



Department of  
Job and Family Services

Ted Strickland, Governor  
Douglas E. Lumpkin, 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  
Ranking House Minority Member  
Chair of Senate Finance  
Ranking Senate Minority Member

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

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

**Date:** January 4, 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. 1 (128<sup>th</sup> General Assembly) the Department is implementing the following cost containment or revenue generation initiatives for State Fiscal Years 2010 and 2011:

30 East Broad Street  
Columbus, Ohio 43215  
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An Equal Opportunity Employer and Service Provider

**SFY2011 Cost Management Initiative Status as of December 31, 2010**

<b>Cost Management Initiative</b>	<b>Implementation Status</b>	<b>2011 Cost Savings Realized to Date</b>	<b>2011 Cost Savings Target</b>
<b>Managed Care Changes</b>			
1) Move Managed Care payments away from prospective payment.	<b>Completed – May, 2010</b>	<b>\$0</b>	<b>\$0</b>
2) Return NE & NW managed care regions to mandatory for ABD populations.	<b>Completed - October 1, 2009</b>	<b>\$10,150,000</b>	<b>\$20,300,000</b>
3) Implement managed care pharmacy carve out.	<b>Completed February 1, 2010</b>	<b>\$15,585,423</b>	<b>\$235,500,000</b>
4) Implement managed care GIS provider panel system.	<b>Delayed until 2011</b>	<b>\$0</b>	<b>\$38,000,000</b>
<b>Program Changes</b>			
5) Take down Disability Medical Assistance program.	<b>Completed October 31, 2009</b>	<b>\$3,056,547</b>	<b>\$9,488,695</b>
8) Restrict access to over-the-counter pharmaceuticals.	<b>Augmented and Delayed until 2011</b>	<b>\$0</b>	<b>\$8,500,000</b>
14) Strengthen TPL by preventing insurance companies from denying claims due to prior authorization.	<b>Completed July, 2009</b>	<b>\$266,935</b>	<b>\$250,000</b>
<b>Rate and Fee Changes</b>			
6) Implement community provider rate reduction.	<b>Completed January 1, 2010</b>	<b>\$18,787,313</b>	<b>\$52,594,918</b>
7) Implement reduction in pharmacy dispensing fee.	<b>Completed January 1, 2010</b>	<b>\$6,482,171</b>	<b>\$14,825,169</b>
9) Move ancillary services into the Nursing Facility rate.	<b>Completed August 1, 2009</b>	<b>\$0</b>	<b>\$0</b>
10) Increase Nursing Facility franchise fee.	<b>Began receiving payments December, 2009</b>	<b>\$48,945,216</b>	<b>\$195,510,000</b>
11) Increase ICF-MR franchise fee.	<b>Began receiving payments November, 2009</b>	<b>\$2,135,537</b>	<b>\$4,376,837</b>
12) Change timing of ICF-MR payment.	<b>To be completed in 2011</b>	<b>\$0</b>	<b>\$45,000,000</b>
13) Implement hospital franchise fee.	<b>Began receiving payments November, 2009</b>	<b>\$66,107,743</b>	<b>\$370,861,816</b>
<b>Total</b>		<b>\$171,516,885</b>	<b>\$995,207,435</b>

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

### *Cost management initiative updates*

- 1) Move managed care payments away from prospective payment

Projected SFY10 savings: \$270,400,000	Actual SFY10 savings:	\$389,797,791
Projected SFY11 savings: \$0	Year-to-date SFY11 savings:	\$0

**UPDATE:** This initiative was designed to eliminate one Medicaid managed care capitation payment during FY 2010. The payments for May 2010 were delayed by two weeks. Instead of prospectively making the capitation payment for May's managed care members in April, ODJFS made this payment mid-May. This resulted in the reduction of one capitation payment in SFY 2010, i.e., only 11 capitation payments were made in SFY 2010 instead of 12. The savings is higher than estimated during HB 1 development because the overall size of the managed care program is larger than when the estimates were developed. Therefore the monthly payments are larger, as is the one time pick up from not making one payment in SFY 2010.

- 2) Return NE & NW managed care regions to mandatory for ABD population

Projected SFY10 savings: \$6,700,000	Actual SFY10 savings:	\$6,700,000
Projected SFY11 savings: \$20,300,000	Year-to-date SFY11 savings:	\$10,150,000

**UPDATE:** The restoration of Aged Blind and Disabled (ABD) mandatory managed care in the northeast and northwest regions was completed October 1, 2009. In December 2010 the northeast region had 25,479 ABD members enrolled. 12,098 ABD members were enrolled in the northwest region in December 2010.

- 3) Implement managed care pharmacy carve out

Projected SFY10 savings: \$5,200,000	Year-to-date SFY10 savings:	\$120,525,098
Projected SFY11 savings: \$235,500,000	Year-to-date SFY11 savings:	\$15,585,423

**UPDATE:** This policy change was implemented on February 1, 2010. One of the purposes of the pharmacy carve out was to enable the state to leverage additional resources through manufacturers' rebates that were not available to managed care plans. The fiscal analysis assumed that no rebates related to this change would be received for approximately six months, and as a result the vast majority of the associated savings estimates are included in FY 11. ODJFS has begun receiving rebates for managed care consumers, but the pharmacy vendor is still in the process of identifying which rebates are associated with managed care consumers and which are associated with fee-for-service consumers.

ODJFS has analyzed changes in the managed care capitation payment related directly to the carve out of pharmaceuticals and some related items (such as syringes), expenditures on pharmaceuticals and related items in a fee-for-service setting by consumers on managed care, administrative components, and tax impacts as of October 2010. One notable experience that was not anticipated in the carve out fiscal analysis which has resulted in a one-time additional savings in this category was a lag between consumers receiving pharmaceuticals (service date) and the payment to pharmacies for the pharmaceuticals (paid date).

Through October 2010, ODJFS realized a savings of \$136,610,711.53 related to the carve out (excluding any rebate revenue). Much of this is the result of the delay of timing of payments.

Potential effects of rebate changes included in the federal health care reform provisions are unknown at this time because interpretation from CMS has not yet been finalized; some additional CMS guidance was received September 28<sup>th</sup> and that information is being reviewed by ODJFS staff. When an analysis is complete ODJFS staff will communicate estimated impacts to the Ohio Medicaid program with interested stakeholders.

Excluding the revenue from the rebate, the impact of the pharmacy carve out was a savings of \$15,585,422.74 for July to October 2010. ODJFS anticipates being able to include rebate revenue in the next quarterly report. The revenue should be significant – for the July to November 2010 period ODJFS has received \$252,020,527 in pharmacy rebates. For the same time period in 2009 (before the carve out), ODJFS received \$124,562,328.

4) Implement managed care GIS provider panel system

Projected SFY10 savings: \$12,000,000	Actual SFY10 savings:	\$0.00
Projected SFY11 savings: \$38,000,000	Year-to-date SFY11 savings:	\$0.00

**UPDATE:** Requiring minimum provider panels is one way ODJFS assures access to care for Medicaid eligibles enrolled in managed care plans as required by federal regulations. This initiative will replace the current provider requirements with a requirement based on a geographic comparison of plan’s contracted provider panel with Medicaid Managed Care enrollees. Because this is the primary requirement ODJFS uses to assure access to care for Medicaid Managed Care consumers and this is an innovative strategy, this initiative requires extensive development. Development of this new requirement has been initiated, but implementation has been delayed until SFY 2011.

5) Eliminate the Disability Medical Assistance program

Projected SFY10 savings: \$2,739,228	Actual SFY10 savings:	\$6,508,901
Projected SFY11 savings: \$9,488,695	Year-to-date SFY11 savings:	\$3,056,547

**UPDATE:** The Disability Medical Assistance program was sunset on October 31, 2009.

6) Implement community provider rate reduction

Projected SFY10 savings: \$29,803,180	Actual SFY10 savings:	\$25,779,287
Projected SFY11 savings: \$52,594,918	Year-to-date SFY11 savings:	\$18,787,313

**UPDATE:** The projected cost savings figures above include state plan, waiver and managed care services reimbursed by ODJFS through October 31, 2010. The Ohio Administrative Code rules implementing the community provider fee decrease were effective on January 1, 2010. A state plan amendment was submitted to CMS in December 2009. CMS has issued a Request for Additional Information (RAI) and responses have been sent to CMS.

7) Implement reduction in pharmacy dispensing fee

Projected SFY10 savings: \$6,177,154	Actual SFY10 savings:	\$6,891,868
Projected SFY11 savings: \$14,825,169	Year-to-date SFY11 savings:	\$6,482,171

**UPDATE:** Dispensing fee reduction was implemented January 1, 2010. A State Plan amendment was submitted to CMS in September 2009. CMS has issued a RAI and the responses have been sent to CMS. Cost savings from SFY2010 and the first quarter of SFY2011 were overstated due to the inclusion of claims for managed care enrollees. The savings from the dispensing fee reduction for pharmacy claims for managed care enrollees were included in the managed care pharmacy carve-out section, item 3 above, so should not have been included in this item. Revised numbers are reflected in this report.

8) Restrict access to OTC pharmaceuticals

Projected SFY10 savings: \$3,541,667	Actual SFY10 savings:	\$0.00
Projected SFY11 savings: \$8,500,000	Year-to-date SFY11 savings:	\$0.00

**UPDATE:** This initiative has been delayed due to the need to retain access for these over-the-counter pharmaceuticals to residents of Intermediate Care Facilities for the Mentally Retarded (ICF-MR), while removing this benefit for adult Medicaid fee for service recipients.

- 9) Move ancillary services into the Nursing Facility rate
- |                              |                             |        |
|------------------------------|-----------------------------|--------|
| Projected SFY10 savings: \$0 | Actual SFY10 savings:       | \$0.00 |
| Projected SFY11 savings: \$0 | Year-to-date SFY11 savings: | \$0.00 |

**UPDATE:** The five bundled ancillary services were moved to the nursing facilities' (NFs) rates effective August 1, 2009. These services include oxygen, custom wheelchairs, medical transportation (ambulance and ambulette), skilled therapies and some over-the-counter drugs. From that date forward fee-for-service providers could not bill and receive reimbursement for these services when provided to a NF resident. The NFs are reimbursed for providing these services to their residents through an increase in the per diem payment mechanism known as the Consolidated Services per diem.

The necessary State Plan Amendments were filed in September 2009. CMS issued a RAI and a response has been sent.

- 10) Increase NF franchise fee (additional revenue to fund 5R20)
- |  |                             |               |
|--|-----------------------------|---------------|
| Projected SFY10 revenue: \$146,632,499 | Actual SFY10 revenue:       | \$146,376,349 |
| Projected SFY11 revenue: \$195,510,000 | Year-to-date SFY11 revenue: | \$48,945,216  |

**UPDATE:** SFY10 additional revenue is based on collections for the first 3 quarterly installments of the FY10 assessment. The installment for SFY10 4<sup>th</sup> quarter was actually due at the beginning of SFY11 (August 14, 2010) and those collections are reflected in the year-to-date SFY11 revenue. The SFY11 1st Quarter installments were due December 15th, 2010. Revenue figures for these payments are not included in the year-to-date SFY11 revenue.

- 11) Increase ICF-MR franchise fee (additional revenue to fund 4K10)
- |                                      |                             |             |
|--------------------------------------|-----------------------------|-------------|
| Projected SFY10 revenue: \$5,096,029 | Actual SFY10 revenue:       | \$3,712,540 |
| Projected SFY11 revenue: \$4,376,837 | Year-to-date SFY11 revenue: | \$2,135,537 |

**UPDATE:** SFY10 additional revenue is based on collections for the first 3 quarterly installments of the FY10 assessment. The installment for SFY10 4<sup>th</sup> quarter was actually due at the beginning of SFY11 (August 14, 2010). The year-to-date SFY11 revenue also includes payments for the 1<sup>st</sup> quarter of SFY11 which were due November 14, 2010.

- 12) Change timing of ICF-MR payment
- |                                       |                             |        |
|---------------------------------------|-----------------------------|--------|
| Projected SFY10 savings: \$0          | Actual SFY10 savings:       | \$0.00 |
| Projected SFY11 savings: \$45,000,000 | Year-to-date SFY11 savings: | \$0.00 |

**UPDATE:** This is a SFY 2011 year end initiative and will be reported closer to the time of implementation.

- 13) Implement hospital franchise fee (additional revenue to 5GF0)
- |  |                             |               |
|--|-----------------------------|---------------|
| Projected SFY10 revenue: \$338,505,283 | Year-to-date SFY10 revenue: | \$338,860,447 |
| Projected SFY11 revenue: \$370,861,816 | Year-to-date SFY11 revenue: | \$66,107,743  |

Sections 5112.40-5112.48 of the Revised Code create the hospital franchise fee program and imposes a fee of 1.52% in SFY 2010 and 1.61% in SFY 2011 on hospitals. The fee basis is each hospital's adjusted total facility costs. The assessment is due in three installments: 28% due the last business day of October; 31% due the last business day of February; and 41% due the last business day of May.

**UPDATE:** The hospital franchise fee (HFF) as outlined in ORC generated \$338.51 million in SFY 2010 and was expected to generate \$370.86 million in SFY 2011. On September 2<sup>nd</sup>, Governor Strickland announced plans to reduce the FY 11 hospital assessment by an aggregate amount of \$150 million. This

was implemented via an emergency rule adopted, effective 10/14/2010, reducing the assessment rate from 1.61% to 1.387%. The HFF is now expected to generate \$238.5 million in SFY 2011.

- 14) Strengthen TPL by preventing insurance companies from denying claims due to prior authorization  
 Projected SFY10 savings: \$250,000                      Actual SFY10 savings: \$721,000  
 Projected SFY11 savings: \$250,000                      Year-to-date SFY11 savings: \$266,935

**UPDATE:** The Pay and chase vendor continues to realize a measurable impact.

**Other required information**

**1) Provider Network Management**

A) HB 1 changed the required period for the re-enrollment of Ohio Medicaid provider agreements from no later than every three years to no later than every seven years. Re-enrollment is occurring in calendar year 2010 for providers who enrolled in 2008 and have a retroactive effective date in 2007. This represents 2039 providers who will be re-enrolled in 2010.

All other providers are being notified that their agreement has been converted from an open-ended agreement to a 7-year time-limited agreement and that their re-enrollment will occur at that the end of that period. Approximately 1,300 notices will be mailed each month until all 76,515 open ended provider agreements have been converted to time-limited agreements. The conversion notice process will extend through December 2015.

The following represents data about re-enrollment and conversions for October, 2010 through December, 2010:

* Re-Enrollment & Conversion Notices			Re-Enrollment Process only	
Month, Fiscal 2011	No. of Providers*	Type of Notice	No. Re-Enrolled	No. Terminated
October	1521	156 re-enrollment notice 1365 conversion notice	In process	In process
November	1646	145 re-enrollment notice 1501 conversion notice	In process	In process
December	1555	203 re-enrollment notice 1352 conversion notice	In process	In process

\* Represents total number of providers notified during the month.

B) HB 1 permitted an exemption from re-enrollment for Ohio Medicaid hospital providers. Due to this exemption hospital providers are no longer included in the department’s re-enrollment data file. Other exclusions include Health Maintenance Organization (HMO), Nursing Facilities (NF) and Intermediate Care Facility-Mental Retardation (ICF-MR).

C) HB 1 permits the department to terminate the provider agreement of any health care provider who has not shared their National Provider Identifier with the department as of the effective date of the budget bill. 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:

- 1,449 providers
- have not billed in 24 months and were sent our No Billing/Termination letter
- 1381 no responders had their provider agreement terminated September 20, 2010

- 1,244 providers
- are billing and were sent letter about no NPI on record
- 218 have responded with their NPI
- 1026 are pending termination of their provider agreement

**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 December 1, 2010, the portal is processing approximately 1,676 claims and 24,027 eligibility inquiries per day. During the reporting period, providers billed approximately \$85 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**

There are no provisions for these in HB 1.

**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 eight-five percent of the covered lives in Ohio are represented with the insurance carrier files already in place. So far in State Fiscal Year 2011, the Third Party Liability Unit has recovered \$24, 679,473 (both state and federal funds).

**5) Implementation of the MITS**

Ohio's new Medicaid claims adjudication system, known as the Medicaid Information Technology System, or MITS, was scheduled to go live on December 7, 2010. Director Lumpkin and Medicaid Director Plouck reviewed progress to date and, in partnership with the MITS vendor, Hewlett Packard, reached a decision that December 7, 2010 was not a viable date to implement the system. We have not established a new implementation date at this time. Progress is being closely monitored.

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

ODJFS continues to work with its vendor to maintain and enhance DSS functionality. The delay to the December 7, 2010 Go Live date for MITS and the resources required to support MITS implementation continue to be the department's highest priority. This delay will result in renewing the existing contract to allow ODJFS personnel to focus on MITS implementation.

**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 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 217 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.

**8) The federal waiver for the nursing home franchise fee.**

Pursuant to Section 3721.511 of the Revised Code enacted in HB1, the department pursued a waiver of federal requirements for provider taxes for the nursing home franchise fee. In accordance with statute, the waiver is designed to be budget neutral. As a result, some providers will see increases in their franchise fee

while others will see a reduction in or an elimination of their franchise fee obligation. The waiver was approved prospectively by CMS in accordance with the Ohio statute and is effective July 1, 2010. Provider payments will first be impacted for the payment due on August 14, 2010.

Attachment 1.

SFY11 Budget Status

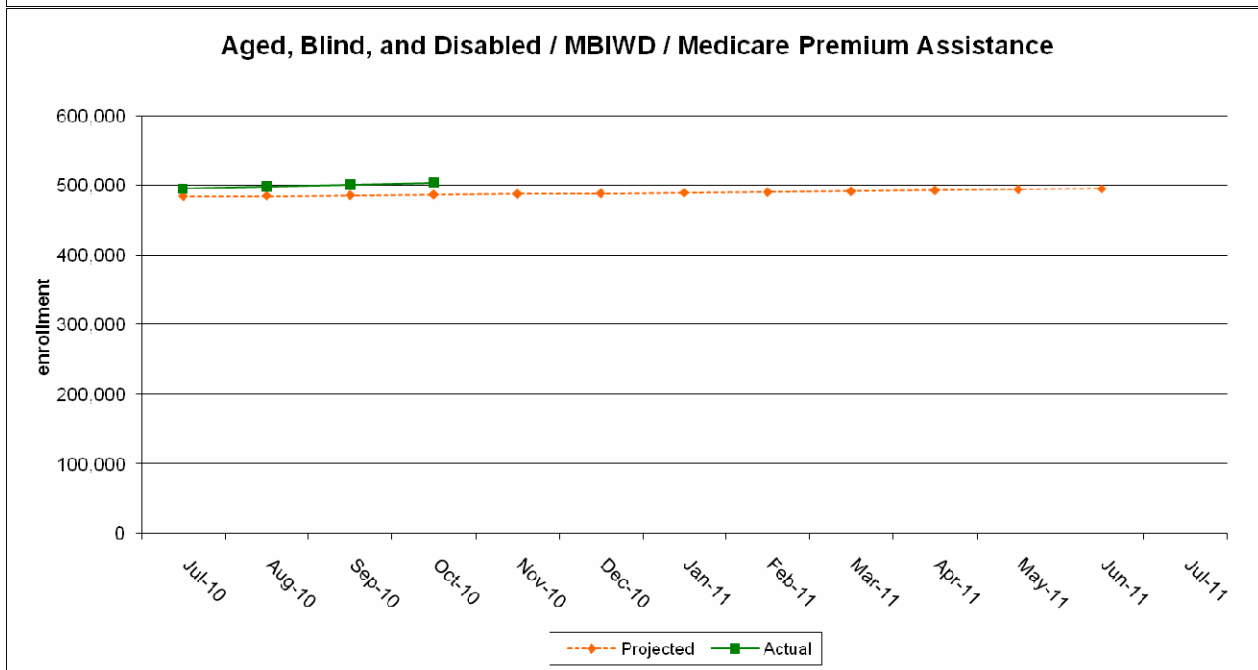
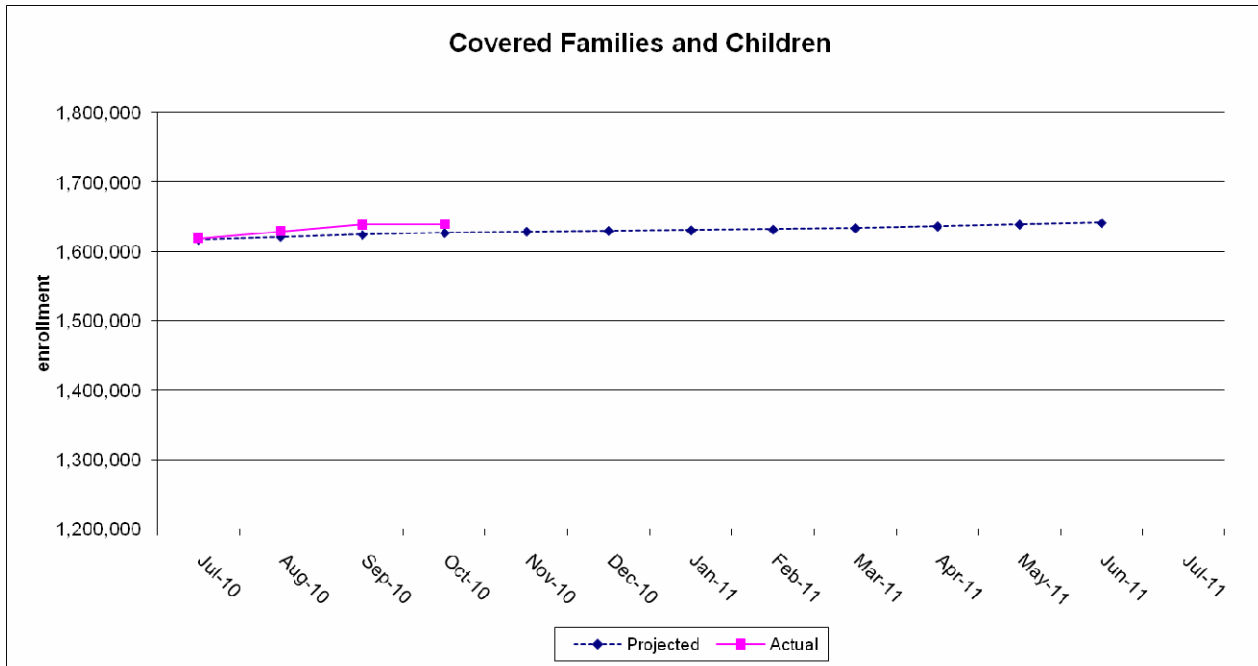
<b>Category</b>	<b>Projection</b>	<b>Expenditure</b>	<b>Variance %</b>
Nursing Homes	\$ 1,148,303,939	\$ 1,129,348,069	-1.65 %
ICF/MR	\$ 228,333,017	\$ 232,891,900	2.00 %
Inpatient Hospital	\$ 478,474,069	\$ 456,085,804	-4.68 %
Outpatient Hospital	\$ 181,963,527	\$ 188,952,356	3.84 %
Physician	\$ 147,315,884	\$ 139,762,423	-5.13 %
Drug	\$ 782,919,734	\$ 703,896,262	-10.09 %
ODJFS Waivers	\$ 160,873,379	\$ 140,244,295	-12.82 %
Managed Care - ABD	\$ 578,562,933	\$ 700,844,742	21.14 %
Managed Care - CFC	\$ 1,440,276,245	\$ 1,773,092,301	23.11 %
Buy-In	\$ 150,344,783	\$ 160,221,259	6.57 %
Other	\$ 508,256,665	\$ 486,009,862	-4.38 %
Medicare Part D	\$ 60,562,511	\$ 61,246,015	1.13 %
<b>Total YTD Vs. Projection</b>	<b>\$ 5,866,186,686</b>	<b>\$ 6,172,595,289</b>	<b>5.22 %</b>

Source: Office of Fiscal and Monitoring Services as of December 16, 2010.

Note: The December 2010 managed care payments were made in November, hence the large variances in managed care and total spending vs. projections.

Attachment 2.

Caseload Trend Data



Source: Office of Fiscal and Monitoring Services as of December 16, 2010.