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: January 1, 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.

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:

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: $2,233,000
   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. More than 11,000 ABD members were 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 reduce the estimated SFY 2010 savings to $0. 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, but implementation is unlikely during SFY '10.

5) Take down Disability Medical Assistance program
   Projected SFY10 savings: $2,739,228 Actual SFY10 savings: $752,192
   Projected SFY11 savings: $9,488,695 Actual SFY11 savings:

   UPDATE: The October, 2009 card was the last Disability Medical Assistance card issued. DMA was successfully sunset on 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. The OAC rules implementing the community provider fee decrease were approved by JCARR on December 7, 2009 with a January 1, 2010 effective date. A state plan amendment will be filed and is in the signature process. Savings will not be realized until the third quarter of SFY '10.

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 filed October 17, 2009 for an effective date of January 1, 2010, with JCARR approval on December 7, 2009. A State Plan amendment was submitted to CMS on September 11, 2009. CMS has issued a Request for Additional Information (RAI). Staff are generating responses to their questions.

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 Facilities for the Mentally Retarded (ICF-MR), 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 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 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, 2009. A ruling by the court on September 15, 2009 further extended the stay through September 30, 2009. On September 30, 2009, the Ohio Academy of Nursing Homes moved to intervene in the lawsuit, challenging the portion of the court's order requiring ODJFS to reduce NF reimbursement to avoid duplicate payments during the period in which the TRO was in effect. The court has not ruled on the motions.

   For Over the Counter Pharmaceuticals, OAC 5101:3-9-03 was filed as an emergency and effective July 31, 2009. The rule was filed through the regular process on August 13, 2009 and expected to be effective on October 29, 2009.

   The necessary State Plan Amendments have been 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: $40,724,717
Projected SFY11 revenue: $195,510,000 Actual SFY11 revenue:

UPDATE: The first payment was due December 15, 2009.

11) Increase ICF-MR franchise fee (additional revenue to fund 4K10)
Projected SFY10 revenue: $5,096,029 Actual SFY10 revenue: $1,295,005
Projected SFY11 revenue: $4,376,837 Actual SFY11 revenue:

UPDATE: The first payments were collected 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: $95.4 M (Nov 09 Pmts)
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.

September 25, 2009, the department, in recognition of the delay in obtaining CMS approval for the Hospital Care Assurance Program (HCAP) 2009 State Plan Amendment (SPA) and the potential impact on hospitals cash flow positions due to a compressed payment schedule for the HCAP Assessment and Hospital Franchise Fee (HFF), the department sought from and received Administration approval to delay

the due date of the HHF, from October 30 to November 30, 2009. The CMS delay caused the timing for both payments to be compressed, and would have required many hospitals to seek outside sources of financing in order to make both fee payments. All other HFF due dates remain unchanged.

Receipts from hospitals for the November 30, 2009, payment cycle are on track to meet projections. However, $1.34 million of the total expected fee revenue is currently at risk due to hospitals filing appeals under ORC 5112.42 (C).

14) Strengthen TPL by preventing insurance companies from denying claims due to prior authorization
Projected SFY10 savings: $250,000 Actual SFY10 savings: $75,000
Projected SFY11 savings: $250,000 Actual SFY11 savings:

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 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. As of January 2010 the department will also begin to phase-in conversion of the open ended agreements of 76,515 active providers. The conversion period will extend through December 31, 2015.

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.

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 was taken to implement this provision of HB 1 in November of 2009. As a result of a data run on October 2, 2009, 10,042 active providers were identified as not having shared their NPI with the department. Of this total, approximately 8,600 providers were identified as not having billed the department in 24 months. Consequently, these 8,600 providers will be deactivated using the HB119 provision permitting the department to terminate providers who have not billed the department for 24 or more months. The 1,300 remaining providers were checked against the NPI registry and it was determined that in excess of 300 providers had received an NPI, but had failed to share it with the department. The NPIs of these providers were added to their provider record in the MMIS Provider Master File. This leaves approximately 1,000 providers who continue to do business with the department without a required NPI. Steps are being taken to notify these providers that the failure to share their NPI with the department will result in termination.

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 December 4, 2009, the portal is processing approximately 1,920 claims and 18,600 eligibility inquiries per day. During the reporting period, providers billed approximately $72 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**
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.

The recent legislative change requiring insurance carriers to not deny Medicaid reclamation claims for no prior authorization have resulted in $ 75,000 in additional recoveries that would have been denied in the past.

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. Development will continue through Q3. The MITS team is focused on paying claims through the new system by the December, 2010 implementation date.

6) **Expansion of the Medicaid data warehouse and decision support system**
EDS has completed their evaluation of the scope and requirements and has requested ODJFS reevaluate the scope and requirements to determine if they are all still valid and appropriate. ODJFS is in the process of reviewing the requirements and scope and expects to complete this by spring 2010.

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

SFY10 Budget Status

SFY 2010 July 1, 2009, to November 30, 2009, Spending Analysis Chart

Category	Projection	Expenditure	Variance %
Nursing Facilities	**$1,144,187,394**	**$1,117,747,848**	**-2.31%**
ICF/MR	$227,213,577	$225,919,759	-0.57%
Inpatient Hospital	$496,583,415	$446,248,657	-10.14%
Outpatient Hospital	$185,823,150	$170,221,897	-8.40%
Physician	$158,891,929	$136,106,369	-14.34%
Drug	$239,544,468	$200,319,899	-16.37%
ODJFS Waivers	$155,882,525	$136,902,726	-12.18%
Managed Care (ABD)	$709,566,003	$703,371,593	-0.87%
Managed Care (CFC)	$1,538,758,201	$1,540,937,289	0.14%
Buy-In	$135,417,741	$134,685,149	-0.54%
Other	$480,156,373	$443,181,317	-7.70%
Medicare Part D	$111,117,410	$108,931,770	-1.97%
Disability Assist.-Medical	$3,550,605	$3,372,787	-5.01%
SFY 2010 Vs. Projection *	**$5,586,692,792**	**$5,367,947,058**	**-3.92%**

Source: OAKS 12/9/2009

* Please note: The November 28, 2009 payment file was budgeted in November, but these expenditures did not post in the OAKS general ledger until December. Adjusted for this timing issue, year-to-date expenditures would be $5,437,812,190, and the FY09 variance through November would be -$148,880,602 (or -2.7%).

Attachment 2

Caseload Trend Data