

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: Jan Allen, Interim Director, ODJFS

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

Date: December 29, 2008

CC: Members of the 127th 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.

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

Attached is the second 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; SFY 2008 = \$43.1 million, SFY 2009 2nd quarter savings = \$14.3 million
Estimated year-to-date savings: \$28.6 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; SFY 2008 = \$87.9 million, SFY 2009 2nd quarter savings = \$26.3 million
Estimated year-to-date savings: \$38 million

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 December, 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 (\$770K) and CFC (\$7.2M) total members' months yields a through December, 2008 year-to-date savings of \$38 million.

- 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; SFY 2008 = increase of \$106 million compared to SFY 2007 (\$73.2 million in Medicare and \$33.1 million in commercial insurance)
Estimated year-to-date savings: \$50.4 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 \$50.4 million (\$26.8 million in Medicare and \$23.6 million in commercial insurance). ODJFS bases these figures on billed charges from providers. The savings translate to roughly \$21.1 million all funds or \$8.4 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. Once implemented, the first year savings is expected to be \$12 million.

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; SFY 2008 = \$1.5 million (\$842,388 savings and \$631,821 additional franchise fees)

Estimated year-to-date savings: \$1,088,520 which represents \$565,036 savings and \$523,485 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 51,036 consumers (4,511 consumers in Aged, Blind and Disabled category of assistance and 46,525 consumers in the Covered Families and Children category of assistance) who were enrolled into a managed care plan one month earlier.

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. This quarter, the first revenues were received by JFS for medical support. These will be reconciled against actual Medicaid expenditures for each child. If more funds are collected than medical services provided, then the difference will be given to the custodial parent. It is too early to estimate the net revenue for this quarter.

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 and was effective as of October 1, 2008.

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 2,200 time-limited provider applications that have been submitted since the January 1, 2008 effective date.

2) Update: Since January 1, 2008 approximately 6,000 providers have been enrolled as Medicaid providers under time limited agreements.

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) Rules regarding the time-limited agreements and the re-enrollment process were promulgated and made effective January 1, 2008 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.

3) Update: The Department is preparing to begin the process of converting all provider agreements to time limited agreements as required by the statute. This conversion process affects providers who were enrolled with open ended provider agreements prior to January 1, 2008 (in excess of 80,000). Beginning January 2009 and extending through December 2010, each provider will receive a 'Notice of Conversion' of their provider agreement. The notice will inform the provider their agreement has been converted to a time limited agreement and provides the date their converted agreement expires. In addition, the notice provides information regarding the necessary actions the provider must take to re-enroll their time limited agreement.

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) 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.

5) Update: Seventeen Medicaid providers have been suspended since the beginning of August 2008, to date. Adjudication of the majority of these cases continues through the judicial system.

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) 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 approximately 19,725 providers were inactivated as of July 31, 2008 completing this process.

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 December 2008, the portal is processing approximately 1,300 claims and 12,300 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 the Deficient Reduction Act of 2005 language, ODFJS' pay and chase vendor has been able to obtain some insurance carrier files it was unable to obtain in the past as well as work with carriers to properly process Medicaid reclamation claims.

In addition, ODJFS has been able to utilize these carrier files to be able to properly update the MMIS billing system with insurance coverage information of Medicaid recipients to increase cost avoidance. ODJFS already has in production the carrier files of insurance companies that represent almost 70% of the covered lives in the state of Ohio. The goal is to keep adding carrier files to reach over 80%.

5) Implementation of the MITS

The MITS implementation is progressing towards implementation. 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 Service Business 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 March, 2009 beginning with large provider groups and hospital emergency departments.

Attachment 1 – SFY09 Budget Status:

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

Category	Projection	Expenditure	Variance %
Nursing Facilities	1,073,792,048	1,081,779,881	0.74%
ICF/MR	228,951,408	222,595,667	-2.78%
Inpatient Hospital	434,182,447	428,177,084	-1.38%
Outpatient Hospital	154,046,105	157,124,218	2.00%
Physician	131,980,689	138,410,726	4.87%
Drug	210,912,504	207,411,669	-1.66%
ODJFS Waivers	140,966,054	131,676,777	-6.59%
Managed Care (ABD)	651,016,083	639,786,233	-1.72%
Managed Care (CFC)	1,518,488,432	1,505,560,723	-0.85%
Buy-In	129,962,806	126,593,544	-2.59%
Other	423,823,057	410,465,887	-3.15%
Medicare Part D	102,630,040	102,899,083	0.26%
Disability Assist.-Medical	5,106,746	4,764,101	-6.71%
SFY 2009 Vs. Projection	5,205,858,418	5,157,245,593	-0.93%

Attachment 2

Caseload Trend Data

