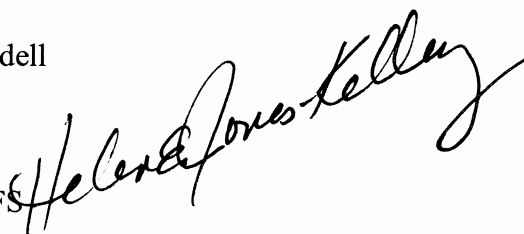




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**MEMORANDUM**

**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:** July 1, 2008

**CC:** Members of the 127th Ohio General Assembly

Below you will find the Ohio Department of Job and Family Services quarterly report on the establishment and implementation of programs designed to control the increase of the cost and increase efficiency of the Medicaid program. It includes the following issue areas:

- 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 to identify questionable claims prior to payment.
- 6) Reduce the time required to enroll new Medicaid eligible 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.

Key accomplishments during the past quarter include but are not limited to:

- 1) Development of a web portal that would allow providers who currently submit by paper to move to submitting claims electronically
- 2) The addition of 27,600 (third party liability)TPL records

*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:** \$43.1 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:** \$87.9 million (through June 2008)

The baseline budget projected an Aged, Blind and Disabled (ABD) per member per month (PMPM) cost of \$1,128.54 and a Covered Families and Children (CFC) PMPM cost of \$215.47. Through June 2008, due to the application of disciplined growth practices, the actual ABD PMPM cost was \$1,094.78 (savings of \$33.76) and the CFC PMPM was \$205.78 (savings of \$9.69). Multiplying the savings due to the lower PMPM costs with the ABD (646,728) and CFC (6,815,564) total members' months yields a through June 2008 year-to-date savings of \$87,876,352.

- 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

This initiative has not been implemented; therefore, no savings have been realized.

- 4) **Improve third-party liability collections and cost avoidance 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:** \$99.7 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 2008 by \$99.7 million (\$66.6 million in Medicare and \$33.1 million in commercial insurance). ODJFS bases these figures on billed charges from providers. The savings translate to roughly \$49.8 million all funds or \$19.9 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:** \$1,474,209 which represents \$842,388 savings and \$631,821 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 2008 on 71,663 consumers (9,036 consumers in the ABD category of assistance and 62,627 consumers in the CFC category of assistance) who were enrolled into a managed care plan one month earlier due to the implementation of this initiative in October.

Managed care enrollments taking place for the June 1, 2008, effective date, that otherwise would have taken place for a July 1, 2008, effective date are 8,007 for CFC and 1,554 for the ABD.

**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

ODJFS still expects the Federal government to adopt final medical child support regulations this summer. These regulations are necessary to implement this initiative fully.

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

**Projected Savings:** SFY 2009 \$20 million

**Status:** In progress

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

ODJFS will implement a preferred drug list with supplemental rebates in the fee-for-service population in October 2008. Selected second generation antipsychotic drugs will require prior authorization for patients who are starting therapy. In addition, ODJFS will collect supplemental rebates from some manufacturers of second generation antipsychotic drugs. Combined with the expected release of a generic version of Risperidone (brand name Risperdal) during the next quarter, the projected savings for this initiative in SFY 2009 are an estimated \$10 million.

***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 seventy thousand existing provider agreements are open-ended and will have to be converted to time-limited agreements by December 31, 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 agreement with the department.
  - 2) Update: OAC rules regarding the re-enrollment process are currently being developed.
- 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, 36 providers have been suspended by the Ohio Medicaid Program. Eight of these cases have ended in termination of the provider agreement. 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 is in the process of purging 25,000 inactive providers from the department’s Medicaid Management Information System (MMIS) provider master file (PMF).

## **2) Electronic claims submission and payment systems**

ODJFS has been testing a pilot of the Medicaid claims submission web portal that allows providers to submit claims via the web. This portal has been performing well in pilot testing and is set to go into live production the first week of July. Additionally, ODJFS is currently working on MITS including a more robust claims portal and improved functionality. 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. Secure access to send eligibility files to ODJFS has been recently granted to Humana, Medco, and Kaiser. United Health Care (UHC) is the only remaining top ten carrier that has not been granted secure access. ODJFS sent a data use agreement to UHC and expects to have an eligibility file no later than August 31, 2008. The top ten carriers represent over eighty-five percent of the covered lives in Ohio.

**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 September, 2008 beginning with large provider groups and hospital emergency departments.

**Attachment 1*****SFY 2008 July 1, 2007, to May 31, 2008, Spending Analysis Chart***

Category	Projection	Disbursements	Variance %
Nursing Facilities	\$ 2,448,838,557	\$ 2,332,901,676	-4.73%
ICF/MR	\$ 485,144,925	\$ 487,142,315	0.41%
Inpatient Hospital	\$ 701,488,432	\$ 894,775,477	27.55%
Outpatient Hospital	\$ 268,672,949	\$ 325,688,423	21.22%
Physician	\$ 272,341,433	\$ 284,841,171	4.59%
Drug	\$ 408,830,357	\$ 433,403,465	6.01%
ODJFS Waivers	\$ 296,048,458	\$ 282,515,793	-4.57%
Managed Care (ABD)	\$ 1,443,922,853	\$ 1,266,684,727	-12.27%
Managed Care (CFC)	\$ 2,568,455,040	\$ 2,551,204,957	-0.67%
Buy-In	\$ 294,391,130	\$ 269,420,757	-8.48%
Other	\$ 778,425,797	\$ 830,269,353	6.66%
Medicare Part D	\$ 231,614,939	\$ 221,819,399	-4.23%
Disability Assist.-Medical	\$ 15,039,185	\$ 14,432,857	-4.03%
<b>SFY 2008 Vs. Projection</b>	<b>\$ 10,213,214,055</b>	<b>\$ 10,195,100,371</b>	<b>-0.18%</b>

Attachment 2

Caseload Trend Data

