

# Key Budget Initiatives and Status Report

## ODJFS Office of Ohio Health Plans

Revised or Temp Code Section #	State Fiscal Years 2008 and 2009 Budget Initiative	Status report
109.572, 5111.028, 5111.03, 5111.031 to 5111.034, and 5111.06	<p>Improve program integrity of Medicaid provider agreements: The budget bill makes the following changes relative to Medicaid provider agreements:</p> <ul style="list-style-type: none"> <li>(1) Requires the use of time-limited provider agreements;</li> <li>(2) Eliminates the five-year limit for termination of a provider agreement based on an action brought by the Attorney General;</li> <li>(3) Authorizes the denial or termination of a provider agreement for any reason permitted or required by federal law;</li> <li>(4) Requires the suspension of a provider agreement held by a noninstitutional health care provider based on an indictment of the provider or its owner, officer, authorized agent, associate, manager, or employee;</li> <li>(5) Authorizes the exclusion of an individual, provider, or entity from participation in Medicaid for any reason permitted or required by federal law; and</li> <li>(6) Modifies the circumstances under which ODJFS is not required to conduct an adjudication when imposing sanctions relative to a provider agreement, including sanctions imposed against a provider for failing to obtain or maintain a required certification.</li> </ul>	<p>Rules that require all new providers to have time-limited agreements become effective January 1, 2008. ODJFS/Ohio Health Plans will send each existing provider a notice that its provider agreement will be converted to a time-limited agreement over the next three years as part of the phased implementation of these requirements.</p>
309.30.13	<p>Requires the ODJFS Director to pay the full cost (100%) of Medicaid cost outlier claims for inpatient admissions at children's hospitals that are less than \$443,463 (adjusted annually for inflation).</p>	Completed
309.30.40	<p>Increase the intermediate care facility for the mentally retarded (ICF/MR) provider rates 2% each year (7/1/2007 and 7/1/2008)</p>	Completed

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309.30.60	Requirement to cover chiropractic services for adult Medicaid recipients in an amount, duration, and scope specified in rules adopted by the Director.	The rules to implement the change are original filed with effective dates of service on or after January 1, 2008. The public hearing is scheduled for November 20, 2007. The rules will be before the Joint Committee on Agency Rule Review (JCARR) December 20, 2007, but may be moved up to December 8, 2007.
309.31.13(B) and 309.31.16(B)	ODJFS Director to analyze the fiscal impact that the federal upper limits (FULs) established under federal law, as amended by the Deficit Reduction Act (DRA), will have on pharmacists in fiscal years 2008 and 2009. The budget bill requires the fiscal impact analysis for 2008 to be completed not later than 30 days after the effective date of the regulation the Secretary of Health and Human Services must promulgate, as discussed above, under Section 6001(c)(3) of the DRA. The fiscal impact analysis for 2009 must be completed not later than March 15, 2008. Each fiscal impact analysis must include a projection of the revenue a pharmacist is expected to lose during fiscal year 2008 or 2009 from each unit of multiple source drug dispensed to a Medicaid recipient. The budget requires the Director to increase the dispensing fee to be paid to pharmacists with a valid Medicaid provider agreement for dispensing a multiple source drug to a Medicaid recipient in fiscal year 2008 or 2009. For each fiscal year, the budget bill requires that the increase be made not later than ten days after the Director completes the fiscal impact analyses described above. The amount of the increase for each fiscal year must be determined in a manner that compensates pharmacists for the loss of revenue the Director projects pharmacists will, on average, incur during fiscal year 2008 or 2009.	ODJFS/Ohio Health Plans cannot analyze the impact of the federal upper payment limits until the Secretary of Health and Human Services adopts them as required under Section 6001(c)(3) of the DRA; the Secretary has yet to do so.
309.32.50	Based on the recommendations made by the Disability Determination Consolidation Study Council, the Rehabilitation Services Commission and ODJFS are required to work together to reduce the duplication of activities performed by each agency and develop a systems interface so that medical information for mutual clients may be transferred between the agencies.	In progress; the Deputy Director of the Office of Ohio Health Plans continues to meet with Social Security Administration and the Rehabilitation Services Commission concerning the sharing of data.

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309.32.60

Requirement that ODJFS Director submit a report on the Primary Alternative Care and Treatment (PACT) program to the General Assembly no later than January 1, 2008. The report is to compare the average monthly medical costs of participants in the program with the average monthly costs of those individuals prior to program participation. The budget bill further requires the Director, no later than January 1, 2009, to submit a report on the total cost savings achieved through the program.

Report preparation is in progress.

309.32.70

By July 1, 2008, ODJFS Director to submit a report to the General Assembly on the effect of Medicare Part D and the care management system on the Supplemental Drug Rebate Program. The report is to evaluate the changing cost of pharmaceuticals for which supplemental rebates are made under the program as a result of the high volume of drug purchases being transferred to Medicare Part D. The report is to include a review of the use of generic drugs by Medicaid recipients and cost savings to be achieved by increasing the use of generic drugs.

Report preparation is in progress.

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3119.022, 3119.023,  
3119.05, 3119.29,  
3119.30, 3119.302,  
3119.32, and 803.03

Cash medical support changes to increase medical child support collections (in cooperation with the Office of Child Support) For children receiving Medicaid, the cash medical support must be paid by the obligor to the Office of Child Support to defray the cost of Medicaid expenditures. ODJFS Director creates and annually updates a table to be used to determine the amount of cash medical support to be paid.

As of November 5, 2007, the Office of Child Support Cash Medical Support Initiative (CMSI) has finished drafting the proposed administrative rules and forms. Office of Child Support (OCS) management and subject matter experts are reviewing the forms and rules before they go through the ODJFS clearance process. OCS also has updated recommended language for the biennial budget corrections bill. None of the recommended language will have a fiscal impact on the budget.

OCS attended a recent federal teleconference on Medical Support. The Office of Child Support Enforcement (OCSE) reiterated that the new federal medical support regulations will likely become effective during the spring of 2008. According to OCSE, the Office of Management and Budget is currently reviewing the regulations.

ODJFS Management Information System staff is reviewing the Business Function Requirements (BFR) document. The BFR includes multiple changes to the support enforcement tracking system (SETS) to calculate the cash medical support obligations that all future child-support orders will include. An obligee will owe the cash medical support obligation when private health insurance does not cover his or her child.

5101.52, 5101.521 to  
5101.526, 5101.528, and  
5101.529

Expansion of the Children's Health Insurance Program (CHIP) Part III for children in families with incomes 200% to 300% of the federal poverty level

Rules were filed October 12, 2007. The Public Hearing is scheduled for November 13, 2007, and the rules will be before the Joint Committee on Agency Rule Review December 3, 2007. ODJFS has submitted a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services.

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5101.5211, 5101.5215,  
5101.5212, 5101.5213,  
5101.5214, and  
5101.5216

Health care for uninsured children in families with income above 300% of federal poverty level. The Director shall submit to the United States Secretary of Health and Human Services an amendment to the state Medicaid plan, an amendment to the state child health plan, one or more requests for a federal waiver, or such an amendment and waiver requests as necessary to seek federal matching funds for this program. The Director may not begin implementing the program until after submitting the amendment, waiver request, or both. However, the Director may begin implementation of the program before receiving approval of the amendment, waiver request, or both using state funds only. The Director is to implement the program regardless of whether the amendment, waiver request, or both are denied.

While Ohio plans to send a State Plan Amendment to Centers for Medicare and Medicaid Services (CMS) to cover these children, staff expects this to be a "state only" program, at least initially. Children will have to be uninsured for at least six months and meet other criteria. Eligibility will not be retroactive. ODJFS will offer coverage on a month-to-month basis and will require a premium payment.

All rules, application, enrollment and medical payment functions will be performed by private vendors outside of state or county government. Automated Health Systems (AHS) will process the premium payment system. A contractor will also handle a web-based intake system. In addition, a contractor will process eligibility information. A statewide managed care plan will provide managed care services to the children.

5111.0111

Medicaid coverage for former foster children

Rules were filed October 12, 2007. The Public Hearing is scheduled for November 13, 2007, and the rules will be before the Joint Committee on Agency Rule Review December 3, 2007. ODJFS has submitted a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS). Section 5111.0111 of the Revised Code does not appear to allow implementation of the expansion without federal approval of the SPA.

5111.014 and 309.30.90

Expanded Medicaid eligibility for pregnant women with family incomes between 150%-200% of the federal poverty level.

Rules were filed October 12, 2007. The Public Hearing is scheduled for November 13, 2007, and the rules will be before the Joint Committee on Agency Rule Review December 3, 2007. ODJFS has submitted a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS). ODJFS implementation is on target for January 2008 unless CMS does not approve the SPA in time. Section 5111.014 of the Revised Code appears to prevent implementation of the expansion without federal approval of the SPA.

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5111.029	Requirement that the Medicaid program cover occupational therapy services provided by a licensed occupational therapist	The occupational therapy rules were original filed on October 16, 2007. The effective date of the rules is January 1, 2008. The public hearing is scheduled for November 20, 2007, and the Joint Committee on Agency Rule Review hearing is scheduled for December 20, 2007. This project is on schedule to have the occupational therapy provider type active by January 1, 2008.
5111.032	Increase program integrity for providers by expanding requirements for criminal records checks	In progress
5111.084	Psychiatrist appointed as member of the Pharmacy and Therapeutics Committee	The ODJFS Director recently signed a letter of appointment to add a psychiatrist to the Pharmacy & Therapeutics Committee. This appointment complies with the new legislative requirement for a psychiatrist to serve on the Committee.
5111.101	Deficit Reduction Act required the education of employees of all entity's receiving \$5 million or more annually from Medicaid.	Completed
5111.11, 2113.041, 2117.061, 2117.25, 5111.112, 5111.113, 5302.221, and 5309.082	Requirement that the administrator of the Medicaid Estate Recovery Program prescribe a form regarding transfer of death deeds and a form regarding survivorship tenancies	In progress
5111.70 and 5111.707	Establish a program for Medicaid buy-in for workers with disabilities	Rules were filed October 12, 2007. The Public Hearing is scheduled for November 13, 2007, and the rules will be before the Joint Committee on Agency Rule Review December 3, 2007. ODJFS has submitted a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services. Section 5111.70 of the Revised Code appears to prevent implementation of the expansion without federal approval of the SPA.
5111.709, 5111.7010, and 309.30.95	Medicaid Buy-In Advisory Council: ODJFS is required to provide the Council with accommodations for it to hold its meetings. ODJFS must also provide the Council with other administrative assistance it needs to perform its duties. The ODJFS Director was required to call the Council to meet for the first time by August 31, 2007.	The Medicaid Buy-In Advisory Council continues to meet and ODJFS continues to provide it with administrative and technical assistance.

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N/A	Increase Medicare enrollment	In progress
N/A	Expedite managed care enrollment	<p>Expediting managed care enrollment will reduce from ninety to forty-five days the average time it takes to enroll a fee-for-service consumer on a managed care plan. This project has been split into two phases to ensure the most appropriate implementation for our consumers. The split allows ODJFS to realize some savings upfront while completing design of the project.</p> <p>The goal for Phase I, which has a target completion date of January 1, 2008, is to reduce from ninety to between sixty and seventy-five days the average time it takes to enroll a consumer on a managed care plan. ODJFS will achieve the reduction by changing the timing of certain required notices. The goal for Phase II, which has a target completion date of July 1, 2008, is to further reduce the average consumer enrollment time from between sixty and seventy-five days to the forty-five day goal. ODJFS will achieve this further reduction by generating the enrollment notice at the time of application instead of after ODJFS authorizes the Medicaid case. This initiative is expected to save \$600 thousand during SFY 2008.</p>
N/A	Conduct the annual inpatient hospital recalibration	<p>ODJFS filed the rule October 16, 2007, and the rule's Public Hearing is scheduled for November 20, 2007. The Joint Committee on Agency Rule Review hearing date is December 20, 2007. This initiative is on track for January 1, 2008, implementation.</p>
N/A	Implement a system to ungroup claims and to identify questionable claims prior to payment (clinical claims editing)	<p>ODJFS will submit an Implementation Advanced Planning Document (IAPD) to the Center for Medicare and Medicaid Services (CMS) for funding and project approval to implement a Clinical Claims Editor within the scope of the Medicaid Information Technology System (MITS) project. ODJFS will base its decision about when to implement the editor on further analysis about the early deployment of MITS and cost-benefits associated with implementation of the Editor.</p>