Ohio | Department of Job and Family Services

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House Health and Human Services Subcommittee
Ohio Department of Job and Family Services, Office of Ohio Health Plans
Executive Budget Recommendations SFY 2012-2013
John McCarthy, Medicaid Director
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Chairman Burke, Ranking Minority Member Goyal and members of the subcommittee, I am John McCarthy, Ohio's Medicaid Director. Thank you for the opportunity to testify before you today, to tell you about the Medicaid portion of the Department of Job and Family Services budget for fiscal years 2012 and 2013.

What is the Medicaid program and who does it serve? Medicaid is the health insurance program for low-income families with children, aged, blind, and disabled. Currently, there are a little over 2.1 million people enrolled in Medicaid. That number breaks down in the following way:

- 1.2 million children;
- 450,000 parents of those children
- 500,000 elderly or individuals with disabilities

The program covers children up to 200% of the federal poverty level, parents of those children to 90% FPL, and the elderly or individuals with disabilities up to 64% FPL, unless they meet an institutional level of care and then it is 150% FPL. I think it is important to know what those levels equate to:

- 200% FPL for a family of four is $44,700 per year. $37,060 for a family of three.
- 90% FPL for a family of four is $20,115 per year. $16,667 for a family of three.
- 64%FPL for a family of one is $6,970 per year. $9,414 for a family of two.
- 150% FPL for a family of one is $16,335. $22,065 for a family of two.

This program faces many challenges. Medicaid spending is growing at an unsustainable rate, four times faster than the economy over the past four years, and now consumes 30% of the total state spending – while still continuing to grow. This budget expects that number to grow to 2.21 million people in fiscal year 2012 and to 2.26 million people in fiscal year 2013. Caseload projections for the high cost ABD population is projected to increase by 7.8% over the next two fiscal years.

Ohio Medicaid is at a crossroads. On one hand is the looming impact of the Affordable Care Act (ACA). Based upon new data from the Ohio Family Health Survey, the projected Medicaid caseload will grow approximately an additional 936,000 people by January 1, 2014. That will

mean an increase of $4.07 billion in all funds in federal fiscal year 2014. On the other hand, US Representative Paul Ryan is proposing to turn the Medicaid program into block grants and give states more flexibility.

With these challenges in mind Ohio needs to revise its current spending habits and focus on improving the system for those that are most expensive and account for 51 percent of spending, but make up only four percent of the total program. However, I would like to point out that we did not take a "slash and burn" approach to balancing the budget. This budget does not cut program eligibility. It also maintains all of Ohio Medicaid's optional services. What it does do is focus on the modernization and the transformation of our delivery system to bring about long-term savings and reform through policy changes.

The state fiscal year 2012-2013 Medicaid budget was built on the foundation of the following four guiding principles:

1) Improve Care Coordination
2) Integrate Behavioral and Physical Health Care
3) Rebalance Long-Term Care
4) Modernize Reimbursement

Improve Care Coordination

Care coordination focuses on treating the whole person by creating a single entry point into the health care system. Our current system rewards providers, but does not incentivize providers for better outcomes. This budget seeks to work with providers to develop effective care delivery across the different regions of the state to treat all: physical; behavioral; long-term care; and social needs of the individual though the following reforms:

Health Homes

The Affordable Care Act placed broad parameters around the definition of health homes. Case management services for people in both managed care plans and in our fee-for-service delivery system will include:

- Timely high quality services;
- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support;
- Referral to community and social support services; and
- The use of health information technology to link services.

For example, individuals receiving long term services in nursing homes and through home and community based waivers in their communities, including approximately 113,000 individuals

eligible for both Medicare and Medicaid, and individuals with severe mental illness, often have complex care needs and are served through a fragmented delivery system. The Integrated Care Delivery System (ICDS) proposed in this budget is an example of a health home model with the potential to reduce the cost of health care over time while improving health outcomes. The ICDS will provide a single point of contact, support choice among settings of care, and ensure the delivery of person-centered care. We will continue to work with interested parties in developing Ohio specific models, which may include managed care, accountable care organizations, or other innovative health home models.

Provide Accountable Care for Children with Disabilities

The budget also proposes moving 37,000 children with disabilities, who do not reside in an institution or receive home and community based waiver services towards a pediatric accountable care organization model. These new delivery models are at different stages around the state and eventually will serve the complex medical and behavioral health needs of children with disabilities. The following chart shows the different stages of these models. This includes first moving these children into managed care and eventually into a pediatric ACO, which would include the full risk and responsibilities of an accountable care organization.

Responsibility	Current	Phase I	Phase II	Phase III
Medicaid Contract	Fee-for-Service	Health Plan	Health Plan	ACO
Care Coordination	None	Health Plan	ACO	ACO
Financial Risk	Medicaid	Health Plan	Health Plan	ACO
Savings	None	Medicaid	Health Plan/ACO	ACO/Medicaid

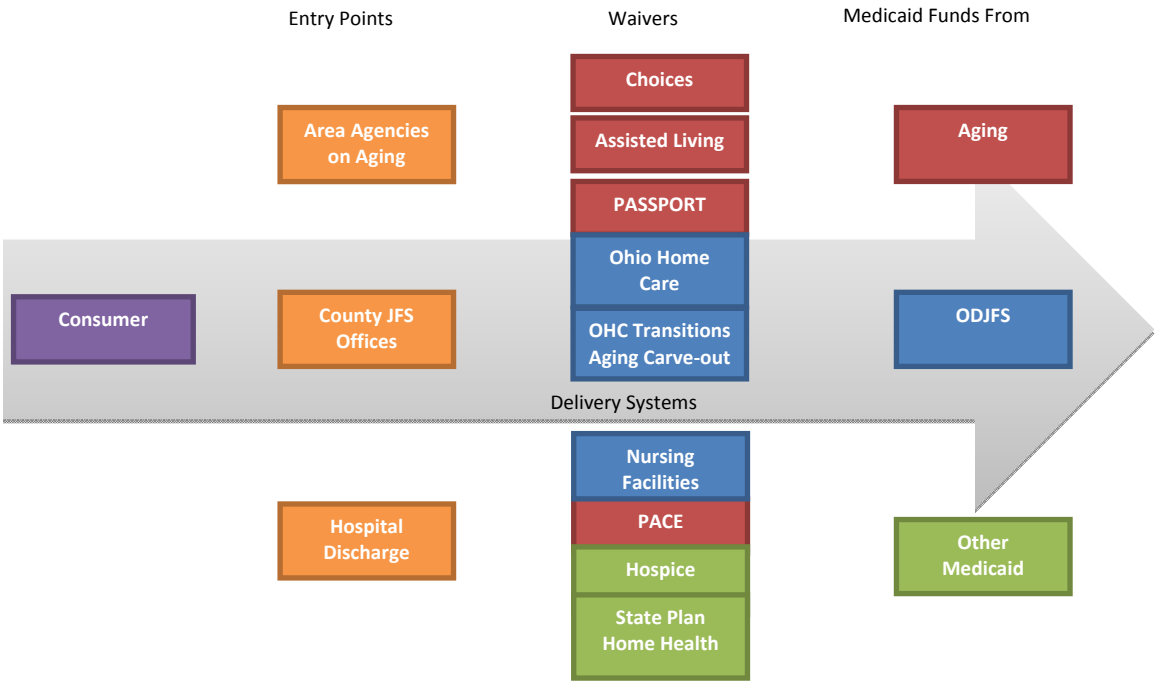
Integrate Behavioral and Physical Health Care

Under the umbrella of the Office of Health Transformation, we are working in conjunction with ODMH, ODADAS, and DODD to transform service delivery into an integrated, behavioral, and physical health care model.

Rebalance Long-Term Care

The current long-term care system is a complex system with multiple entry points, and multiple waiver programs, funded by multiple state agencies. Just look at the following chart:

Current Long-Term Care Delivery System



This budget changes that, by taking two important steps toward a unified long term care system. The first of these is consolidating all funds into a single line item. The funding associated with Medicaid programs administered by the Department of Aging is being transferred to the Medicaid 525 line, allowing money to truly follow the person.

The second is the implementation of a single home and community based waiver serving individuals with a nursing home level of care in FY 2013. Today an individual seeking long term services may have to choose among as many as nine programs with different points of entry, different eligibility requirements, and different service packages. The complexity in the delivery system may lead to the "simple, most obvious and convenient choice" – nursing home placement when people find they need additional support services. Last week Director Kantor Burman spoke about the role of the Aging system in providing a single point of entry. By combining the current HCBS waivers requiring a nursing home level of care, we will further simplify the delivery system and take a step toward offering meaningful choice of settings to consumers with long term care needs.

Modernizing Reimbursements

This proposal attempts to strategically place scarce resources where they will be the most effective for the individual.

Nursing Homes

Ohio's nursing homes are a critical piece of the long-term care system and will continue to be an important component of the delivery system. However, Ohio has built a system which permits only about 85% of the beds to be occupied on any given day. The unused capacity in the delivery system adds significant costs for those individuals using nursing homes to meet their long term care needs. Attached is a chart showing the percentage of total bed days in each county that were not used in calendar year 2009.

In an effort to achieve a balanced delivery system, this budget first proposes full implementation of the pricing model enacted in the SFY2006-2007 biennial budget. Then those prices are modified, maintaining the 25th percentile originally established as the base for the prices originally for direct care and ancillary and support services. The price for capital is reduced from the median to the 25th percentile. The consolidated services per diem is shifted to direct care, and the franchise fee per diem and workforce development incentive payment are moved to the quality incentive payment, reflecting the focus on access to person-centered services for individuals with the greatest needs. The pricing system being proposed for full implementation for nursing homes will invest a larger percentage of resources in direct care services and in homes that achieve quality. The Medicaid long-term care provider rate currently invests about 50% of the per diem in direct care and quality. The current quality incentive payment averages only about three dollars a day, or about 1.7 percent of the rate. With the proposed changes about 60% of the rate will be invested in direct care and quality; with a quality incentive payment of $14.41 per day, representing about 8.75% of the rate.

As we increase the focus on quality as we set rates, it is important that we shift the focus from the current measures which target business performance, to measures focused on person-centered care, placing value on quality of care, choice and good outcomes for individuals. For example, we would like to reward programs that allow individuals to choose when and what they eat, and that allow them to wake up and go to bed when they choose. We will establish a collaborative process with stakeholders to develop measures that every nursing home in the state could meet and we expect all nursing facilities to have the opportunity to receive the entire quality incentive payment.

Hospitals

Further modernizing is necessary for our hospital reimbursement system, as well. Right now, Ohio Medicaid uses prospective payment methods developed in the late 1980s for hospitals. However, these payment methods are volume-based and are not able to reward providers for improved outcomes. As a result, we propose changing the current system and working with the Ohio Hospital Association and the Ohio Children's Hospital Association on the best way to address this.

Strategic pricing changes include paying no more than cost for certain outpatient services, making improvements to how we pay for inpatient hospital services and moving to mirror federal law to no longer pay for provider-preventable conditions or "never events".

Managed Care

For managed care, we propose to reduce the administrative and medical trend portion of the capitation rate by 1 percentage point. These changes reflect the maturity of the managed care plans' experience in Ohio, reductions in administrative requirements placed on the plans by the Ohio Medicaid program, actual managed care plan experience and national trends. Also, the expansion of the managed care delivery system to include children with disabilities will allow the plans to more efficiently spread their administrative costs across more lives.

We are proposing to reverse the pharmacy carve-out that was implemented in 2010. At the time, the carve-out allowed the department to collect rebates on pharmaceuticals and to provide for a single drug list and prior authorization process. However, the Affordable Care Act allows us to collect rebates on pharmaceuticals provided through the managed care plans and supports the movement towards improved care coordination.

The proposal also requires hospitals that will not contract with managed care plans to instead receive reimbursement at no more than the Medicaid fee-for-service rates. Currently, contracts between hospitals and managed care plans pay, on average, more than 104 percent above the Medicaid fee-for-service rates.

Medicaid Services for Individuals with Developmental Disabilities

Last week Director Martin testified about the Medicaid services administered by the Department of Developmental Disabilities. The Office of Ohio Health Plans also administers two programs specifically for individuals with developmental disabilities: Intermediate Care Facilities and the Transitions Carve-out Waiver-DD. In an important step toward an integrated delivery system for individuals with developmental disabilities, the budget provides for the transfer of both of those programs to DODD so that financing will be available to support the choice of individuals and families between institutional care and home and community based waiver care. In anticipation of that transfer we are working with DODD and stakeholders to explore options for establishing rates for these facilities.

Modernizing Medicaid

Funding Structure

This budget looks very different in terms of how the dollars flow through certain line items and the increased need for state GRF, which has led to confusion. The growth of the Medicaid 525 line is due to:

- The transfer of line items from sister agencies to create a unified long-term care budget and eventual incorporation of a single waiver system;
- Increased caseload projections over FY11; and
- The decrease in the federal share of Medicaid.

MITS

We are replacing our antiquated Medicaid claims payment system. This will permit providers in Ohio Medicaid to use the same tools they use with other insurance companies when they provide and bill for care. Director Colbert will talk more about this tomorrow.

Generic Prescriptions

At this time, the generic dispensing rate, or the percentage of drug claims that are billed for generic drugs, for Ohio Medicaid is 73%. This is in contrast to a study completed by a large health care corporation in 2009 that had achieved an industry-leading overall generic prescription drug penetration rate of 69 percent.

In closing, I would like to emphasize that we welcome the input of any and all interested parties on ways to improve this budget proposal. Economic realities are requiring us to change how we do business. However, those realities also are presenting us with a historic opportunity to create reforms that will (1) allow us to operate more cost-effectively, and (2) better serve those we help. I look forward to working with the Office of Health Transformation, our sister agencies, our stakeholders and members of the General Assembly on implementing the best plan for Ohio.

Thank you again for the opportunity to speak today. I will now be happy to answer any questions.