



Department of  
Job and Family Services

Ted Strickland, Governor  
Douglas E. Lumpkin, Director

**MEMORANDUM**

**To:** Ohio House Speaker, Armond Budish  
Ohio Senate President, Bill Harris  
Ohio House Minority Leader, Bill Batchelder  
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:** October 8, 2010

**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.

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

**SFY2010 Cost Management Initiative Status: End of SFY 2010**

<b>Cost Management Initiative</b>	<b>Implementation Status</b>	<b>2010 Cost Savings Realized to Date</b>	<b>2010 Cost Savings Target</b>
<b>Managed Care Changes</b>			
1) Move Managed Care payments away from prospective payment.	<b>Completed – May, 2010</b>	<b>\$389,797,791</b>	<b>\$270,400,000</b>
2) Return NE & NW managed care regions to mandatory for ABD populations.	<b>Completed - October 1, 2009</b>	<b>\$6,700,000</b>	<b>\$6,700,000</b>
3) Implement managed care pharmacy carve out.	<b>Completed February 1, 2010</b>	<b>\$120,525,098</b>	<b>\$5,200,000</b>
4) Implement managed care GIS provider panel system.	<b>Delayed until 2011</b>	<b>\$0</b>	<b>\$12,000,000</b>
<b>Program Changes</b>			
5) Take down Disability Medical Assistance program.	<b>Completed October 31, 2009</b>	<b>\$6,508,901</b>	<b>\$2,739,228</b>
8) Restrict access to over-the-counter pharmaceuticals.	<b>Augmented and Delayed until 2011</b>	<b>\$0</b>	<b>\$3,541,667</b>
14) Strengthen TPL by preventing insurance companies from denying claims due to prior authorization.	<b>Completed July, 2009</b>	<b>\$721,000</b>	<b>\$250,000</b>
<b>Rate and Fee Changes</b>			
6) Implement community provider rate reduction.	<b>Completed January 1, 2010</b>	<b>\$25,779,287</b>	<b>\$29,803,180</b>
7) Implement reduction in pharmacy dispensing fee.	<b>Completed January 1, 2010</b>	<b>\$8,300,000</b>	<b>\$6,177,154</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>\$146,376,349</b>	<b>\$146,632,499</b>
11) Increase ICF-MR franchise fee.	<b>Began receiving payments November, 2009</b>	<b>\$3,712,540</b>	<b>\$5,096,029</b>
12) Change timing of ICF-MR payment.	<b>To be completed in 2011</b>	<b>\$0</b>	<b>\$0</b>
13) Implement hospital franchise fee.	<b>Began receiving payments November, 2009</b>	<b>\$338,860,447</b>	<b>\$338,505,283</b>
<b>Total</b>		<b>\$1,047,281,413</b>	<b>\$827,045,040</b>

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

**SFY2011 Cost Management Initiative Status As of September 30, 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>\$3,383,333</b>	<b>\$20,300,000</b>
3) Implement managed care pharmacy carve out.	<b>Completed February 1, 2010</b>	<b>(\$3,197,940)</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>\$789,401</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>\$90,335</b>	<b>\$250,000</b>
<b>Rate and Fee Changes</b>			
6) Implement community provider rate reduction.	<b>Completed January 1, 2010</b>	<b>\$4,558,717</b>	<b>\$52,594,918</b>
7) Implement reduction in pharmacy dispensing fee.	<b>Completed January 1, 2010</b>	<b>\$10,400,000</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>\$1,319,257</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>\$0</b>	<b>\$370,861,816</b>
<b>Total</b>		<b>\$66,288,319</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:	\$3,383,333

**UPDATE:** The restoration of Aged Blind and Disabled (ABD) mandatory managed care in the northeast and northwest regions was completed October 1, 2009. In June 2010 the northeast region had 24,675 ABD members enrolled. 11,898 ABD members were enrolled in the northwest region in June 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:	(\$3,197,940)

**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 is still in the process of identifying which rebates are associated with managed care consumers and which are associated with fee-for-service consumers; as a result, the FY 10 savings associated with this initiative may be subject to a small amount of change in the next quarterly report in the event that any rebates received in June are linked to managed care enrollees during the carve out period.

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 April 2010. While the savings estimates related to pharmacy carve out rebates are consistent with expectations, there has been one notable area of experience that was not anticipated in the carve out fiscal analysis which has resulted in a one-time additional savings in this category:

Through July 2010, ODJFS realized a savings of \$117,327,158 related to the carve out (excluding any rebate revenue), which was mainly the result of a longer lag between consumers receiving pharmaceuticals (service date) and the payment to pharmacies for the pharmaceuticals (paid date). The state's pharmacy benefit manager holds claims for 14 days resulting in a lag between when pharmacies submit claims for payment and the submission from the vendor to the state of Ohio for payment. This delay of timing was not quantified in the previous estimates; however, it is one-time in nature and is not expected to have any positive or negative effect on the estimates currently in place for FY 11.

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 \$3,197,940 in increased spending in July 2010. Savings from the Pharmacy Carve Out due to the change in capitation accrue monthly. Additional expenditures due to pharmacy claims for the managed care population are paid weekly. July 2010 happened to be a month with five pay cycles (most months have four pay cycles), so pharmaceutical expenditures slightly exceeded savings from the lowered capitation.

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:	\$789,401

**UPDATE:** The October 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:	\$4,558,717

**UPDATE:** The projected cost savings figures above include state plan, waiver and managed care services reimbursed by ODJFS through July 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:	\$8,300,000
Projected SFY11 savings: \$14,825,169	Year-to-date SFY11 savings:	\$10,400,00

**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.

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.

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:	\$1,319,257

**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.

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:	\$0

**UPDATE:** 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. Hospital payments from the first two assessments of SFY 2010 that have not been received have been certified to the Attorney General's Office for collections.

The hospital franchise fee as outlined in ORC is expected to generate \$338.51 million in SFY 2010 and \$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. Detailed implementation plans are not yet finalized with CMS; when a plan is approved a revised FY 11 revenue estimate will be added to the quarterly cost containment report.

- 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: \$90,335

**UPDATE:** The Pay and chase vendor is realizing 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 April, 2010 through September, 2010:

Re-Enrollment & Conversion Notices			Re-Enrollment Process only	
Date, Fiscal 2010	No. of Providers*	Type of Notice	No. Re-Enrolled	No. Terminated
April	1474	177 re-enrollment notice 1297 conversion notice	161	44
May	1477	146 re-enrollment notice 1331 conversion notice	158	42
June	1514	183 re-enrollment notice 1331 conversion notice	In process	In process
Date, Fiscal 2011	No. of Providers*	Type of Notice	No. Re-Enrolled	No. Terminated
July	2063	156 re-enrollment notice 1907 conversion notice	In process	In process
August	1451	145 re-enrollment notice 1306 conversion notice	In process	In process
September	1781	203 re-enrollment notice 1578 conversion notice	In process	In process

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

B) HB 1 permitted an exemption from the required Medicaid re-enrollment provision in HB 119 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
- have until September 20 to reply about desire to keep their provider agreement and to give us their NPI
- no responders will have provider agreement terminated

1,244 providers

- are billing and were sent letter about no NPI on record
- have until December 1 to respond with NPI
- no responders will have provider agreement terminated

## 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 September 1, 2010, the portal is processing approximately 2,008 claims and 24,426 eligibility inquiries per day. During the reporting period, providers billed approximately \$80 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. In State Fiscal Year 2010, the Third Party Liability Unit recovered \$76,285,306.68 (both state and federal funds).

## 5) **Implementation of the MITS**

ODJFS continues to work toward the December 7, 2010 MITS implementation target. Staff lead and participate in activities for implementation planning, operational readiness planning, parallel test planning, user acceptance test activities, help desk preparation, procedure manuals review and user manuals review. Training for both providers and staff is underway. The help desk platform was implemented and is currently in use by call center staff. In order to ensure that the system is developed and sufficiently tested to successfully respond to the current Medicaid program payment requirements, a "policy black out" period is underway wherein no additional items are being added to the MITS functionality scope for go-live.

**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 December 7<sup>th</sup> 2010 near term Go Live date for MITS and the resources required to support MITS implementation continue to be the department's highest priority. It is expected this constraint will result in renewing the existing contract for a while longer 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 119 medical practices 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

SFY10 Budget Status

<b>Category</b>	<b>Projection</b>	<b>Expenditure</b>	<b>Variance %</b>
Nursing Homes	\$2,733,082,634	\$2,677,199,970	-2.04%
ICF/MR	\$542,927,799	\$543,391,659	0.09%
Inpatient Hospital	\$1,107,879,517	\$1,031,630,443	-6.88%
Outpatient Hospital	\$422,472,714	\$414,840,354	-1.81%
Physician	\$363,312,126	\$328,916,365	-9.47%
Drug	\$1,021,326,877	\$841,129,598	-17.64%
ODJFS Waivers	\$359,488,019	\$322,927,052	-10.17%
Managed Care - ABD	\$1,476,313,196	\$1,434,891,583	-2.81%
Managed Care - CFC	\$3,395,339,276	\$3,348,739,312	-1.37%
Buy-In	\$339,940,661	\$349,136,592	2.71%
Other	\$1,103,643,512	\$1,063,158,878	-3.67%
Medicare Part D	\$221,686,721	\$173,855,239	-21.58%
DMA	\$5,204,562	\$3,449,101	-33.73%
<b>Total SFY10 Vs. Projection</b>	<b>\$13,092,617,614</b>	<b>\$12,533,266,147</b>	<b>-4.27%</b>

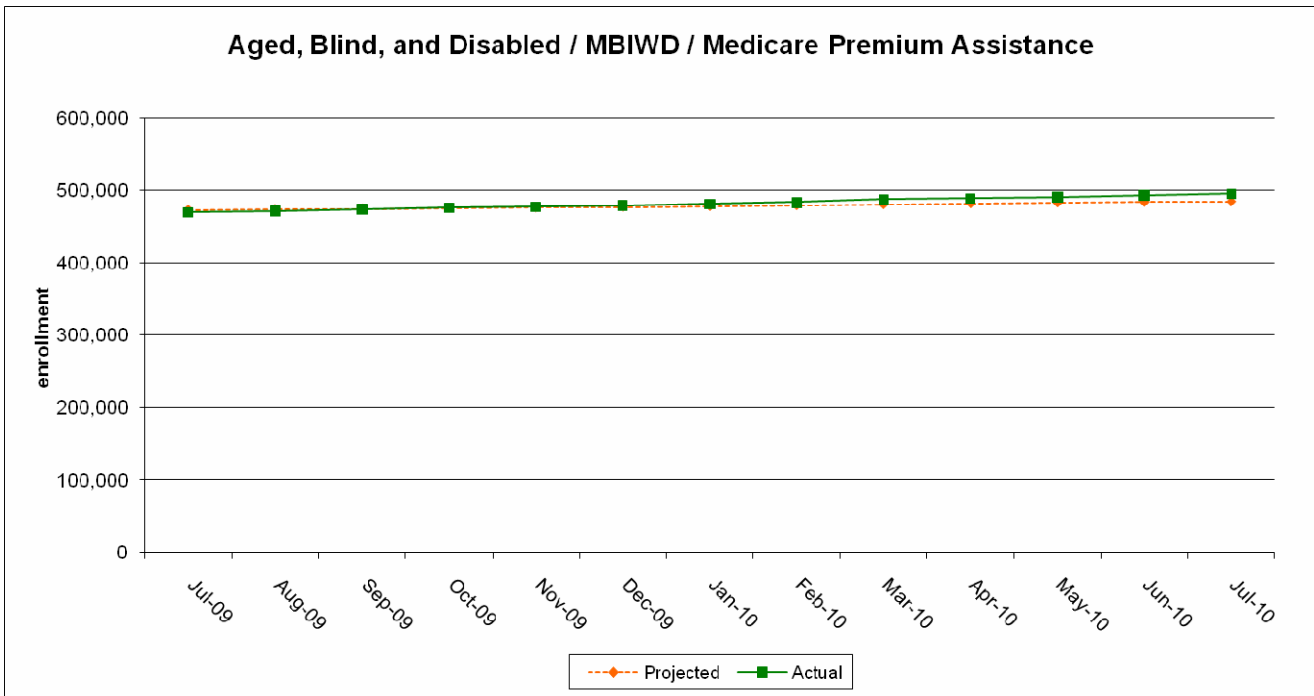
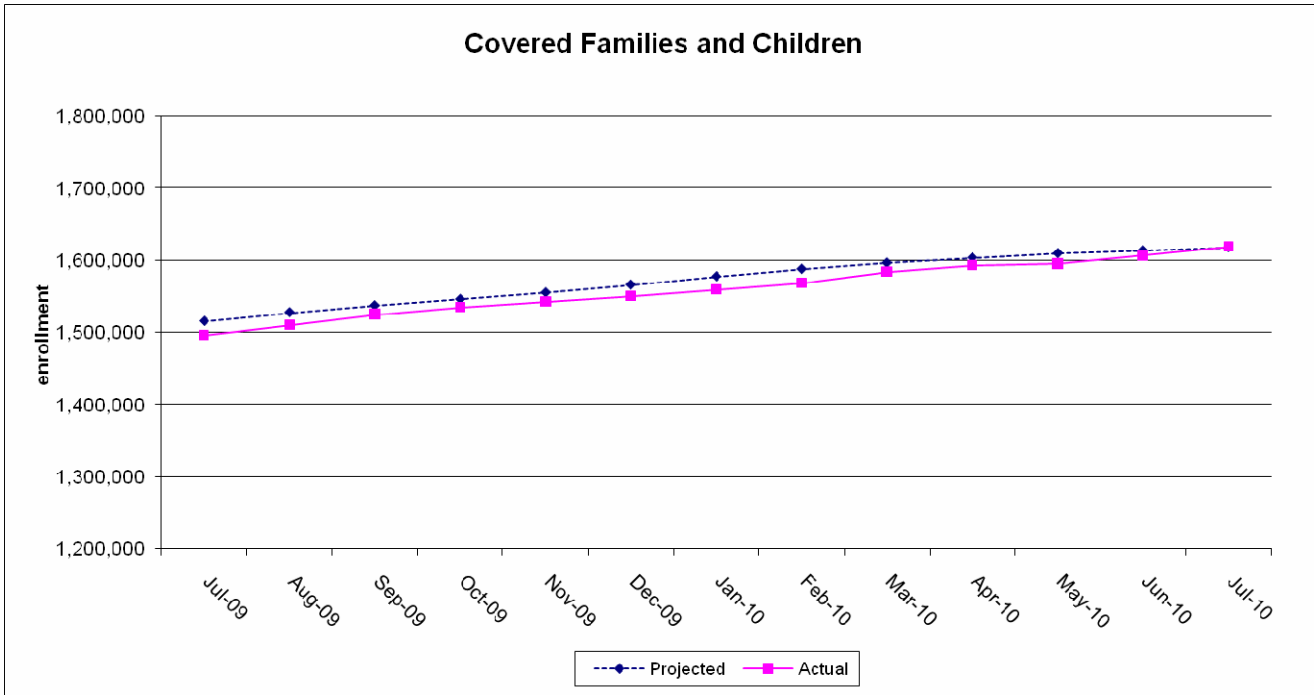
SFY11 Budget Status

<b>Category</b>	<b>Projection</b>	<b>Expenditure</b>	<b>Variance %</b>
Nursing Homes	\$455,802,468	\$451,534,300	-0.94%
ICF/MR	\$91,035,418	\$91,816,014	0.86%
Inpatient Hospital	\$188,074,490	\$190,765,755	1.43%
Outpatient Hospital	\$73,303,406	\$79,620,577	8.62%
Physician	\$59,814,000	\$60,785,676	1.62%
Drug	\$304,202,133	\$296,275,770	-2.61%
ODJFS Waivers	\$65,520,157	\$60,683,884	-7.38%
Managed Care - ABD	\$231,430,260	\$231,836,716	0.18%
Managed Care - CFC	\$573,827,727	\$587,569,736	2.39%
Buy-In	\$59,844,783	\$63,807,799	6.62%
Other	\$197,415,940	\$197,966,331	0.28%
Medicare Part D	\$0	\$11,823,287	0.00%
<b>Total YTD Vs. Projection</b>	<b>\$2,300,270,782</b>	<b>\$2,324,485,844</b>	<b>1.05%</b>

Source: Office of Fiscal and Monitoring Services as of September 13, 2010.

Attachment 2

Caseload Trend Data



Source: Office of Fiscal and Monitoring Services as of September 14, 2010.