



Department of
Job and Family Services

John R. Kasich, Governor
Michael B. Colbert, Director

MEMORANDUM

To: Ohio House Speaker, Bill Batchelder
Ohio Senate President, Tom Niehaus
Ohio House Minority Leader, Armond Budish
Ohio Senate Minority Leader, Capri Cafaro
Chair of House Finance, Ron Amstutz
Ranking Minority Member, Vernon Sykes
Chair of Senate Finance, Chris Widener
Ranking Minority Member, Michael Skindell

From: Michael B. Colbert, Director ODJFS *MC*

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

Date: October 31, 2011

CC: Members of the 129th Ohio General Assembly

Section 5111.091 of the Revised Code requires the Ohio Department of Job and Family Services (the Department) 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 on the following Medicaid-related efforts:

- 1) Provider network management.
- 2) Electronic claims submission and payment systems.
- 3) Limited provider contracts and payments based on performance.
- 4) Enforcement of 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.

Pursuant to Am. Sub. H.B. 153 (129th General Assembly) the Department implemented the following cost containment or revenue generation initiatives for State Fiscal Years 2012 and 2013:

SFY2012 Cost Management Initiative Status as of Sept 30, 2011

Cost Management Initiative	Implementation Status	2012 Cost Savings / Revenue Enhancement Realized to Date	2012 Cost Savings Savings / Revenue Enhancement Target
1) Hospital franchise fee	On track for 10/11		\$338,752,392
2) Hospital payment modernization	On track for 1/12		\$163,194,000
3) NF payment modernization	Some changes made 7/11; On track for 1/12	\$31,535,542	\$195,660,688
4) ICF/MR franchise fee	On track for assessment in November 2011		\$8,768,001
5) Shift June ICF/MR Payment Back to June 2011	Completed	\$46,627,623	\$46,737,240
6) Capitation Rates (Administration and Trend)	On track for 1/12		\$24,219,700
7) Eliminate the Children's Buy-In	On track for 1/12		\$4,000,000
8) Physician Payment Codes	On track for 1/12		\$1,036,724
9) Nursing and Home Health Services Base Rate	On track for 10/12		\$15,000,000
10) Nutritional Products	On track for 1/12		\$1,700,000
11) Selective Contracting	On track for FY 13		\$0
12) National Correct Coding Initiative (NCCI)	Some changes made 8/11; On track for 1/12		\$174,375
Total		\$78,163,165	\$799,243,120

Key to Implementation Status: Blue = Complete, Green = On Track, Yellow = Delay or Other Issue, Red = Significant Delay or Issue

Note: These are cost containment or revenue enhancement initiatives related to the ODJFS Medicaid budget only. As not all budget initiatives are included, and non-ODJFS Medicaid initiatives are not included, the total savings does not reflect previously released ODJFS or OHT budget savings totals. OHT budget savings reflect a comparison to initial trend and include savings from sister agencies.

Cost management initiative updates

- 1) Budgeted GRF - state share reductions from hospital franchise fee
- | | | | |
|--------------------------|---------------|-----------------------------|-----|
| Projected SFY12 savings: | \$338,752,392 | Year-to-date SFY12 savings: | \$0 |
| Projected SFY13 savings: | \$345,241,284 | Year-to-date SFY13 savings: | \$0 |

UPDATE: Administrative code rules to implement the updated franchise fee amount have been filed on an emergency basis to be effective on October 1, 2011. After consultation with the hospital industry, we will begin collecting the fee on a quarterly basis beginning in November.

Companion work on the supplemental payment programs supported by the franchise fee is underway and state plan amendments will be sent to CMS by September 30, 2011.

- 2) Hospital payment modernization
- | | | | |
|--------------------------|---------------|-----------------------------|-----|
| Projected SFY12 savings: | \$163,194,000 | Year-to-date SFY12 savings: | \$0 |
| Projected SFY13 savings: | \$281,184,000 | Year-to-date SFY13 savings: | \$0 |

UPDATE: Payment system modifications to eliminate payment for hospital acquired conditions were implemented at MITS go live. Administrative code rules are in the process of being proposed to modify outliers, outpatient pricing to change fixed percentages to pay hospital cost, and Medicare cost sharing. These are scheduled to take effect January 1, 2012.

- 3) NF payment modernization
- | | | | |
|--------------------------|---------------|-----------------------------|--------------|
| Projected SFY12 savings: | \$195,660,688 | Year-to-date SFY12 savings: | \$31,535,542 |
| Projected SFY13 savings: | \$210,888,787 | Year-to-date SFY13 savings: | \$0 |

UPDATE: NF rate methodology changes have been implemented effective July 1, 2011. Year-to-date SFY 12 savings represents changes to the rate methodology only for July and August services. Changes to Leave Day Policy and Crossover Pricing are not effective until January 1, 2012.

- 4) Change in ICF/MR franchise fee
- | | | | |
|--------------------------|--------------|-----------------------------|-----|
| Projected SFY12 savings: | \$8,768,001 | Year-to-date SFY12 savings: | \$0 |
| Projected SFY13 savings: | \$12,286,835 | Year-to-date SFY13 savings: | \$0 |

UPDATE: The savings estimates are based on collecting three quarters at the increased rate during SFY12 and four quarters at an increased rate in SFY13. No year-to-date savings realized yet because the first assessment installment is not due until November 14, 2011.

- 5) Shift June ICF/MR Payment Back to June 2011
- | | | | |
|--------------------------|--------------|-----------------------------|--------------|
| Projected SFY12 savings: | \$46,737,240 | Year-to-date SFY12 savings: | \$46,627,623 |
| Projected SFY13 savings: | \$0 | Year-to-date SFY13 savings: | \$0 |

UPDATE: Completed, the ICF-MR payment was made in June 2011. By making the payment on the traditional schedule in June, the state not only removed an obligation from the SFY12-13 biennium, but also was able to receive \$2,475,927 in addition federal funds from the ARRA enhanced FMAP which expired June 30, 2011.

6) Capitation Rates (Administration and Trend)

Projected SFY12 savings:	\$ 24,219,700	Year-to-date SFY12 savings:	\$0
Projected SFY13 savings:	\$ 119,834,300	Year-to-date SFY13 savings:	\$0

UPDATE: The fourth quarter CY 2011 rates were updated during September 2011 to include changes in outliers, to carve the pharmacy benefit back into the capitation rate and make adjustments in administrative and trend components. Currently, the CY 2012 rate development is on target and it includes adjustments for cost containment items.

7) Eliminate the Children's Buy-In Program

Projected SFY12 savings:	\$4,000,000	Year-to-date SFY12 savings:	\$0
Projected SFY13 savings:	\$5,000,000	Year-to-date SFY13 savings:	\$0

UPDATE: Work is underway to bring the program to a close by January 1, 2012. The web application used to apply for Children's Buy-In has been closed and the applicable administrative code rules are in the process of being rescinded.

8) Physician Payment Codes

Projected SFY12 savings:	\$1,036,724	Year-to-date SFY12 savings:	\$0
Projected SFY13 savings:	\$2,073,449	Year-to-date SFY13 savings:	\$0

UPDATE: Administrative code rules are in the process of being proposed to limit payment for physician services to Medicare rates. This affects approximately 105 procedure codes that were paid above the Medicare rate. The rules and rate changes are on target for a January 1, 2012 implementation date.

9) Nursing and Home Health Services Base Rate

Projected SFY12 savings:	\$15,000,000	Year-to-date SFY12 savings:	\$0
Projected SFY13 savings:	\$20,000,000	Year-to-date SFY13 savings:	\$0

UPDATE: Rules implementing the reduction in the base rate were final filed with JCARR for a October 1, 2011 effective date. System work is on track for timely implementation.

10) Nutritional Products

Projected SFY12 savings:	\$1,700,000	Year-to-date SFY12 savings:	\$0
Projected SFY13 savings:	\$3,400,000	Year-to-date SFY13 savings:	\$0

UPDATE: Staff are currently formulating several options that could be used to implement a maximum payment rate and prior authorization review criteria for nutritional products.

11) Selective Contracting

Projected SFY12 savings:	\$0	Year-to-date SFY12 savings:	\$0
Projected SFY13 savings:	\$13,500,000	Year-to-date SFY13 savings:	\$0

UPDATE: The first product for selective contracting will be diabetic test strips. The department is considering a number of optional approaches to implement selective contracting for this item.

12) National Correct Coding Initiative			
Projected SFY12 savings:	\$174,375	Year-to-date SFY12 savings:	\$0
Projected SFY13 savings:	\$1,115,000	Year-to-date SFY13 savings:	\$0

UPDATE: Portions of the national correct coding initiative were implemented with MITS. The next phase of implementation has begun and staff are participating in joint application development sessions with HP.

Other required information

1) Provider Network Management

A) ORC 5111.06 (D) (13) permits the department to terminate the provider agreement of any health care provider who has not shared their National Provider Identifier with the department. In August 2010, letters were sent to typical providers who are required to have an NPI but have no record of an NPI in our Provider Master File. These letters were sent to 1,244 providers who are billing, and 26 were ODA/Passport providers. An active status was maintained for these ODA/Passport providers to accommodate ODA budgeting procedures until July 2011. In July 2011 23 of the 26 providers responded with record of their NPI, and 3 providers had their agreement terminated.

B) Provisions in the Affordable Care Act, implemented in regulations at 42 CFR Part 1007, established requirements for revalidation of existing provider agreements on a 5-year basis. As a first step to meet this new requirement, OHP sent letters dated May 17, 2011 to 98,123 providers with active status in the provider master file to both inform providers about this new requirement and to verify both their NPI and Medicare number. The OHP intent was to implement a revalidation process for Medicaid-only providers. Since our May 17, 2011 letter, both CMS and OHP revalidation requirements have changed to focus more on specific provider types for revalidation, rather than include the entire active status populations. As a result, we have suspended verification of NPI and Medicare information until more definitive requirements are established for our revalidation procedures.

2) Electronic claims submission and payment systems

The current portal's functionality 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 October 1, 2011, the portal is processing approximately 44,736 claims and 37,073 eligibility inquiries per day. During the reporting period, providers billed approximately \$385 million in claims through the Medicaid web portal. Please note that the numbers reflected this reporting period reflect one month of data coming from the old MMIS claims payment system and portal, and two months of data from the new MITS claims payment system and portal.

3) Limited provider contracts and payments based on performance

Medicaid MCP contracts were modified to introduce a new Accountability System starting with the CY 2012 evaluation period. Ohio Medicaid's Quality Strategy guided the selection of national measures to be used to hold MCPs accountable to specific performance levels. Performance expectation levels for twenty-two national measures were established. Six of these measures will be included a revised Pay-for-Performance system where MCPs can earn incentive money for better performance. Minimum performance levels were set for the remaining sixteen measures where MCPs will receive a monetary

sanction for poor performance. Incentives and/or monetary penalties based on this new Accountability System will be determined 6 to 9 months after the evaluation period (June – September 2013). System changes necessary for January 2012 are being implemented.

4) Efforts to enforce third party liability

The Coordination of Benefits Section continues to actively solicit insurance carriers to turn over their eligibility files. Over eighty-five percent of the covered lives in Ohio are represented with the insurance carrier files already in place. For State Fiscal Year 2011, the Third Party Liability (TPL) pay and chase vendor had recovered over \$88 million (both state and federal funds). This is a \$12 million increase over SFY 2010. The change in R.C. 5111.58 not allowing insurance carriers to deny Medicaid TPL pay and chase claims for not having obtained prior authorization has resulted in a \$458,500 in additional recoveries in SFY 2011 that would have normally been denied in the past. In SFY 2010 the recoveries were \$451,900 for claims that normally would have been denied for no prior authorization.

5) Implementation of the MITS

Ohio's new Medicaid claims adjudication system, known as the Medicaid Information Technology System, or MITS, went live on August 2, 2011. All of ODJFS, along with our partner, HP, were committed to the implementation of this new system. Together we worked to ensure that all components of the new system are ready to support consumers and providers through a seamless transition. Director Colbert and Medicaid Director McCarthy continue to closely monitor the system. ODJFS and HP are directly addressing any issues that arise with the new system as quickly as possible.

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

The expansion of the Medicaid data warehouse and decision support system depended upon implementation of MITS. Because MITS implementation was delayed until August, 2011, it was necessary to delay the expansion of the Medicaid data warehouse and decision support system and the current contract for vendor operation of the DSS was extended. Focused work is now underway to link MITS with the Medicaid data warehouse. This is necessary for the current DSS to be fully functional for current users.

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

ODJFS 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 also provides the ability for prescribers to generate an electronic prescription, after verifying Medicaid coverage. The Ohio Board of Pharmacy approved the system for electronic faxing of prescriptions on September 21, 2009. There are over 200 hospitals, medical practices and pharmacies registered to use the system, in addition to the Medicaid-contracting managed care plans and the Medicaid-contracted case management company CareStar. Additional practices continue to be added.

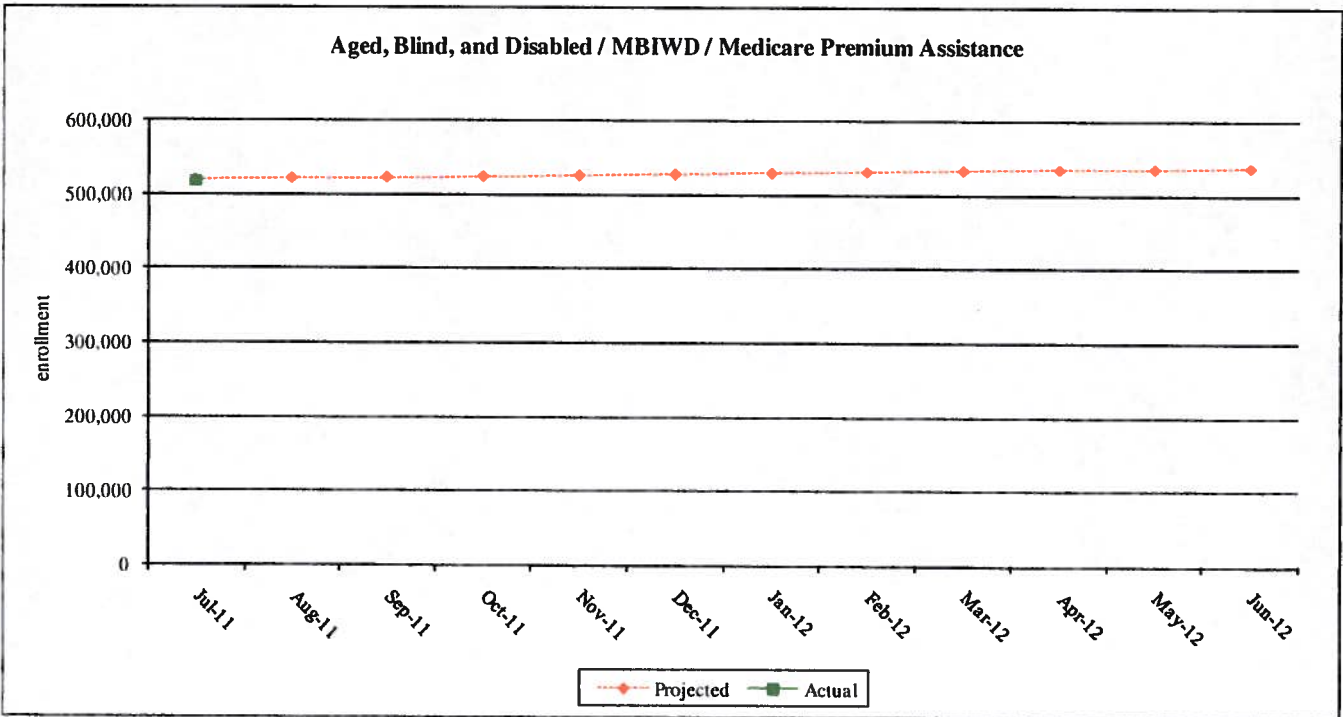
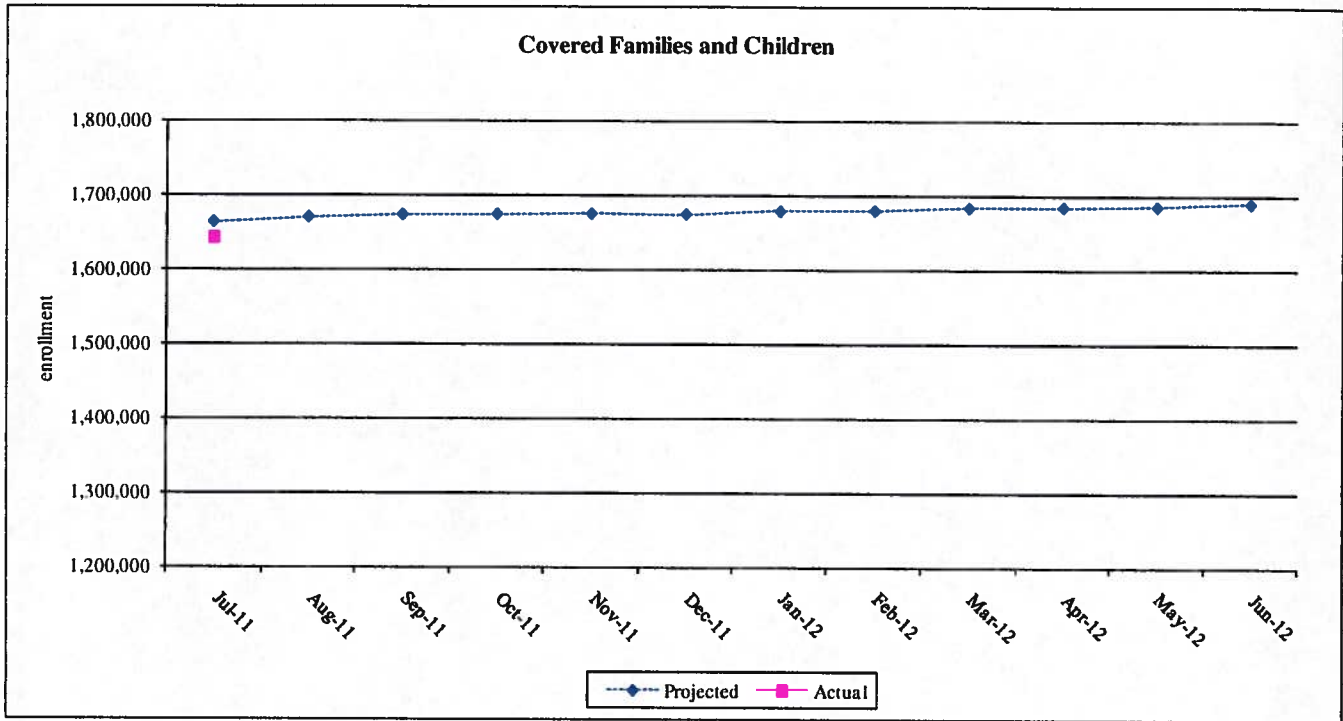
On June 1, 2011, ODJFS implemented the incentive payment system for meaningful use of Electronic Health Records (EHR) that is a part of the Health Information Technology for Economic and Clinical Health Act (HITECH). ODJFS is now in the planning phase of year two meaningful use for EHRs that are a part of HITECH. Since June 1, 2011, ODJFS has paid out over twenty million dollars in 100% federal monies to Ohio hospitals and healthcare professionals.

Attachment 1.
SFY12 Budget Status

Category	Projection	Expenditure	Variance %
Nursing Facility	\$427,688,244	\$411,937,617	-3.68%
Dept of Aging Waivers	\$121,128,685	\$124,197,915	2.53%
Transitions Waiver Aging (JFS)	\$9,237,043	\$8,630,650	-6.56%
ICF/MR	\$93,128,411	\$92,667,882	-0.49%
Transitions Waiver DD (JFS)	\$10,835,139	\$10,542,269	-2.70%
Home Care Waiver (JFS)	\$40,623,377	\$34,776,043	-14.39%
Inpatient Hospital	\$174,357,242	\$140,374,836	-19.49%
Outpatient Hospital	\$75,584,548	\$65,696,586	-13.08%
Physician	\$59,082,860	\$47,949,510	-18.84%
Prescribed Drugs	\$299,856,987	\$305,065,424	1.74%
Managed Care - ABD	\$250,233,127	\$250,233,127	0.00%
Managed Care - CFC	\$593,734,428	\$593,734,428	0.00%
All Other	\$204,430,536	\$199,366,706	-2.48%
Medicare Buy-In	\$69,762,716	\$65,706,824	-5.81%
Medicare Part D	\$42,940,991	\$42,530,609	-0.96%
Total YTD Vs. Projection	\$2,472,624,335	\$2,393,410,425	-3.20%

Source: Office of Fiscal and Monitoring Services as of September 7, 2011.

**Attachment 2.
Caseload Trend Data**



Source: Office of Fiscal and Monitoring Services as of September 12, 2011.