




Department of
Job and Family Services

Ted Strickland, Governor
Helen E. Jones-Kelley, Director

MEMORANDUM

To: Ohio House Speaker Jon Husted
Ohio House Minority Leader, Representative Joyce Beatty
Ohio Senate President Bill Harris
Ohio Senate Minority Leader, Senator Ray Miller
Chair of House Finance Jay Hottinger
Ranking Minority Member Michael Skindell
Chair of Senate Finance John Carey
Ranking Minority Member Capri Cafaro

From: Helen Jones-Kelley, J.D., Director, ODJFS 

Re: Quarterly Cost Management Report on Ohio's Medicaid Program

Date: October 1, 2008

CC: Members of the 127th Ohio General Assembly

Section 5111.09.1 of the Revised Code requires the Ohio Department of Job and Family Services to report quarterly on the establishment and implementation of programs designed to control the increase of the cost and increase efficiency of the Medicaid program, and promote better health outcomes. It also requires our Department to report regarding:

- 1) Provider network management.
- 2) Electronic claims submission and payment systems.
- 3) Limited provider contracts and payments based on performance.
- 4) Efforts to enforce third party liability.
- 5) Implementation of the Medicaid information technology system.
- 6) Expansion of the Medicaid data warehouse and decision support system.
- 7) Development of infrastructure policies for electronic health records and e-prescribing.

Through Am. Sub. H.B. 119 (127th General Assembly) the Department proposed the following cost containment initiatives in the State Fiscal Year (SFY) 2008 and SFY 2009 biennium:

- 1) Limit the intermediate care facility rate increases to two percent each year.
- 2) Discipline growth in managed care rates to reflect increased effectiveness and efficiency.
- 3) Recalibrate inpatient hospital rates annually.
- 4) Enhance current efforts to ensure the Medicaid program is the payer of last resort.
- 5) Implement a medical claims editing system to ungroup claims and identify questionable claims prior to payment.
- 6) Reduce the time required to enroll new Medicaid eligibles in a managed care plan.
- 7) Increase medical support collections related to child support cases.

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8) Prior approve select anti-psychotic drugs for which there is a generic equivalent.

Attached is the first quarterly report for SFY 2009. Note that the projected savings in this report are all funds (i.e., include both state and federal funds) and were included in the February, 2008 Medicaid reprojected.

Cost management initiative updates

- 1) **Limit the ICF/MR rate increases to two percent each year**
Projected Savings: SFY 2008: \$43.1 million, SFY 2009: \$57.1 million
Status: Completed
Estimated year-to-date savings: \$14.3 million

- 2) **Discipline growth in managed care rates to reflect increased effectiveness and efficiency**
Projected Savings: SFY 2008: \$104 million, SFY 2009: \$186.4 million
Status: In progress
Estimated year-to-date savings: \$ 11.6 million (through August 2008)

The baseline budget projected an Aged, Blind and Disabled (ABD) per member per month (PMPM) cost of \$1,143.96 and a Covered Families and Children (CFC) PMPM cost of \$222.69. Through August 2008, due to the application of disciplined growth practices, the actual ABD PMPM cost was \$1,115.82 (savings of \$28.14) and the CFC PMPM was \$222.46 (savings of \$0.23). Multiplying the savings due to the lower PMPM costs with the ABD (384K) and CFC (3.6M) total members' months yields a through August 2008 year-to-date savings of \$11,608,543.

- 3) **Annual inpatient hospital rate recalibration**
Projected Savings: FY 2008: \$3.7 million, FY 2009: \$11.4 million
Status: Delayed
Estimated year-to-date savings: \$0

ODJFS will achieve no savings under this initiative until recalibration is implemented.

- 4) **For third-party liability, implement a system to ensure the Medicaid program is the payer of last resort**
Projected Savings: SFY 2008: \$50 million, SFY 2009: \$94.4 million
Status: In progress
Estimated year-to-date savings: \$31.4 million in year-to-date cost avoidance higher than the same time period in SFY 2007 and third-party liability recoveries. (ODJFS bases cost avoidance figures on billed charges from providers)

Over the same period in SFY 2007, cost avoidance has increased in SFY 2009 by \$31.4 million (\$20.3 million in Medicare and \$11.2 million in commercial insurance). ODJFS bases these figures on billed charges from providers. The savings translate to roughly \$15.7 million all funds or \$6.3 million in state matching share.

- 5) **For the Claims Editing System, implement a system to group and ungroup claims as needed and identify questionable claims prior to payment**
Projected Savings: SFY 2008: \$9.3 million, SFY 2009: \$39.7 million
Status: Delayed until ODJFS implements the Medicaid Information Technology System (MITS)
Estimated year-to-date savings: \$0

The Claims Editing System will be delayed until SFY 2010 when MITS is implemented.

- 6) Expedite managed care enrollment by reducing the time required to get new Medicaid enrollees into managed care**
Projected Savings: SFY 2008: \$2.6 million, SFY 2009: \$2.0 million
Status: In progress
Estimated year-to-date savings: \$586,333 which represents \$304,586 savings and \$281,747 additional franchise fees.

ODJFS has reduced from ninety to sixty days the average time for a consumer to enroll in a managed care plan.

ODJFS bases the dollar savings achieved to date in SFY 2009 on 27,037 consumers (2,537 consumers in Aged, Blind and Disabled category of assistance and 24,500 consumers in the Covered Families and Children category of assistance) who were enrolled into a managed care plan one month earlier.

Managed care enrollments taking place for the September 1, 2008 effective date, that otherwise would have taken place for a October 1, 2008 effective date is 9,327 for Covered Families and Children and 1,111 for the Aged, Blind or Disabled.

- 7) Increase medical support collections related to child support cases**
Projected Savings: SFY 2008: \$12.5 million, FY 2009: \$37.5 million
Status: Delayed
Estimated year-to-date savings: \$0

The federal regulations have been promulgated and state level work is in progress to achieve full implementation. Staff are conducting data matches between child support and Medicaid enrollment to assist with decision making.

- 8) Prior approve select anti-psychotic drugs for which there is a generic equivalent**
Projected Savings: SFY 2009 \$20 million
Status: OAC rule 5101:3-9-12, which allows ODJFS to prior authorize certain antipsychotic drugs, was approved by JCARR on August 25 for an effective date of October 1.
Estimated year-to-date savings: \$0

Other required information

1) Provider network management

a) Time limited Agreements (5111.028):

1) According to the statute, on and after January 1, 2008, with the exception of contracts for Long Term Care Facilities, Intermediate Care Facilities for the Mentally Retarded, and Managed Care Organizations, all providers applying to be an Ohio Medicaid provider received a time-limited provider application. To date the department is processing approximately twenty-two hundred time-limited provider applications that have been submitted since the January 1, 2008 effective date.

2) Update: Currently, up to eighty thousand existing provider agreements are open-ended and will have to be converted to time-limited agreements by

December 31, 2010. The process for conversion of these open-ended agreements will begin in January of 2009 with conversion letters being mailed to approximately three thousand providers each month until conversion is completed in December of 2010.

b) Re-Enrollment of providers (5111.028):

- 1) Once a Medicaid provider is enrolled under a time-limited agreement the statute requires the provider be re-enrolled by the department not later than three years from the effective date of their time limited agreement with the department.
- 2) Update: Rules regarding the time-limited agreements and the re-enrollment process were promulgated and made effective January 1, 2008 in order to coincide with the required time limited agreements that were to be made available to providers who applied to become Medicaid providers on and after January 1, 2008. The department is in the process of determining if subsequent rule development will be necessary.

c) Suspension of non-institutional providers upon and/or during an indictment (5111.031):

- 1) Under the statute, when a provider is suspended they must cease providing services to consumers, including doing business with other Medicaid providers or risk contractors. The provider receives no reimbursement from Medicaid during the suspension period. Claims submitted for services rendered prior to the date of suspension may be subject to prepayment review.
- 2) Non-institutional providers that are defined as "non-agency providers" are subject to suspension for an extensive list of specific disqualifying offenses which can be found in section 5111.034(D) of the Ohio Revised Code.
- 3) Non-institutional providers other than "non-agency" providers are subject to suspension for Medicaid fraud related offenses.
- 4) Update: Since this provision's effective date on October 1, 2007, 52 providers have been suspended by the Ohio Medicaid Program. Nineteen of these cases have ended in termination of the provider agreement. Of these 19 cases: 10 were convicted and terminated; 3 took voluntary terminations; 1 provider went out of business and was terminated; and 5 were terminated with an adjudication order for non-compliance with program policy. The remaining cases are pending court action.

d) Purging inactive Medicaid Providers:

- 1) Under the statute, whenever the provider agreement is terminated or not renewed, because the provider has not billed or otherwise submitted a Medicaid claim to ODJFS for two years or longer and ODJFS has determined that the provider has moved from the address on record with ODJFS without leaving an active forwarding address with ODJFS, the provider is not eligible for a hearing under Chapter 119 of the Ohio Revised Code.
- 2) Update: The department identified 25,000 providers from the ODJFS Medicaid Management Information System (MMIS) provider master file (PMF) who met the statutory definition of an "inactive" provider (a provider who has not submitted a claim to the department in 24 consecutive months). A notice was sent to each provider informing them of the department's intent to inactivate their provider record in the PMF. Subsequent to the notice approximately 5,000 providers submitted a request to remain active in the PMF. Their request was honored and their names removed from the list of providers to be inactivated. A

notice of inactivation was then sent to the remaining providers informing them that their record had been inactivated. From this second and last notice nearly three hundred providers responded with requests to remaining active. The end result was that approximately 19,725 providers were inactivated as of July 31, 2008.

2) Electronic claims submission and payment systems

The interactive applications on the Medicaid web portal moved into production on July 1, 2008. The portal's functionality currently includes claim submission, eligibility verification and remittance advice viewing. The portal's claims application was designed to permit providers, primarily small providers submitting paper claims, to directly submit their claims to the Department electronically at no cost to them. Additionally, the portal is available to all providers to verify Medicaid eligibility, including third party liability, on a near real time basis. As of September, the portal is processing approximately 1,100 claims and 6,000 eligibility inquiries per day. ODJFS is currently developing MITS to include a more robust web portal with expanded claim submission and eligibility verification capabilities, in addition new functionality will include prior authorization submission and other provider administrative tasks. MITS implementation is scheduled for October 2009.

3) Limited provider contracts and payments based on performance

Progress as reported as indicated under *Provider network management* above.

4) Efforts to enforce third party liability

With the passage of Deficient Reduction Act of 2005 language, ODJFS' pay and chase vendor has been able to obtain some carrier files it was unable to obtain in the past as well as work with carriers to properly process Medicaid reclamation claims.

Carrier	Date to obtain file	Notes	# of lives	To be in production by 10-1-08
Aetna	04/30/08	HMS has provided to be in production by 9-30-2008	900,000	
American Community	04/15/08	HMS has provided to be in production by 12-31-2008	20,000	
Anthem BC/BS	05/31/08	In production 9-10-2008	3,500,000	3,500,000
BC/BS of Indiana	05/31/08	In production 9-10-2008		
Caremark (commercial)	09/30/08	Filed received to be in production by 11-30-08		
Central Benefits	04/15/08	In production as of 7-25-08	73,000	73,000
Cigna	05/31/08	In production as of 8-20-2008	230,000	230,000
Express Scripts	12/31/08	Working with contact at Express Scripts		
Great West Life	04/15/08	In production as of 7-8-2008	35,000	35,000
Humana	10/31/08	FTP access granted. Humana to provide directly to ODJFS by 9-30-08	315,000	
Health Plan of Ohio	09/15/08	Carrier has sent file to be reviewed and in production by 9-30-08	78,000	
John Alden	9/30/2008	Part of Assurant - working with carrier to have HMS to provide data		
Kaiser	9/30/2008	Have received 2005 and 2006 data. Should receive rest	140,000	

		of data by 9-30-08		
Medco	10/31/08	FTP access granted. File to be received by 10-31-08	1,000,000+	
Medical Mutual of OH	in place	Already in place	1,700,000	1,700,000
Medicare	in place	Already in place	380,000	380,000
Paramount	06/15/08	HMS has provided to be in production by 11-30-2008		
Principal	12/31/08	working on obtaining a contact with carrier		
Summacare	05/15/08	HMS has provided to be in production by 12-31-2008		
Tricare	in place	Already in place Updated file received 7-21-2008	120,000	120,000
United Healthcare	12/31/08	UHC working to provide file directly to ODJFS by 12-31-08	1,500,000	
			8,991,000	6,038,000

5) Implementation of the MITS

The MITS implementation is on schedule and phase one is scheduled to go on-line October, 2009. Staff continues to lead and participate in Business Transformation activities, data conversion, Joint Application and Design sessions, and weekly management meetings for MITS.

6) Expansion of the Medicaid data warehouse and decision support system

ODJFS has completed an analysis to determine the degree to which MITS can service the data warehousing or Decision Support System functions (or both). ODJFS is reviewing the results of the analysis and will make a recommendation. Once the recommendation is decided, ODJFS will work with the Office of Information Technology and the Executive Medicaid Management Agency to gain consensus before moving forward. ODJFS' recommendation will integrate with the State of Ohio Enterprise Enterprise Service Bus architecture.

7) Development of infrastructure policies for electronic health records and e-prescribing

ODJFS has entered into a contract with Affiliated Computer Services (ACS) to provide online access, for Medicaid providers, to view the fee-for-service pharmacy claims history for their patients. This system will provide the ability for e-prescribing and faxing prescriptions, after verifying Medicaid coverage. The system is expected to be rolled out December, 2008 beginning with large provider groups and hospital emergency departments.

Attachment 1

The final Managed Care payment (which is usually disbursed on the fourth Monday of every month) and several other June 2008 provider payments, totaling \$434 million dollars, were disbursed from the fiscal year 2009 appropriation instead fiscal 2008 funds. This resulted in a high negative variance for the month of June and SFY2008. At the close of the fiscal year, JFS encumbered the remaining appropriation balance of \$304 million in line item 600-525 Health Care/Medicaid. These encumbered funds combined with the corrective bill funding will be used for the Medicaid program in SFY2009. The 2009 budget numbers in this report reflect both usage of the encumbered funds and the additional corrective bill appropriation. The budget numbers in the caseload trend data also ties to the corrective bill appropriations starting with the July 2008 data point.

SFY 2008 July 1, 2007, to June 30, 2008, Spending Analysis Chart

Category	Projection	Expenditure	Variance %
Nursing Facilities	2,672,694,838	2,543,519,828	-4.83%
ICF/MR	530,041,149	532,009,513	0.37%
Inpatient Hospital	773,015,657	962,945,002	24.57%
Outpatient Hospital	295,959,499	351,594,026	18.80%
Physician	300,244,049	303,661,397	1.14%
Drug	451,189,244	468,314,558	3.80%
ODJFS Waivers	327,017,319	306,440,563	-6.29%
Managed Care (ABD)	1,579,762,582	1,266,774,499	-19.81%
Managed Care (CFC)	2,809,135,833	2,577,956,596	-8.23%
Buy-In	323,124,474	294,577,350	-8.83%
Other	867,260,204	899,871,923	3.76%
Medicare Part D	253,516,011	243,172,531	-4.08%
Disability Assist.-Medical	16,466,950	15,362,011	-6.71%
SFY 2008 Vs. Projection	11,199,427,808	10,766,199,798	-3.87%

SFY 2009 July 1, 2008, to August 30, 2008, Spending Analysis Chart

Category	Projection	Expenditure	Variance %
Nursing Facilities	428,300,180	428,744,647	0.10%
ICF/MR	89,754,343	88,119,365	-1.82%
Inpatient Hospital	181,326,308	173,120,376	-4.53%
Outpatient Hospital	58,893,828	60,530,389	2.78%
Physician	52,278,361	53,525,696	2.39%
Drug	77,180,826	75,823,185	-1.76%
ODJFS Waivers	55,102,100	53,328,769	-3.22%
Managed Care (ABD)	345,701,051	344,812,761	-0.26%
Managed Care (CFC)	740,482,253	736,117,520	-0.59%
Buy-In	50,981,599	50,177,617	-1.58%
Other	163,399,471	163,036,959	-0.22%
Medicare Part D	41,469,371	41,460,534	-0.02%
Disability Assist.-Medical	2,090,115	2,026,304	-3.05%
SFY 2009 Vs. Projection	2,286,959,805	2,270,824,123	-0.71%

Attachment 2

Caseload Trend Data

