



Department of
Job and Family Services

Ted Strickland, Governor
Douglas E. Lumpkin, Director

MEMORANDUM

To: Ohio House Speaker, Armond Budish
Ohio House Minority Leader, Bill Batchelder
Ohio Senate President, Bill Harris
Ohio Senate Minority Leader, 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: July 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.

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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 fourth 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 4th quarter savings = \$14.3 million **Estimated year-to-date savings:** \$57.1 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; SFY 2008 = \$87.9 million, SFY 2009 4th quarter savings = \$55.9 million **Estimated year-to-date savings:** \$149.7 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 (\$44.8M) and CFC (\$104.9M) total members' months yields a through May, 2009 estimated SFY 2009 savings of \$149.7 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 recalibrate hospital rates this SFY. No savings will be achieved under this initiative this biennium.

- 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 \$169.7 million (\$133.4 million in Medicare and \$36.3 million in commercial insurance – these are billed charges) **Current year-to-date savings:** Over the same period in SFY 2007, cost avoidance has increased in SFY 2009 by \$169.7 million (\$133.4 million in Medicare and \$36.3 million in commercial insurance). ODJFS bases these figures on billed charges from providers. The savings translate to roughly \$71.3 million all funds or \$28.5 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. Implementation date is scheduled for December 15th, 2010. Once implemented, the first full year savings are 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 SFY 2009 savings:** \$2,281,749 which represents \$1,181,533 savings and \$1,100,216 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 in SFY 2009 on 107,537 consumers (9,302 consumers in Aged, Blind and Disabled category of assistance and 98,235 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 were promulgated after a nearly two year delay. State level work is proceeding to achieve full implementation. Staff are conducting data matches between child support and Medicaid enrollment to assist with decision making. The revenues are being 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. Through May 2009, approximately \$500,000.00 has been received from child support.

- 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 \$6 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) As of June 16, 2009, 14,816 providers have been enrolled under time limited agreements since January 1, 2008.
- 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) Through May, 2009, 14,802 provider agreements have been converted to time limited agreements. This number represents

providers who had an agreement prior to January 1, 2008, and the first five months of a 24-month notification process. These providers were sent a conversion notice letter informing them their agreement is changed to time limited and their reenrollment information would be sent at a later 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) As of 6/16/09, Eighteen providers have been suspended from March 2009 through June 15, 2009. This brings the total since the inception of the statutory requirement for suspension to 85 providers. Fifty four (54) have been terminated, forty three (43) of those by convictions. The remaining thirty one (31) providers 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) The February 2009 MMIS request for an additional purge of Medicaid providers who have not billed the department in a 24 month period prior (for dates of service prior to January 2009) has netted a list of more than 12,000 providers. As this list represents an overlap of the prior purge, any provider requesting to maintain their active provider status from the prior period whose name shows up on the current list will be deleted from the list so their wishes to remain active can be accommodated. The remainder of the providers on the list (approx 10,010) will be notified their active status will be terminated unless they contact the department requesting that their active status as a Medicaid provider be maintained. Those providers who fail to contact the department requesting to continue to be an active provider will be terminated. To maintain an up to date provider file in preparation for the transition to the new Medicaid Information Technology System (MITS) this purging process will be repeated periodically.

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 June 2009, the portal is processing approximately 1,450 claims and 12,500 eligibility inquiries per day. During the reporting period, providers billed approximately \$51 million in claims through the Medicaid web portal. 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.

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, ODJFS' 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 continue to participate in many activities for the MITS project. Business transformation, design, development, and testing preparations activities make up the majority of the current work. The detailed system design for iteration three was received and approved during the last reporting cycle. This document lays the ground work for the first of the Ohio specific modifications to the base transfer system and begin to align the product to Ohio requirements. The MITS project schedule now reflects the new time line of implementation by December 14, 2010.

High-level risk: Components of MITS iteration three continue to be moved into iteration four. This could potentially result in compounding resource issues to include:

1) Increasing the level and number of requirements that would need to be tested in iteration four. Iteration four is the first opportunity that JFS has to test the system end-to-end and as we move requirements from one iteration to another, the amount of JFS resources needed will likely increase in the later iteration. This is problematic in light of reduced resource levels at JFS.

2) Testing resources: while JFS is currently managing towards the testing time frames (keeping in mind risk 1 above), the Vendor continues to struggle with providing the necessary quantity of reviewable test cases that is needed to meet the current time frame. This also has the potential of overloading the testing resources all at once.

3) Reduced resource levels at JFS continue to be a challenge. Planning and mitigation for resources continue each week for the project however, any further reduction in numbers or availability would be at the risk of schedule delay or quality or both.

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. 6/18/09 Update: ODJFS has delivered the requirements documentation to the MITS vendor. They are currently sizing the changes and expect to submit time and cost to ODJFS by the end of June 2009.

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 claims history portion of the program is being rolled out to providers, and Ohio Board of Pharmacy approval for the e-prescribing system is expected by August 2009.

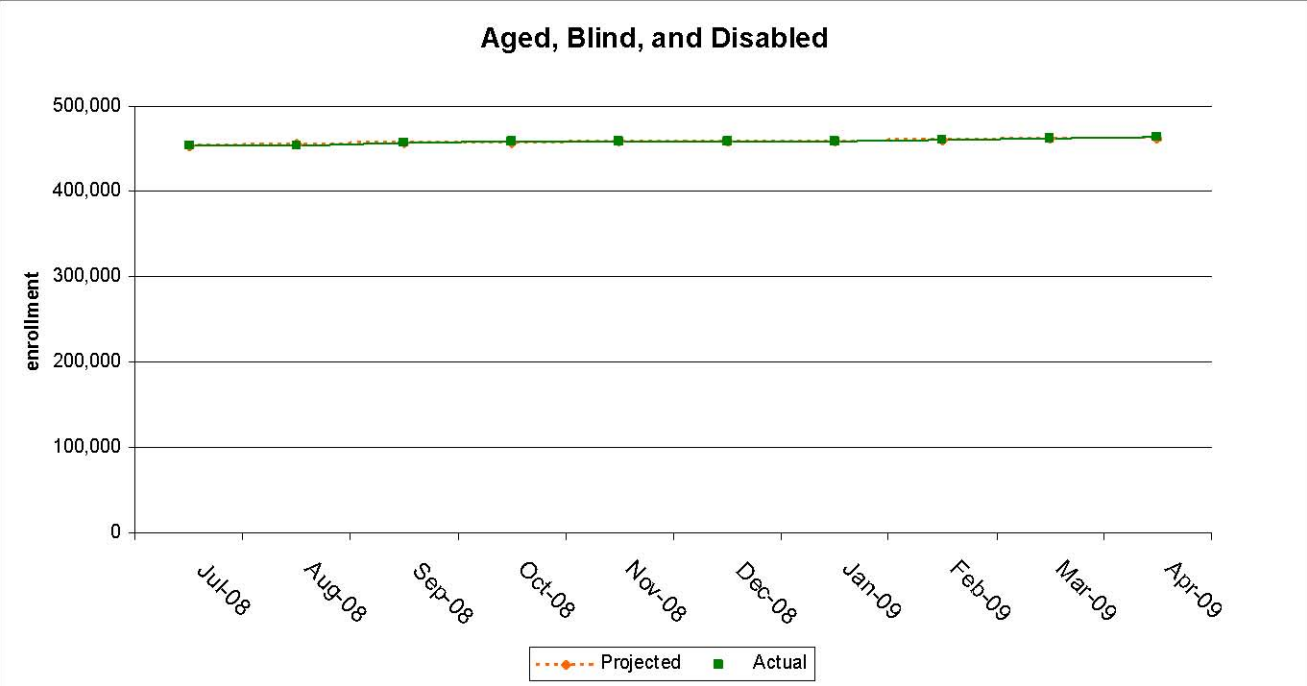
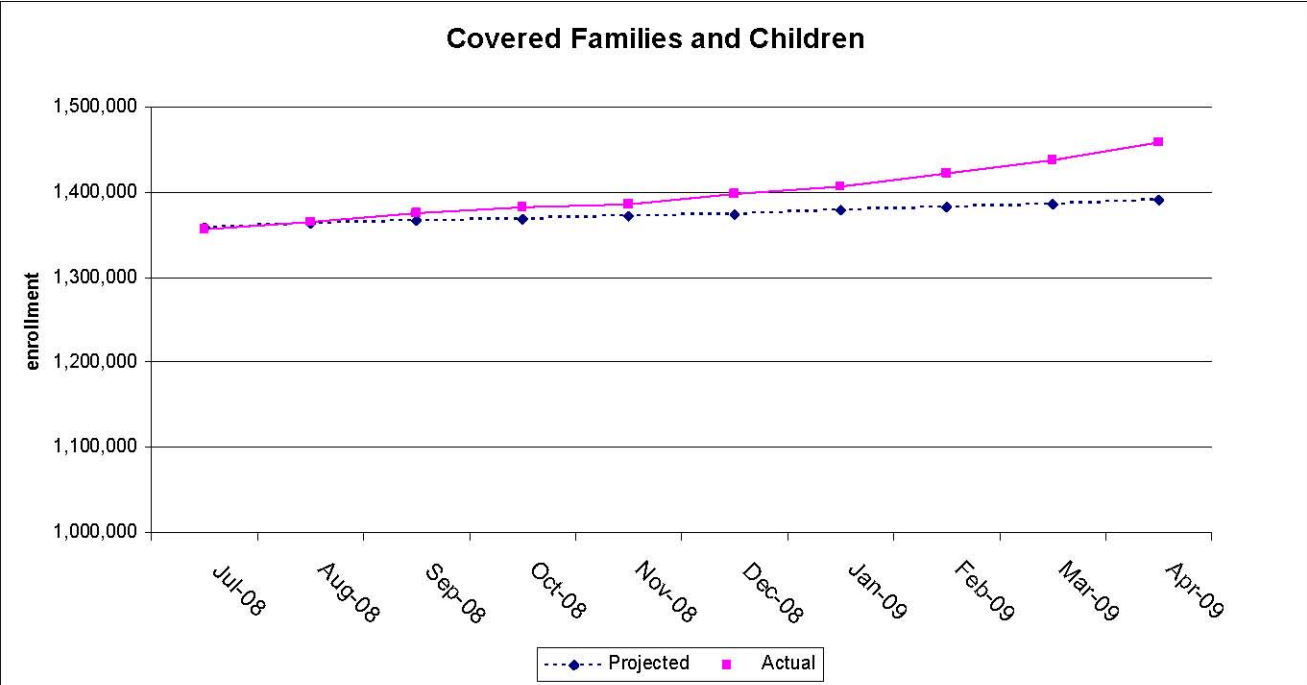
Attachment 1 – SFY09 Budget Status:

SFY 2009 July 1, 2008, to May 31, 2009, Spending Analysis Chart

Category	Projection	Expenditure	Variance %
Nursing Facilities	2,345,114,752	2,350,273,930	0.22%
ICF/MR	501,368,990	490,840,905	-2.10%
Inpatient Hospital	967,183,863	956,937,770	-1.06%
Outpatient Hospital	343,326,839	367,064,644	6.91%
Physician	302,228,586	324,026,661	7.21%
Drug	486,771,511	496,364,506	1.97%
ODJFS Waivers	312,839,896	287,938,778	-7.96%
Managed Care (ABD)	1,406,164,204	1,269,167,113	-9.74%
Managed Care (CFC)	3,179,912,185	3,188,145,042	0.26%
Buy-In	288,981,690	284,206,539	-1.65%
Other	943,008,205	936,348,853	-0.71%
Medicare Part D	228,397,030	229,248,376	0.37%
Disability Assist.-Medical	10,102,445	9,641,681	-4.56%
SFY 2009 Vs. Projection	11,315,400,195	11,190,204,799	-1.11%

Attachment 2

Caseload Trend Data



Month Projection	Expenditure	Variance	%
July 1,359,904,539\$	\$ 1,359,904,539	\$ -	0.00%
August 907,846,847\$	\$ 907,846,847	\$ -	0.00%
September 1,007,330,761\$	\$ 1,007,330,761	\$ -	0.00%
October 932,878,980\$	\$ 932,878,980		0.00%
November 949,285,625\$	\$ 949,285,625	\$ -	0.00%
December 1,022,052,965\$	\$ 1,022,052,965	\$ -	0.00%
January 948,931,395\$	\$ 948,931,395	\$ -	0.00%
February 990,744,607\$	\$ 990,808,057	\$ 63,451	0.01%
March 1,073,462,742\$	\$ 1,067,948,150	\$ (5,514,592)	-0.51%
April 1,032,436,401\$	\$ 994,365,062	\$ (38,071,340)	-3.69%
May 1,030,383,734\$	\$ 1,008,852,418	\$ (21,531,317)	-2.09%
June			
Total Projection 11,255,258,596\$	\$ 11,190,204,799	\$ (65,053,798)	-0.58%

Year-To-Date Analysis - Source GL Table

Category	Projection	Expenditure	Variance	%
Nursing Homes \$	2,354,367,158	\$ 2,350,273,930	\$ (4,093,228)	-0.17%
ICF/MR \$	495,040,303	\$ 490,840,905	\$ (4,199,398)	-0.85%
Inpatient Hospital \$	998,603,244	\$ 956,937,770	\$ (41,665,475)	-4.17%
Outpatient Hospital \$	359,931,843	\$ 367,064,644	\$ 7,132,800	1.98%
Physician \$	318,926,454	\$ 324,026,661	\$ 5,100,208	1.60%
Drug \$	501,775,184	\$ 496,364,506	\$ (5,410,678)	-1.08%
ODJFS Waivers \$	297,990,873	\$ 287,938,778	\$ (10,052,095)	-3.37%
Managed Care - ABD \$	1,280,231,232	\$ 1,269,167,113	\$ (11,064,119)	-0.86%
Managed Care - CFC \$	3,170,465,224	\$ 3,188,145,042	\$ 17,679,818	0.56%
Buy-In \$	286,534,383	\$ 284,206,539	\$ (2,327,843)	-0.81%
Other \$	948,987,467	\$ 936,348,853	\$ (12,638,615)	-1.33%
Medicare Part D \$	232,404,783	\$ 229,248,376	\$ (3,156,407)	-1.36%
Disability Assistance - Medical \$	10,000,448	\$ 9,641,681	\$ (358,767)	-3.59%
Total YTD Vs. Projection \$	11,255,258,596	\$ 11,190,204,799	\$ (65,053,798)	-0.58%

Analysis for the Month - Source GL Table

Month	Projection	Expenditure	Variance	%
Nursing Homes \$	211,513,819	\$ 208,252,988	\$ (3,260,831)	-1.54%
ICF/MR \$	45,252,788	\$ 43,324,368	\$ (1,928,420)	-4.26%
Inpatient Hospital \$	98,314,428	\$ 85,059,064	\$ (13,255,363)	-13.48%
Outpatient Hospital \$	32,587,735	\$ 34,048,606	\$ 1,460,871	4.48%
Physician \$	28,019,121	\$ 28,676,458	\$ 657,337	2.35%
Drug \$	47,409,484	\$ 44,353,708	\$ (3,055,776)	-6.45%
ODJFS Waivers \$	27,915,186	\$ 25,185,880	\$ (2,729,306)	-9.78%
Managed Care - ABD \$	109,174,587	\$ 105,360,012	\$ (3,814,576)	-3.49%
Managed Care - CFC \$	284,894,392	\$ 299,888,343	\$ 14,993,951	5.26%
Buy-In \$	27,027,748	\$ 26,337,508	\$ (690,240)	-2.55%
Other \$	94,698,771	\$ 85,883,258	\$ (8,815,513)	-9.31%
Medicare Part D \$	22,740,477	\$ 21,802,782	\$ (937,695)	-4.12%
Disability Assistance - Medical \$	835,200	\$ 679,443	\$ (155,756)	-18.65%
Month Vs. Projection \$	1,030,383,734	\$ 1,008,852,418	\$ (21,531,317)	-2.09%

Budget Status By Appropriation Line Item

Source GL Table

May Budget	May 2009	As of 6/09/2009	YTD Budget	YTD Expenditures	YTD Variance
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GRF

525 Current & Prior Yr		\$706,975,393	\$ 691,311,718	\$ (15,663,675)	\$9,362,157,475
526 Current & Prior Yr		\$ 22,740,477	\$ 21,802,782	\$ (937,695)	232,404,784\$
Subtotal GRF		\$ 729,715,870	\$ 713,114,500	\$ (16,601,370)	9,594,562,258\$

Non GRF

692 MEDICAL SERVICES		\$ 17,121,842	\$ 15,738,171	\$ (1,383,671)	\$ 82,372,100
639 Medicaid Revenue and Collections		\$ 7,594,684	\$ 7,423,413	\$ (171,271)	\$ 67,734,889
613 NF FRANCHISE FEE (4J5)				\$ -	\$ -
621 ICF/MR FRANCHISE FEE (4K1)		\$ 1,250,000	\$ 1,250,000	\$ -	\$ 10,000,000
671 IMD DSH/MR Drug OFFSET (5C9)		\$ 8,750,000	\$ 8,750,000	\$ -	\$ 52,500,000
608 MEDICAID Nursing Facilities (5R2)		\$ 19,444,444	\$ 19,444,444	\$ -	\$ 155,555,552
653 MANAGED CARE ASSESSMENT (5BG)		\$ 32,331,981	\$ 32,331,981	\$ 0	\$ 184,552,267
623 HEALTH CARE FEDERAL		\$ 214,174,914	\$ 210,799,909	\$ (3,375,005)	\$ 1,107,981,531
Subtotal Non GRF		\$ 300,667,864	\$ 295,737,918	\$ (4,929,946)	\$ 1,660,696,339

Total		\$ 1,030,383,734	\$ 1,008,852,418	\$ (21,531,317)	\$ 11,255,258,552
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