



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: October 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. 1 (128th General Assembly) the Department proposed the following cost containment or revenue generation initiatives for the State Fiscal Year (SFY) 2010 and SFY 2011 biennium:

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Cost management initiative updates

- 1) Move managed care payments away from prospective payment
Projected SFY10 savings: \$270,400,000 Actual SFY10 savings: \$0.00
Projected SFY11 savings: \$0 Actual SFY11 savings:

UPDATE: Payments for May, 2010 are scheduled to be delayed by two weeks. Instead of prospectively making the capitation payment for May's managed care members in April, ODJFS will make this payment mid-May. This will result in the reduction of one capitation payment in SFY 2010, i.e., only 11 capitation payments will be made in SFY 2010 instead of 12. The savings from this initiative will be realized during April, 2010.

- 2) Return NE & NW managed care regions to mandatory for ABD population
Projected SFY10 savings: \$6,700,000 Actual SFY10 savings: \$0.00
Projected SFY11 savings: \$20,300,000 Actual SFY11 savings:

UPDATE: The restoration of Aged Blind and Disabled (ABD) mandatory managed care in the northeast and northwest regions is on schedule and will be completed October 1, 2009. In the northeast region 24,000 ABD members were enrolled as of September 1, 2009. As of October 1, 2009 we expect 11,000 ABD members will be enrolled in the northwest region.

- 3) Implement managed care pharmacy carve out
Projected SFY10 savings: \$5,200,000 Actual SFY10 savings: \$0.00
Projected SFY11 savings: \$235,500,000 Actual SFY11 savings:

UPDATE: Due to a delay in finalizing the budget, this initiative has been delayed one month until February 1, 2010. This delay will eliminate the projected savings in SFY2010. This will occur because the first drug rebate revenues will now be received during the beginning of SFY '11 rather than the very end of SFY '10.

- 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 Actual SFY11 savings:

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.

- 5) Take down Disability Medical Assistance program
Projected SFY10 savings: \$2,739,228 Actual SFY10 savings: \$0.00
Projected SFY11 savings: \$9,488,695 Actual SFY11 savings:

UPDATE: This initiative is progressing as planned. Rules have been original filed and will be before JCARR on October 5th. CRISE programming is in final stages. IT release is scheduled for October 9th. A communication was sent to all enrollees on September 10, 2009. The termination notice will be sent upon the automated IT takedown following the release. The October, 2009 card will be the last Disability Medical Assistance card issued with program officially ending October 31, 2009.

6) Implement community provider rate reduction

Projected SFY10 savings: \$29,803,180	Actual SFY10 savings: \$0.00
Projected SFY11 savings: \$52,594,918	Actual SFY11 savings:

UPDATE: The projected cost savings figures above include state plan, waiver and managed care services reimbursed by JFS. OAC rule implementing the provider rate decreases were put into clearance the week of September 7th, 2009 with a scheduled effective date of January 1, 2010. There are no savings to report at this time.

7) Implement reduction in pharmacy dispensing fee

Projected SFY10 savings: \$6,177,154	Actual SFY10 savings: \$0.00
Projected SFY11 savings: \$14,825,169	Actual SFY11 savings:

UPDATE: OAC Rule 5101:3-9-05 was placed in clearance. Clearance ends September 25, 2009. The rule will be filed October 17, 2009 for an effective date of January 1, 2010. A State Plan amendment was submitted to CMS on September 11, 2009. Once CMS acknowledges receipt, there will be a 90 day approval period.

8) Restrict access to OTC pharmaceuticals

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

UPDATE: This initiative has been delayed due to the need to retain access for these over-the-counter pharmaceuticals to residents of Intermediate Care for the Mentally Retarded (ICF-MR) facilities, while removing this benefit for adult Medicaid fee for service recipients. The OTC pharmaceuticals to be removed are listed below in item #9.

9) Move ancillary services into the Nursing Facility rate

Projected SFY10 savings: \$0	Actual SFY10 savings: \$0.00
Projected SFY11 savings: \$0	Actual SFY11 savings:

UPDATE: The five bundled ancillary services were moved to the nursing facilities' (NFs) rates effective 8/1/09. 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.

The bundling of medical transportation; however, was the subject of a lawsuit brought by the Ohio Ambulance and Medical Transportation Association (OAMTA). Two successive temporary restraining orders stayed the implementation of this particular bundling provision for the period from August 18 through September 14. A ruling by the court on September 15th further extends the stay through September 30, 2009.

For Over the Counter Pharmaceuticals, OAC 5101:3-9-03 was filed as an emergency and effective 7/31/09. The rule was filed through the regular process on 8/13/09 and expected to be effective on 10/29/09.

A State Plan Amendment will be filed.

The following Over the Counter (OTC) drugs will not be separately reimbursable to a pharmacy when billed for a resident of a nursing facility. Instead, payment for these OTC drugs is part of the per diem payment made to the NF:

- (1) Analgesics, including urinary analgesics;
- (2) Compounding vehicles and bulk chemicals;
- (3) Cough and cold preparations and antihistamines, except preparations containing cetirizine and loratadine;
- (4) Ear preparations;
- (5) Gastrointestinal agents, except histamine-2 receptor antagonists, proton pump inhibitors, and loperamide;
- (6) Hemorrhoidal preparations;
- (7) Nasal preparations;
- (8) Ophthalmic agents, except antihistamines;
- (9) Saliva substitutes;
- (10) Sedatives;
- (11) Topical agents, except antifungal and acne preparations; or
- (12) Vitamins and minerals, except prenatal vitamins and fluoride.

10) Increase NF franchise fee (additional revenue to fund 5R20)

Projected SFY10 revenue: \$146,632,499	Actual SFY10 revenue: \$0.00
Projected SFY11 revenue: \$195,510,000	Actual SFY11 revenue:

UPDATE: First payment is due December, 2009.

11) Increase ICF-MR franchise fee (additional revenue to fund 4K10)

Projected SFY10 revenue: \$5,096,029	Actual SFY10 revenue: \$0.00
Projected SFY11 revenue: \$4,376,837	Actual SFY11 revenue:

UPDATE: First payment is due November, 2009.

12) Change timing of ICF-MR payment

Projected SFY10 savings: \$0	Actual SFY10 savings: \$0.00
Projected SFY11 savings: \$45,000,000	Actual SFY11 savings:

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

13) Implement hospital franchise fee (additional revenue to 5GF0)

Projected SFY10 revenue: \$338,505,283	Actual SFY10 revenue: \$0.00
Projected SFY11 revenue: \$370,861,816	Actual SFY11 revenue:

UPDATE: Section 5112.40 - 5112.48 of the Revised Code creates the Hospital Franchise Fee Program (HFF) and imposes a fee 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. The fee is expected to generate \$338.51 million in SFY 2010 and \$370.86 Million in SFY 2011. Status: Preliminary Assessments were mailed to hospitals on 9/16/09, "announcing" the program and advising hospitals of their payment due amounts. The final assessment letters (fee invoice) will be mailed the first week of October, 2009.

- 14) Strengthen TPL by preventing insurance companies from denying claims due to prior authorization
Projected SFY10 savings: \$250,000 Actual SFY10 savings: \$0.00
Projected SFY11 savings: \$250,000 Actual SFY11 savings:

UPDATE: Too little time has passed from the implementation of the law for the pay and chase vendor 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 year to no later than every seven years. The Ohio Department of Job and Family Services will require certain providers to complete the re-enrollment process beginning in January of 2010. Providers enrolled with open ended agreements prior to January 1, 2008 will be notified of the conversion of their open ended provider agreements to time limited provider agreements, in addition to being notified of their assigned re-enrollment period, before December 31, 2010.

B) HB 1 permitted an exemption from the required Medicaid re-enrollment provision in HB 119 for Ohio Medicaid hospital providers.

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. Action will be taken to implement this provision of HB 1 in November of 2009.

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 September 15, 2009, the portal is processing approximately 1,635 claims and 15,200 eligibility inquiries per day. During the reporting period, providers billed approximately \$60 million in claims through the Medicaid web portal.

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

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 85% of the covered lives in the state of Ohio.

5) Implementation of the MITS

ODJFS continues to mitigate resource challenges to achieve cost containment initiatives and implement MITS. Staff lead and participate in activities for the MITS project. Business transformation, design, development, and testing preparations activities make up the majority of the current work. MITS Phase 1 System Design has been completed for the set of functionality to meet Ohio requirements for an operational Medicaid management system. The MITS project schedule now reflects the new December, 2010 implementation date.

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

EDS has finished their evaluation of the scope and requirements but has not finished the cost and time estimates. ODJFS expects these documents by November, 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 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.

Attachment 1

SFY09 Budget Status

SFY 2010 July 1, 2009, to August 31, 2009, Spending Analysis Chart

Category	Projection	Expenditure	Variance
Nursing Facilities	446,355,381	433,388,596	-2.91%
ICF/MR	89,493,201	88,189,207	-1.46%
Inpatient Hospital	214,430,618	202,538,685	-5.55%
Outpatient Hospital	81,093,645	76,662,779	-5.46%
Physician	68,415,443	61,501,921	-10.11%
Drug	108,016,480	99,329,247	-8.04%
ODJFS Waivers	65,894,957	65,680,516	-0.33%
Managed Care (ABD)	261,062,477	259,748,493	-0.50%
Managed Care (CFC)	590,270,396	593,829,508	0.60%
Buy-In	53,769,869	80,407,065	49.54%
Other	208,208,171	199,994,831	-3.94%
Medicare Part D	44,368,651	43,871,687	-1.12%
Disability Assist.-Medical	1,570,991	1,582,944	0.76%
SFY 2010 Vs. Projection	2,232,950,282	2,206,725,483	-1.17%

Attachment 2

Caseload Trend Data

