

## MEMORANDUM

**To:** Ohio House Speaker, Armond Budish  
Ohio House Minority Leader, Representative Bill Batchelder  
Ohio Senate President, Bill Harris  
Ohio Senate Minority Leader, Senator Capri Cafaro  
Chair of House Finance, Vernon Sykes  
Ranking Minority Member, Ron Amstutz  
Chair of Senate Finance, John Carey  
Ranking Minority Member, Dale Miller

**From:** Douglas E. Lumpkin, Director, ODJFS

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

**Date:** April 1, 2009

**CC:** Members of the 128th 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 (127<sup>th</sup> 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 third 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 3rd quarter savings = \$14.3 million  
**Estimated year-to-date savings:** \$42.8 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 3rd quarter savings = \$55.8 million  
**Estimated year-to-date savings:** \$93.8 million

The baseline budget projected an Aged, Blind and Disabled (ABD) per member per month (PMPM) cost of \$1,241.43 and a Covered Families and Children (CFC) PMPM cost of \$237.97. Beginning January, 2009, due to the application of disciplined growth practices, the actual ABD PMPM cost was \$1,211.48 (savings of \$29.95) and the CFC PMPM was \$225.73 (savings of \$12.24). Multiplying the savings due to the lower PMPM costs with the ABD (\$33.4M) and CFC (\$60.4M) total members' months yields a through March, 2009 year-to-date savings of \$93.8 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 not be recalibrate hospital rates this SFY. No savings will be achieved 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 2009 = increase of \$114 million (\$86.2 million in Medicare and \$33.1 million in commercial insurance)  
**Current year-to-date savings:** Over the same period in SFY 2007, cost avoidance has increased in SFY 2009 by \$111.4 million (\$86.2 million in Medicare and \$25.2 million in commercial insurance). ODJFS bases these figures on billed charges from providers. The savings translate to roughly \$46.7 million all funds or \$18.7 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 implemented with MITS Phase 1. 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:** \$1,490,931 which represents \$773,067 savings and \$717,864 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 69,842 consumers (6,180 consumers in Aged, Blind and Disabled category of assistance and 63,662 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:** A delay in federal regulations has delayed implementation of this initiative.

**Estimated year-to-date savings:** \$0

The federal regulations have finally 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 October 1, 2008. This rule update included changes to the Preferred Drug List (PDL) including antipsychotic drugs and other drug classes. Due to a decision to “grandfather” patients on existing mental health drug regimens (not ask patients to change their mental health drug therapy), the PDL savings were revised to approximately \$6 million in SFY09. In the first several months after the new PDL became effective, there has been an increase in utilization of the preferred antipsychotics that were chosen based on their clinical superiority and lower cost compared with the non-preferred antipsychotics.

**Estimated year-to-date savings:** The PDL changes are estimated to have saved \$3 million since October 2008.

***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: As of March 13, 2009, 10,902 providers have been enrolled under time limited agreements since January 1, 2008 (the date in the statute requiring the department to enroll providers using time limited instead of open ended 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) Update: 3/13/09: 10,738 provider agreements have been converted to time limited agreements through the month of March 2009. This means that over 10,000 providers have been informed of the date that their current provider agreement became a time limited agreement (either January 1, February 1, or March 1, 2009), and that three years from that date their time limited agreement will expire. These providers will be notified 90 days in advance of the expiration date that they must re-enroll as providers in the Medicaid program by the expiration date.

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: Six providers have been suspended from December, 2008 through February, 2009. This brings the total since the inception of the statutory requirement for suspension began to 67 providers. All but 22 of these providers have been terminated due to conviction, and those remaining continue to process 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) Update: The department submitted an MMIS request in February 2009 to conduct an additional purge of the provider master file (PMF). The purge occurring on July 31, 2008 incorporated the 24 month period prior to June 2007, and the new request incorporates the 24 month period prior to January 1, 2009. This request is not expected to net the large numbers of inactive providers (25,000) as was captured in the July 31, 2008 purge, however, in an effort to avoid sending notices of re-enrollment to inactive providers, the purge will enable the department to terminate these providers and thereby avert the unnecessary costs of postage.

## 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 March 2009, the portal is processing approximately 1,400 claims and 11,300 eligibility inquiries per day. During the reporting period, providers billed approximately \$44 million in claims through the Medicaid web portal. .

**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 over 82% of the covered lives in the state of Ohio. The goal was to keep adding carrier files to reach over 80% by March 2009.

**5) Implementation of the MITS**

Staff continues to lead and participate in Business Transformation activities, data conversion, and weekly management meetings for MITS. Staff are currently involved in use case creation and modeling. This effort will better relate and explain the system design in business terms. Once the Detailed System Design document is finalized, the Vendor will continue with the development of the Ohio specific system modifications. The joint Ohio project team is also continuing with the business transformation, training development and testing preparation work that is required.

**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 (DSS) functions (or both). ODJFS and OIT have reviewed the gap analysis conducted between the proposed DSS RFP and the MITS vendor solution. A significant number of the DSS RFP requirements appear to be met with the MITS application. Approval for engaging EDS (MITS vendor) to do an impact analysis and cost estimate has been obtained and the project team is finalizing the scope and requirements documentation for EDS to size and price. We expect to deliver these documents soon and once we have a cost schedule and impact statement back from EDS we will work with the MITS executive steering committee and Centers for Medicaid and Medicare Services to finalize the approach.

**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 will be piloted with several Medicaid providers in 2009.

**Attachment 1 – SFY09 Budget Status:**

*SFY 2009 July 1, 2008, to February 28, 2009, Spending Analysis Chart*

<b>Category</b>	<b>Projection</b>	<b>Expenditure</b>	<b>Variance %</b>
<b>Nursing Facilities</b>	1,718,918,200	1,725,748,896	0.40%
<b>ICF/MR</b>	367,549,418	360,857,785	-1.82%
<b>Inpatient Hospital</b>	700,890,701	681,388,511	-2.78%
<b>Outpatient Hospital</b>	248,012,737	255,697,448	3.10%
<b>Physician</b>	214,650,460	226,478,028	5.51%
<b>Drug</b>	352,012,458	348,559,765	-0.98%
<b>ODJFS Waivers</b>	225,739,903	208,903,892	-7.46%
<b>Managed Care (ABD)</b>	989,008,250	953,484,179	-3.59%
<b>Managed Care (CFC)</b>	2,342,174,044	2,322,933,304	-0.82%
<b>Buy-In</b>	209,146,970	205,681,177	-1.66%
<b>Other</b>	682,329,918	657,693,396	-3.61%
<b>Medicare Part D</b>	164,166,808	164,363,850	0.12%
<b>Disability Assist. - Medical</b>	7,722,013	7,248,938	-6.13%
<b>SFY 2009 Vs. Projection</b>	8,222,321,880	8,119,039,169	-1.26%

Attachment 2

Caseload Trend Data

