as a result of an appeal hearing.

The benefits of this consolidated process are:

- An estimated \$2 million in cost savings to ODJFS and county departments of job and family services;

- Applicants will have a single disability application form, a single release of information, and a single disability determination process for Medicaid and SSI or SSDI.
- Duplicate administrative functions will be eliminated for collection and review of medical documentation and determination of the presence of a disability;
- The process can be implemented within approximately 18 months and will build upon existing process improvements already underway within ODJFS Office of Ohio Health Plans.

Director Riley has signed the report and sent it to the Speaker of the House, the President of the Senate and the Governor as required in HB 66. We await feedback in order to determine our next course of action. If the Council’s recommendations are to be accepted, we estimate an 18 month implementation timeframe.

3. Overview of Ohio Medicaid’s Third Party Liability (TPL)

ODJFS is responsible for the coordination of benefits for Medicaid consumers in order to assure that Medicaid is the last payer. Benefits Coordination includes the following three general functions:

- **Cost Avoidance:** Preventing Medicaid payment when other health insurance coverage exists;
- **Payment Coordination:** Processing a claim when Medicaid is the secondary payer; and
- **Recoveries:** Recovery of Medicaid payments made when other commercial or public health insurance coverage should have been billed for, and paid for, the service. (This is usually what is referred to as Third Party Liability or TPL)

The goal of benefits coordination is to minimize Medicaid’s financial liability when enrollees have other sources of health insurance. Ohio Medicaid has traditionally emphasized up front cost avoidance because it is more cost efficient and more successful than back end third party liability where we literally “pay and chase.” To illustrate the success of up-front cost avoidance, i.e., coordination of benefits, compared to TPL, in SFY 2005, Ohio Medicaid cost avoided \$474 million up front while collecting \$180 million via our third party liability recoupments. (Note: These amounts represent both state & federal shares; the federal share is returned to the federal government. From a state share perspective, Ohio Medicaid cost avoided \$191 million up front and collected \$73 million through TPL. Also, the TPL amounts are prior to commission payments to our third party liability vendor.)

While up-front cost avoidance activities provide a greater opportunity for value to the state, ODJFS is committed to maximizing its “pay and chase” performance as well. The department currently has two contracts for the post payment review and collection of Medicaid payments when third party coverage exists. Committee members may be familiar with the quarterly reports we send to the members of the Legislative Controlling Board outlining the progress of our competitively bid TPL functions. Beginning with this fiscal year, we switched vendors based on the outcome of the competitive bid results. So, currently, ODJFS has two separate contracts:

- A “run-off” contract with Health Management Systems to bring to closure recoveries related to Medicaid services delivered prior to July 1, 2005. This is a \$6 million contract to pay

contingency fees of 8.5% of actual recoveries. For the period September – December 2005, HMS recoveries were \$31.4 million, for which the state paid approximately \$2.7 million in commission. Please refer to the most recent quarterly report summarizing this information.

- A contract with Public Consulting Group for services delivered from July 1, 2005 through June 30, 2007. This is a \$7 million contract with a contingency fee of 3.95% of actual recoveries. Because this is a new vendor, work just began this fall. For the period November through December, 2005, PCG has identified over \$61 million in potential accounts receivable and sent out first billing notices to insurance carriers. Recoveries will be sought by PCG based on this potential universe of TPL claims, and amounts will be realized by the state in the coming months. To date, PCG work has led to nearly \$150,000 in tort recoveries since October. This amount is expected to increase over time as well. Again, please refer to the quarterly report for additional detail.

4. Update regarding Medicaid Information Technology System

As you may recall, ODJFS must have Federal approval before we the MITS Request for Proposals can be released for review & response by potential vendors. ODJFS submitted the Advanced Planning Document and RFP for CMS's approval in December 2005. On February 17th, ODJFS received a list of questions related to the submitted documents. Staff are in the process of answering those questions and plan to have responses submitted to CMS by March 3rd. We hope our responses will secure CMS's approval of the IAPD for enhanced funding and the RFP for public release. As you are aware, there is a high degree of sensitivity regarding the types of questions that I can answer regarding the procurement process at this point, but nonetheless I hope that you find this MITS update helpful.

This concludes my prepared testimony for today. I'd be happy to respond to questions.