

**Testimony of John R. Corlett
Ohio Medicaid Director
Ohio House Committee on Finance and Appropriations
May 21, 2008**

Chairman Hottinger, ranking member Skindell and members of the Committee. My name is John Corlett and I am the state Medicaid Director. Thank you for inviting me to come today to speak with you about the contents of HB 562, the Capital Appropriations and Budget Corrections Bill as they relate to the Ohio Medicaid Program.

I would like to begin by discussing Medicaid caseload and spending along with our cost containment initiatives and their performance. I will conclude by briefly reviewing the requested Medicaid policy initiatives included in HB 562 and those not included.

Medicaid Caseload and Spending

Ohio is in the midst of an economic slow down that is having its greatest impact on Ohioans with low and moderate incomes. As you know, Medicaid is a counter cyclical program, meaning demand and caseload grows when the economy slows, and that is exactly what we are experiencing now.

For 17 consecutive months, the Medicaid caseload has exceeded the budgeted estimate. Through March, Medicaid enrollment totaled 1.77 million recipients, which was 27,979 or 1.6 % more than the estimate. Enrollment among the lower income populations, children and their parents with incomes up to 90 percent of the federal poverty level, continue to drive this increase. The Healthy Families Expansion group is nearly 17% over projections. Although the forecast for SFY 2008-2009 assumed a caseload increase for this group, we did not predict the speed or intensity of growth that we are now experiencing.

By the end of the biennium, we project an all funds shortfall of \$344 Million, (representing \$121.8 Million in state share). This is based on updated caseload estimates that project a caseload increase of 66,000 by the end of SFY 2009. Although Medicaid has experienced higher-than-projected caseloads for the past 17 months, expenditures have not risen as quickly. We believe this is a short lived trend, and that Medicaid spending growth will catch up with caseload in the coming months.

Medicaid Cost Containment

H.B. 119 envisioned implementation of a series of Medicaid cost containment measures. At this point in SFY 2008, we do not project that we will achieve all of the cost containment savings assumed in HB 119. Some of the responsibility for these shortfalls rest on our department while others were impacted by developments outside of our control. We estimate that our cost containment initiatives have already saved Ohio at least \$127 million. The biggest contributors have been our efforts to:

- Limit the intermediate care facility rate increases to two percent each year yielded over \$30 million in savings year to date;
- Limit growth in managed care rates to increase effectiveness and efficiency yielded \$36 million dollars in savings;
- Reduce the time required to enroll new Medicaid eligibles in a managed care plan by one third yielded \$1 million in savings; and

- Ensure the Medicaid program is the payer of last resort which we also call Third Party Liability or “TPL” with \$21 million in cost avoidance higher than this same point in SFY '07 and \$39 million in recoveries

Cost avoidance is a key element in our overall cost containment plan. Our objective is to ensure that the Medicaid program is the payer of last resort. Between July, 2007 and April, 2008 we avoided paying Medicaid costs of approximately \$259 million all funds by directing claims towards either commercial payers or Medicare. While that represents substantial savings, it is considerably less than what was projected under H.B. 119.

On April 10 when I last testified on this issue before the Joint Committee on Medicaid Information, Technology and Reform I indicated that we expected to receive insurance files from several additional commercial insurance carriers within a month. I am pleased to report that we have now added six carriers to our set of active insurance files.

We now have carrier files from the following commercial insurers: **Tricare, Medical Mutual of Ohio, Anthem, Aetna, Cigna, Central Benefits, Great West Life, and American Community Insurance**

By the end of June we should have eligibility files as well from Kaiser, Aultcare, SummaCare, Paramount, United HealthCare, and Medco. All together we will have over 85% of all commercially covered lives in Ohio included in our active insurance files.

Another way to measure our progress in this area is to look at the number of active TPL files that we have in our system. In January, 2007 we had 238,606 active TPL files, as of May 16 we had 590,992 active TPL files. We would expect these numbers to continue to grow as we add additional carrier files.

There are five initiatives on which we have made slower than anticipated progress due to a variety of issues. They are:

1. **Recalibrate inpatient hospital rates annually** – This initiative was postponed indefinitely to offer some relief to hospitals since we were unable to implement planned hospital rate increases.
2. **Requiring Medicare eligible Medicaid consumers to enroll in Medicare** – We continue to examine this issue; particularly weighing the cost of paying Medicare premiums for this population vs. the costs of claims that we might be able to avoid.
3. **Implement a medical claims editing system to ungroup claims and identify questionable claims prior to payment** - The clinical claims editor is a business requirement for our Medicaid Information Technology System, (MITS). It is scheduled to be implemented in October, 2009. Once this critical tool is in place, we anticipate opportunities for cost containment in the 2010-2011 budget.
4. **Increased medical support collections related to child support cases** – We have not been able to implement this initiative because the Federal government has not yet finalized its regulations. In the interim, we and our colleagues in the ODJFS Office of Child Support are preparing for implementation once regulations are finalized.
5. **Pre-Approve Psychiatric Drugs** – Savings in this area were based on an assumption that a generic form of Risperdal would be available January 1, but this was delayed until July 1 by

the Federal government. Approximately 44,000 patients use this drug in fee for service Medicaid. We are currently in the process of implementing a preferred drug list for some behavioral health drugs which should allow us to achieve savings in FY 2009 and beyond.

Ohio Medicaid Policy Initiatives Proposed for the Budget Corrections Bill

Included in the as introduced version of the bill were the following proposals requested by ODJFS Medicaid:

1. **CBI eligibility set at 250% FPL (Reduced from 300%)** - This item lowers the income threshold for the state funded Children's Buy In program (CBI) in order to close the health care coverage gap once Ohio obtains Federal approval for a Medicaid/SCHIP expansion for children up to 250% FPL
2. **Creating a new line item for enhanced matching funds for the MFP program**
This change corrects an accounting need by creating a line item to receive enhanced FFP for Ohio's Money Follows the Person grant.
3. **Criminal background checks** – This item is purely a technical correction of an incorrect cross-reference that was included in HB 119.
4. **MBI-WD and CBI premiums deposited in 5DL** – This item addresses an accounting issue to collect revenue from these two new programs that collect premiums from participants

Items requested by ODJFS Medicaid that were not included in the As Introduced bill are:

CBI streamlining and technical corrections - As you know, Children's Buy-In program (CBI) is designed to allow certain families to purchase health care coverage for their uninsured children. The target population is uninsured children in families with incomes over 300 percent of the federal poverty level. Thus, CBI is funded with 100% state dollars. Operationally, CBI was designed to function much like Ohio Medicaid program. However because CBI is a state only funded program, there are several ORC sections that are inappropriate for CBI. These are mostly technical corrections needed because the details of the CBI program were finalized late in development of House Bill 119. I urge including the ODJFS-proposed technical changes to CBI in the bill.

Establishing a Medicaid Schools Program – ODJFS suggests adding provisions authorizing the Medicaid Schools Program (MSP). Under MSP, children can receive psychological, nursing, speech therapy or other important services while they are at school and schools can become eligible to receive federal matching funds for their services to Medicaid enrolled children. This is especially important to children with disabilities and developmental delays. Today, most school districts are providing these services using only state and local funds. By including this language, and giving ODJFS and the Department of Education clear authority to operate this program, MSP could generate \$30 to \$50 million in federal revenue for participating schools.

This concludes my prepared testimony. I would be happy to respond to any questions.