Ohio Department of Medicaid: FY16-17 Budget Priorities

House Finance Subcommittee on Health and Human Services
February 26, 2015

John McCarthy, Medicaid Director
Today’s Topics

• Overview
• Medicaid Enrollment Overview
  – Newly Eligible Population
• Simplification and Consistency in Eligibility Policy
• Changes in Long-term Care Enrollment
• Changes in School-based Services Benefits
• Reform Hospital Payments
• Reform Nursing Facility Reimbursements
• Reform Managed Care Payments
• Reform Non-Institutional Provider Reimbursement
• Fight Fraud, Waste, and Abuse
• Payment Innovation
<table>
<thead>
<tr>
<th>2011 Ohio Crisis</th>
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<tbody>
<tr>
<td>• $8 billion state budget shortfall</td>
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<td>• 89-cents in the rainy day fund</td>
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</table>
Additional Key Successes

- Procured and implemented a new Medicaid managed care program
- Designed and launched ‘Ohio Benefits’, the state’s new integrated eligibility system
- Successfully implemented the MITS provider payment system
- Introduced a managed care approach to coordinating benefits for dual-eligible beneficiaries (‘MyCare Ohio’)
- Achieved 50-50 ‘balance’ in long-term care spending
- Launched a stand-alone state Medicaid agency
Ohio Medicaid Annual Growth Projections (calculated on a Per Member Per Month basis)

<table>
<thead>
<tr>
<th>State Fiscal Year</th>
<th>JMOC (Optumas) Upper Bound</th>
<th>Medical CPI</th>
<th>JMOC (Optumas) Target</th>
<th>Executive Budget (All Agencies)</th>
<th>Executive Budget (Excluding DD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>3.00%</td>
<td>3.30%</td>
<td>3.00%</td>
<td>1.38%</td>
<td>0.75%</td>
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<tr>
<td>2017</td>
<td>3.60%</td>
<td>3.30%</td>
<td>3.30%</td>
<td>4.50%</td>
<td>4.05%</td>
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<tr>
<td>Avg.</td>
<td>3.30%</td>
<td>3.30%</td>
<td>3.15%</td>
<td>2.94%</td>
<td>2.40%</td>
</tr>
</tbody>
</table>

Source: Ohio Department of Medicaid, [Overall Budget Impact](January 2015).
# Ohio Medicaid Spending (All Funds)

<table>
<thead>
<tr>
<th>All Funds</th>
<th>SFY 2015</th>
<th>%</th>
<th>SFY 2016</th>
<th>%</th>
<th>SFY 2017</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Total</td>
<td>$ 24,764</td>
<td>18.7%</td>
<td>$ 27,309</td>
<td>10.3%</td>
<td>$ 28,252</td>
<td>3.5%</td>
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<tr>
<td>Executive Budget Reforms</td>
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<tr>
<td>Eligibility Reforms</td>
<td>$ (23)</td>
<td></td>
<td>$ 137</td>
<td></td>
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<tr>
<td>Benefit Reforms</td>
<td>$ 57</td>
<td></td>
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<tr>
<td>Reform Health Plan Payments</td>
<td>$ (73)</td>
<td></td>
<td>$ (270)</td>
<td></td>
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<tr>
<td>Reform Physician Payments</td>
<td>$ -</td>
<td></td>
<td>$ 25</td>
<td></td>
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<tr>
<td>Reform Hospital Payments</td>
<td>$ (66)</td>
<td></td>
<td>$ (167)</td>
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<tr>
<td>Reform Nursing Facility Payments</td>
<td>$ -</td>
<td></td>
<td>$ 61</td>
<td></td>
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<tr>
<td>Reform Home Care Payments</td>
<td>$ -</td>
<td></td>
<td>$ (19)</td>
<td></td>
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<tr>
<td>Enhance Community Developmental Disabilities Services</td>
<td>$ 80</td>
<td></td>
<td>$ 219</td>
<td></td>
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<tr>
<td>Program Integrity</td>
<td>$ 9</td>
<td></td>
<td>$ -</td>
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<tr>
<td><strong>Subtotal</strong></td>
<td>$ (16)</td>
<td></td>
<td>$ (91)</td>
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<tr>
<td><strong>Subtotal with Budget Reforms</strong></td>
<td>$ 24,764</td>
<td>18.7%</td>
<td>$ 27,293</td>
<td>10.2%</td>
<td>$ 28,161</td>
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<tr>
<td>Include: Transfers</td>
<td>$ 1,895</td>
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<td>$ 91</td>
<td></td>
<td>$ 91</td>
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<tr>
<td>Executive Budget</td>
<td>$ 26,660</td>
<td>21.5%</td>
<td>$ 27,384</td>
<td>2.7%</td>
<td>$ 28,253</td>
<td>3.2%</td>
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<tr>
<td>Ohio Department of Medicaid</td>
<td>$ (96)</td>
<td></td>
<td>$ (310)</td>
<td></td>
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<tr>
<td>Ohio Department of Developmental Disabilities</td>
<td>$ 80</td>
<td></td>
<td>$ 219</td>
<td></td>
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</tr>
</tbody>
</table>

Source: Ohio Department of Medicaid, [Overall Budget Impact](#) (January 2015).
# Ohio Medicaid Spending (GRF State Share)

<table>
<thead>
<tr>
<th>GRF State Share</th>
<th>SFY 2015</th>
<th>%</th>
<th>SFY 2016</th>
<th>%</th>
<th>SFY 2017</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Total</td>
<td>$ 5,715</td>
<td>6.8%</td>
<td>$ 6,095</td>
<td>6.7%</td>
<td>$ 6,527</td>
<td>7.1%</td>
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<tr>
<td><strong>Executive Budget Reforms</strong></td>
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<tr>
<td>Eligibility Changes</td>
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<td>Benefit Changes</td>
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<tr>
<td>Health plan changes</td>
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<tr>
<td>Physician changes</td>
<td>$ (12)</td>
<td></td>
<td>$ (35)</td>
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<tr>
<td>Hospital changes</td>
<td>12.9</td>
<td></td>
<td>42.3</td>
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<tr>
<td>Nursing Facility changes</td>
<td></td>
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<tr>
<td>Home care changes</td>
<td></td>
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<tr>
<td>Developmental Disabilities System Redesign</td>
<td>$ 30</td>
<td></td>
<td>$ 82</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Fight fraud and Abuse</td>
<td></td>
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<tr>
<td><strong>Subtotal</strong></td>
<td>$ (127)</td>
<td></td>
<td>$ (193)</td>
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<tr>
<td><strong>Executive Budget</strong></td>
<td>$ 5,715</td>
<td>6.8%</td>
<td>$ 5,968</td>
<td>4.4%</td>
<td>$ 6,334</td>
<td>6.1%</td>
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<tr>
<td>Ohio Department of Medicaid</td>
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<tr>
<td>Ohio Department of Developmental Disabilities</td>
<td>$ (157)</td>
<td></td>
<td>$ (275)</td>
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</tr>
</tbody>
</table>

Source: Ohio Department of Medicaid, Overall Budget Impact (January 2015).
Regular FMAP Over Time: SFY 2010-17

Source: Ohio Department of Medicaid
Medicaid Enrollment Overview

• Current Enrollment: 2,979,563 (24,199 below estimates)

• Nearly 4 of 5 individuals covered by a managed care plan (78%)

• Children with special health care needs and dual-eligible individuals now have access to managed care benefits

• Coverage extended to 492,000 newly eligible Ohioans in 2014 (all enrolled in private managed care plans)

• Long-term care: approximately 86,500 served by HCBS waivers; 56,500 living in long-term care facilities
Medicaid Enrollment Overview

Newly Eligible Population:

• Enrollment began in December 2013 with eligibility effective January 1, 2014.

• 138,000 individuals enrolled in first month of eligibility (January).

• Preliminary data (First 4-6 months) indicates:
  – Areas of pent-up demand
  – Near even split among men and women
  – Clear need for behavioral health care and services
# Group VIII Enrollment by Month

**Showing Retroactivity:**

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</tr>
</thead>
<tbody>
<tr>
<td>Jan 2014</td>
<td>23,156</td>
<td>22,093</td>
<td>17,310</td>
<td>33,839</td>
<td>11,981</td>
<td>7,015</td>
<td>14,650</td>
<td>2,724</td>
<td>2,005</td>
<td>1,432</td>
<td>564</td>
<td>455</td>
<td>723</td>
<td>137,947</td>
</tr>
<tr>
<td>Feb 2014</td>
<td>8,782</td>
<td>18,993</td>
<td>8,092</td>
<td>5,706</td>
<td>3,135</td>
<td>2,424</td>
<td>1,073</td>
<td>830</td>
<td>398</td>
<td>197</td>
<td>198</td>
<td>(640)</td>
<td>49,188</td>
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</tr>
<tr>
<td>Mar 2014</td>
<td>15,904</td>
<td>23,741</td>
<td>18,616</td>
<td>7,398</td>
<td>8,540</td>
<td>3,114</td>
<td>2,362</td>
<td>1,002</td>
<td>275</td>
<td>257</td>
<td>(1,204)</td>
<td>80,005</td>
<td></td>
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<tr>
<td>Apr 2014</td>
<td>12,761</td>
<td>11,737</td>
<td>5,166</td>
<td>5,984</td>
<td>2,554</td>
<td>2,627</td>
<td>1,139</td>
<td>518</td>
<td>365</td>
<td>5</td>
<td>42,856</td>
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<tr>
<td>May 2014</td>
<td>10,519</td>
<td>8,686</td>
<td>3,334</td>
<td>1,997</td>
<td>2,543</td>
<td>1,345</td>
<td>602</td>
<td>249</td>
<td>(19)</td>
<td>29,256</td>
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<tr>
<td>Jun 2014</td>
<td>10,923</td>
<td>7,584</td>
<td>2,525</td>
<td>3,165</td>
<td>2,402</td>
<td>1,021</td>
<td>439</td>
<td>135</td>
<td>28,194</td>
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<td>Jul 2014</td>
<td>10,638</td>
<td>6,235</td>
<td>3,695</td>
<td>2,923</td>
<td>2,002</td>
<td>820</td>
<td>403</td>
<td>26,716</td>
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<tr>
<td>Aug 2014</td>
<td>8,466</td>
<td>7,631</td>
<td>2,481</td>
<td>1,691</td>
<td>1,586</td>
<td>663</td>
<td>22,518</td>
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<tr>
<td>Sep 2014</td>
<td>9,054</td>
<td>7,009</td>
<td>1,330</td>
<td>1,578</td>
<td>2,169</td>
<td>21,140</td>
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<tr>
<td>Oct 2014</td>
<td>9,504</td>
<td>5,378</td>
<td>1,264</td>
<td>1,513</td>
<td>17,659</td>
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<tr>
<td>Nov 2014</td>
<td>6,421</td>
<td>5,974</td>
<td>1,863</td>
<td>14,258</td>
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<td></td>
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<tr>
<td>Dec 2014</td>
<td>7,274</td>
<td>8,451</td>
<td>15,725</td>
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<tr>
<td>Jan 2015</td>
<td>6,659</td>
<td>6,659</td>
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<tr>
<td><strong>Total</strong></td>
<td>23,156</td>
<td>30,875</td>
<td>52,207</td>
<td>78,433</td>
<td>58,559</td>
<td>42,323</td>
<td>53,154</td>
<td>28,688</td>
<td>33,912</td>
<td>29,635</td>
<td>19,999</td>
<td>20,459</td>
<td>20,721</td>
<td>492,121</td>
</tr>
</tbody>
</table>
Medicaid Enrollment Overview

Group VIII: Demographics – Men / Women

- Men: 52%
- Women: 48%

Source: Ohio Department of Medicaid
Based on data through February 14, 2015
Medicaid Enrollment Overview

Group VIII: Demographics - Age

- Age 19-34: 42%
- Age 35-44: 18%
- Age 45-54: 23%
- Age 55-64: 17%
Medicaid Enrollment Overview

Group VIII: Individuals with Income

- Working: 42%
- Non-Working: 50%
- Metro: 8%

Source: Ohio Department of Medicaid
Based on data through February 14, 2015
Medicaid Enrollment Overview

Group VIII: Individuals with a Claim

- With a Claim: 82%
- Without a Claim: 18%

Source: Ohio Department of Medicaid
Based on data through February 14, 2015
Medicaid Enrollment Overview

Group VIII: Individuals with a Preventive Visit

- 65% With a Visit
- 35% Without a Visit

Source: Ohio Department of Medicaid
Based on data through February 14, 2015
Preliminary Utilization Comparison: Group VIII vs. ABD and CFC Managed Care (ages 19-64)

Inpatient: Non-Deliveries

Source: Ohio Department of Medicaid
Claims data: QDSS; January-April 2014 dates of service, with claims to date in system as of January 2015.
Preliminary Utilization Comparison: Group VIII Vs. ABD and CFC Managed Care (ages 19-64)

Emergency Department: Outpatient

Source: Ohio Department of Medicaid
Claims data: QDSS; January-April 2014 dates of service, with claims to date in system as of January 2015.
Preliminary Utilization Comparison:
Group VIII Vs. ABD and CFC Managed Care (ages 19-64)

Source: Ohio Department of Medicaid
Claims data: QDSS; January-April 2014 dates of service, with claims to date in system as of January 2015.
Preliminary Utilization Comparison: Group VIII Vs. ABD and CFC Managed Care (ages 19-64)

Pharmacy

[Graph showing prescriptions per 1,000 MIM for ABD MC 19-64, CFC MC 19-64, and Group VIII 19-64 from January to June 2014.]

ABD Trend Line change due to data incompleteness in May and June

Source: Ohio Department of Medicaid
Claims data: QDSS; January-April 2014 dates of service, with claims to date in system as of January 2015.
Preliminary Utilization Comparison: Group VIII Vs. ABD and CFC Managed Care (ages 19-64)

Behavioral Health

Source: Ohio Department of Medicaid
Claims data: QDSS; January-April 2014 dates of service, with claims to date in system as of January 2015.
Group VIII Comparison of PMPM (MC and FFS) Categories of Costs: Shifting FROM Uncoordinated Care Settings (Inpatient and Emergency) TO Coordinated Care Services

January – June 2014 With MCP Estimated IBNR

Source: Ohio Department of Medicaid Q3 MCP Cost Report data through June 2014
Group VIII Comparison of PMPM (MC and FFS) Categories of Costs:
Shifting FROM Uncoordinated Care Settings (Inpatient) TO Coordinated Care Services

January – June 2014 With MCP Estimated IBNR

- Inpatient
- Medical, Outpatient, Dental & Pharmacy

Source: Ohio Department of Medicaid
Q3 MCP Cost Report data through June 2014
Medicaid Enrollment Overview

Percent of Population with a Condition Prescribed One or More Recommended Medications
## Group VIII Income and Health Status

<table>
<thead>
<tr>
<th>Group VIII Income Level</th>
<th>Percent of People</th>
<th>Percent with either: BH procedure; DMHAS provider service; Inpatient Patient Psych claim; IP Detox; or BH Drug (including substance abuse)</th>
<th>Percent with either: BH procedure; DMHAS provider service; Inpatient Patient Psych claim; IP Detox; BH Drug (including substance abuse); or BH primary diagnosis</th>
<th>Percent with Inpatient Psych claim</th>
<th>Percent with Inpatient Detox Claim</th>
<th>Percent with a DMHAS visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earned Income</td>
<td>42%</td>
<td>29%</td>
<td>38%</td>
<td>0.9%</td>
<td>0.4%</td>
<td>11%</td>
</tr>
<tr>
<td>No Earned Income</td>
<td>50%</td>
<td>39%</td>
<td>47%</td>
<td>1.7%</td>
<td>0.9%</td>
<td>20%</td>
</tr>
<tr>
<td>Metro Waiver and/or Unavailable</td>
<td>8%</td>
<td>30%</td>
<td>37%</td>
<td>0.7%</td>
<td>0.6%</td>
<td>12%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>34%</td>
<td>42%</td>
<td>1.3%</td>
<td>0.7%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Source: Ohio Department of Medicaid
# Group VIII Income and Health Status

<table>
<thead>
<tr>
<th>Group VIII Income Level</th>
<th>Percent with Cancer</th>
<th>Percent with Chronic Clinical Condition (includes BH)</th>
<th>Percent with Chronic Clinical Condition that is not Behavioral Health</th>
<th>Percent with a Possible Disabling Clinical Condition</th>
<th>Percent with IP Stay (not delivery)</th>
<th>Percent with a Claim</th>
<th>Percent with a Preventive Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earned Income</td>
<td>5%</td>
<td>72%</td>
<td>68%</td>
<td>11%</td>
<td>8%</td>
<td>8%</td>
<td>80%</td>
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<tr>
<td>No Earned Income</td>
<td>5%</td>
<td>77%</td>
<td>71%</td>
<td>18%</td>
<td>14%</td>
<td>14%</td>
<td>83%</td>
</tr>
<tr>
<td>Metro Waiver and/or Unavailable</td>
<td>6%</td>
<td>78%</td>
<td>74%</td>
<td>15%</td>
<td>7%</td>
<td>7%</td>
<td>86%</td>
</tr>
<tr>
<td>Total</td>
<td>5%</td>
<td>75%</td>
<td>70%</td>
<td>15%</td>
<td>11%</td>
<td>11%</td>
<td>82%</td>
</tr>
</tbody>
</table>

**Source:** Ohio Department of Medicaid
Simplification and Consistency in Eligibility Policy
Disabled Ohioans Have to Prove It Twice

• Every year, about 50,000 Ohioans with a disability qualify for Medicaid coverage:
  – Includes DD, mentally ill, frail elderly and others
  – Some reside in an institution but most live in the community
  – Some have income but “spend down” to qualify for Medicaid
  – Can keep a house and car but no assets above $1500

• Today these Ohioans have to prove they are disabled twice:
  – Via county JFS offices for Medicaid and also
  – Via OOD for Social Security Income (SSI)

• Most states (33) have already eliminated this duplication and automatically enroll SSI individuals in Medicaid
  – Ohio could do this via OOD for SSI and Ohio Medicaid
What is the difference between 209(b) and 1634?

- In a 209(b) state like Ohio, individuals granted Supplemental Security Income (SSI) by the Social Security Administration (SSA) must complete a separate Medicaid application and disability determination process.

- In a 1634 state, individuals eligible for SSI are automatically enrolled in Medicaid.

- 209(b) states are required to operate a Medicaid spend down program; 1634 states are not required to do so.
What is a Spend Down Program?

- A spend down program allows individuals who have income over the eligibility threshold but otherwise meet the requirements for Medicaid under the aged, blind or disabled (ABD) categories to receive coverage.

- Individuals with income over the threshold are assigned an amount of medical expenses they must incur each month (spend down) prior to receiving Medicaid benefits.

- An individual’s spend down is equal to the amount his or her income exceeds the eligibility limit after accounting for applicable income deductions.
Impact on Current Medicaid Enrollees

No change in enrollment for most current beneficiaries:

• Social Security and Ohio Medicaid use exactly the same definitions of disability

• 403,000 beneficiaries, including those in institutions or on home and community based services (HCBS) waivers, will continue to receive Medicaid benefits

• Some in this group at higher income levels will need to put their income in a trust to continue to qualify for Medicaid (currently they “spend down” income every month to qualify)
Impact on Current Medicaid Enrollees

• 7,110 Ohioans who are currently on SSI (but not yet enrolled in Medicaid) will be automatically enrolled in Medicaid

• Most of this group is eligible for Medicaid now but not enrolled – the only newly eligible enrollees will be individuals whose assets are between the Medicaid limit ($1500) and the SSI limit ($2000)
Impact on Current Medicaid Enrollees

*Other coverage options:*

- 4,554 disabled Ohioans would no longer qualify for Medicaid because their income is too high ($>$721 monthly)

- However, Ohio Medicaid will use the 1915(i) state plan option to create a special program for the 3,660 individuals with severe and persistent mental illness with incomes that are too high

- The remaining 924 may enroll in the Exchange or may qualify through a Miller Trust
How does a Miller Trust Work?

- A Miller Trust is a legal structure that allows income in excess of the eligibility limit for Medicaid to be disregarded.

- An individual must place the portion of his or her monthly income that is greater than the current income standard into the trust.

- Individuals may apply certain deductions to these funds, and the remaining amount in the trust is paid to the institution or health care providers.

- On a monthly basis Miller trust funds pay for the cost of care, and Medicaid pays for the care not funded by the trust.

- In cases of a recipient’s death, and should they be subject to a state recovery, any and all funds remaining in the Miller trust, up to the total cost of care, are paid to Medicaid.
Benefits of One System Instead of Two

• Much easier for eligible individuals with disabilities to navigate

• Eliminates the current and significant administrative burden on individuals, counties, and providers

• Advantages for those who move to the Exchange:
  – More affordable to pay premiums and copays on the Exchange but otherwise preserve income that would have been spent down to qualify for Medicaid
  – Continuous coverage without interruption instead of month-to-month Medicaid eligibility based on spend down
# Summary of Policy Changes

<table>
<thead>
<tr>
<th>Policy</th>
<th>Federal SSI</th>
<th>Ohio Medicaid</th>
<th>Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Test</td>
<td>• Defined in federal law</td>
<td>• Same</td>
<td>• Same</td>
</tr>
<tr>
<td></td>
<td>• Same</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income Limit</td>
<td>• 75% of poverty ($721 monthly)</td>
<td>• 64% of poverty ($632 monthly)</td>
<td>• 75% of poverty ($721 monthly)</td>
</tr>
<tr>
<td></td>
<td>• However, no effective limit because federal law requires non-SSI states to allow individuals of any income to “spend down” income to qualify for Medicaid</td>
<td>• Option to establish a Miller Trust to disregard income</td>
<td></td>
</tr>
<tr>
<td>Asset Limit</td>
<td>• $2,000</td>
<td>• $1,500</td>
<td>• $2,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Eligibility Changes

• Align upper threshold of non-ABD adult eligibility with the federal exchange at 138% of the federal poverty level:
  • Pregnant women
  • BCCP
  • Family planning services eligibility group (not the benefit)

• Change the Temporary Medical Assistance (TMA) policy back to the pre-recession policy:
  • Quarterly reporting required
  • Six months of additional Medicaid enrollment with two additional quarters possible if quarterly reported income remains below 185% FPL

• Premiums for non-ABD adults with incomes over 100% FPL
Changes in Long Term Care Benefits
Improve Quality in Home Care

• Ensuring effective, quality **home care oversight** has posed significant challenges among state Medicaid programs.

• Particularly, the oversight of **independent providers** has proven difficult within the high-risk arena of home care.

**During Calendar Years 2010-2014:**

• Medicaid Fraud Control Unit of the Ohio Attorney General’s Office (MFCU) received **1,473 referrals** for home health-related Medicaid fraud. Of those 1,473 fraud referrals, **634 (~43%) were tied to independent providers.**

• MFCU **indicted 535** home health providers. Of those 535 fraud indictments, **335 (~63%) were for independent providers.**

• **479 home health providers were criminally convicted,** and **independent providers accounted for 306 (~64%) of those convictions.**
Improve Quality in Home Care

• 90,000+ Ohioans rely on direct care workers. Most are employed by agencies, but roughly 13,000 are independent providers.

• A majority of states and Medicare only do business with agencies.

• The Budget transitions to an agency-only model over three years:
  – Prohibition on new independent provider enrollment beginning July 2016
  – Prohibition on provider agreement revalidations beginning July 2016
  – Provider revalidations are to be done every three years

• Independent providers will continue to be permitted under ‘self-directed’ waivers/services.
Modernize Nursing Benefit

• There is currently a proposed rule with an effective date of July 1, 2015 to implement new rationalized rates.

• Continue to reform Private Duty Nursing (PDN) by changing the benefit from a state plan long-term benefit to a short-term benefit by July 1, 2016.

• Add nursing to all waivers for individuals that need long-term nursing services:
  – Improves care management through the waiver service coordinator.

• Add the same delegated nursing services available in the DODD waivers to ODM and ODA waivers.
Changes in School-Based Services Benefits
Medicaid in Schools Program

- Ohio Medicaid reimburses schools through the Medicaid in Schools Program (MSP) for services provided to children with an Individualized Education Plan (IEP).

- Reimbursable services are limited to:
  - behavioral health
  - nursing
  - occupational therapy
  - targeted case management
  - specialized transportation

- The school is responsible for providing these services, but can draw federal funds through the MSP program to reimburse 63 percent of the cost.

- Currently 580 school systems enrolled in the MSP program serving 61,000 Medicaid-eligible students with an IEP.
Medicaid in Schools Program

- Proposed expansion of the services that are Medicaid reimbursable include:
  - Intensive behavioral services provided by a Certified Ohio Behavioral Analyst (COBA)
  - Services provided by an aide under the direction of a registered nurse or COBA
  - Specialized transportation from a child’s home to school

- This provision will allow schools to claim additional federal funds of $46.4 million that the school districts otherwise would have been required to provide with their own funds.

- There will be no impact on the state general revenue fund because the school districts provide the local match, through expenditures tied to eligible IEP services, to draw federal Medicaid funds.
Reform Hospital Payments
Reform Hospital Payments

• Reforms the payment methodology for drugs given in a hospital outpatient setting by paying the FFS fee schedule rates instead of 60% of cost

• Consolidates outpatient charges within 72 hours before and after an inpatient stay

• Eliminates the 5% outpatient rate add-on for non-children’s hospitals
Reform Hospital Payments

• Assumes a 1% reduction in potentially preventable readmissions (PPR) because PPR rates are posted to the ODM website:
  – http://www.medicaid.ohio.gov/RESOURCES/ReportsandResearch/ModernizeHospitalPayments.aspx

• New penalties and incentives for PPR rates starting in SFY 17

• Implements National Correct Coding Initiative (NCCI) standards for outpatient hospital claims

• Converts direct medical education subsidy into primary care rate increase

• Increases the hospital franchise fee from 2.75 to 3.0 percent
  – Returns a portion of fees paid via the upper payment limit program

Source: Office of Health Transformation, Reform Hospital Payments (February 2015).
## Reform Hospital Payments: Franchise Fee

<table>
<thead>
<tr>
<th>All funds in millions</th>
<th>SFY 2014 actual</th>
<th>SFY 2015 estimated</th>
<th>SFY 2016 proposed</th>
<th>SFY 2017 proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Baseline (FFS + MCO)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Hospital Franchise Fee</td>
<td>$ 4,302</td>
<td>$ 5,434</td>
<td>$ 5,722</td>
<td>$ 6,105</td>
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<tr>
<td>Proposed increase from 2.75 to 3.0 percent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Hospital Franchise Fee</td>
<td>$ 514</td>
<td>$ 554</td>
<td>$ 554</td>
<td>$ 554</td>
</tr>
<tr>
<td>Proposed increase from 2.75 to 3.0 percent</td>
<td></td>
<td>$ 107</td>
<td>$ 142</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Baseline (FFS + MCO) minus Franchise Fee</strong></td>
<td>$ 3,788</td>
<td>$ 4,880</td>
<td>$ 5,061</td>
<td>$ 5,410</td>
</tr>
<tr>
<td><strong>Supplemental Payments Supported by the Franchise Fee</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managed Care Incentive</td>
<td>$ 162</td>
<td>$ 162</td>
<td>$ 162</td>
<td>$ 162</td>
</tr>
<tr>
<td>Current Upper Payment Limit Program</td>
<td>$ 492</td>
<td>$ 582</td>
<td>$ 582</td>
<td>$ 582</td>
</tr>
<tr>
<td>Proposed UPL gain from increasing the franchise fee</td>
<td></td>
<td>$ 30</td>
<td>$ 62</td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>$ 654</td>
<td>$ 744</td>
<td>$ 774</td>
<td>$ 806</td>
</tr>
<tr>
<td><strong>Baseline Plus Supplemental Payments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$ 4,442</td>
<td>$ 5,624</td>
<td>$ 5,835</td>
<td>$ 6,216</td>
</tr>
</tbody>
</table>

Source: Office of Health Transformation, [Reform Hospital Payments](#) (February 2015).
# Reform Hospital Payments: Other Reforms

<table>
<thead>
<tr>
<th>All funds in millions</th>
<th>SFY 2014 actual</th>
<th>SFY 2015 estimated</th>
<th>SFY 2016 proposed</th>
<th>SFY 2017 proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Plus Supplemental Payments</td>
<td>$4,442</td>
<td>$5,624</td>
<td>$5,835</td>
<td>$6,216</td>
</tr>
</tbody>
</table>

## Hospital Payment Reforms (All Funds)

- Reform payment method for detail-coded drugs
  
  - $22
  
  - $44

- Consolidate outpatient charges
  
  - $6
  
  - $11

- Eliminate 5 percent rate add-on for outpatient services
  
  - $50
  
  - $107

- Reduce potentially preventable hospital readmissions
  
  - $14
  
  - $32

- Implement correct coding standards
  
  - $5
  
  - $10

- Convert medical education subsidies into a primary care rate increase
  
  - $-
  
  - $25

**Subtotal**

| $97 | $229 |

## Ohio Medicaid Hospital Spending

<table>
<thead>
<tr>
<th></th>
<th>SFY 2014</th>
<th>SFY 2015</th>
<th>SFY 2016</th>
<th>SFY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ohio Medicaid Hospital Spending</td>
<td>$4,442</td>
<td>$5,624</td>
<td>$5,738</td>
<td>$5,987</td>
</tr>
</tbody>
</table>

Percent Change

- 26.6%
- 2.0%
- 4.3%

Total Amount of Uncompensated Care - 2013

- Northwest: $170.7 million
- Southwest: $512.9 million
- Southeast: $100.9 million
- Northeast: $489.2 million
- Central: $352.7 million
Estimated Uncompensated Care w/ Group VIII - 2014

**Northwest:**
- Total w/o Expansion: $152.5m
- Actual total w/ Expansion: $57.3m
- 2013-14 Change: -66.42%

**Southwest:**
- Total w/o Expansion: $464.6
- Actual total w/ Expansion: $252.1m
- 2013-14 Change: -50.86%

**Central:**
- Total w/o Expansion: $349.4m
- Actual total w/ Expansion: $176.5m
- 2013-14 Change: -49.95%

**Northeast:**
- Total w/o Expansion: $512.8m
- Actual total w/ Expansion: $185.2m
- 2013-14 Change: -62.75%

**Southeast:**
- Total w/o Expansion: $95.4m
- Actual total w/ Expansion: $65.9m
- 2013-14 Change: -34.66%
Reform Nursing Facility
Reimbursement
Reform Nursing Facility Reimbursement

- Increases NF reimbursement $84 million in 2017 by rebasing the formula (+$154 million) and updating the “grouper” (-$70 million)

- Implements RUGS IV same as Medicare:
  - Ohio uses nationally recognized acuity measurement software that utilizes clinical data collected by CMS.
  - In 2010 CMS updated the data collection tool (to MDS 3.0) and offered states the option of using an updated grouper (RUGS IV).
  - Ohio continued using the older grouper because it aligned with the rate components in effect.
  - The new grouper that reflects current clinical practice will be implemented as the new rate components are calculated.
  - In addition, Ohio will move from 45 acuity groups to 66 acuity groups so that facility payments are more reflective of the differences in the needs of the individuals served.
Reform Nursing Facility Reimbursement

- Links 100 percent of the increase to quality performance
  - Staffing levels above current minimums (recommended by the Consumer Voice, a national advocacy group representing nursing facility residents and their families)
  - Consistent assignment of nurse aides
  - Rate of pressure ulcers across the facility census (both long-stay and short-stay measures)
  - Rate of atypical antipsychotic use for both long-stay and short-stay residents
  - Rate of avoidable inpatient admissions from nursing facilities
Reform Nursing Facility Reimbursement

- Reduces reimbursement for low acuity individuals (-$24 million)
  - Current budget implemented a reduced rate for low acuity individuals.
  - The rate per day paid for the lowest acuity individuals in Ohio’s nursing facilities will be reduced from $130 per resident day to $91.70 per resident day.
  - The Medicaid rate will better align with the needs of the individual while recognizing necessary costs related to room and board and the regulatory requirements related to a licensed setting.

- Removes the nursing facility reimbursement formula from statute
Reform Managed Care Payments
Reform Managed Care Payments

• Sets managed care rates at the bottom actuarial boundary for the third budget in a row

• Uses one-time unearned pay-for-performance (P4P) funds to offset the cost of moving additional populations into managed care and support for health plan activities to reduce infant mortality

• Budgets P4P funds at 63% instead of 100%
Additional Populations

- Additional populations will be served through private insurance companies instead of government run fee-for-service:
  - Adopted and foster children
  - Immediate enrollment into a plan instead of, on average, a 45 day waiting period in FFS
  - Individuals with intellectual and developmental disabilities (optional with an assumed 5% take up rate)
Additional Benefits

Behavioral Health
• Behavioral health benefits will be provided through managed care
  – Behavioral-Health Health Home payment methodology phased out
• ODM, ODMHAS, and OHT will work with stakeholders through a process to decide best delivery model during SFY15

Care Coordination
• Use community health workers from the communities where infant mortality is the highest in order to engaged in culturally connected care coordination and education
Reform Non-Institutional Provider Reimbursement
Reform Non-Institutional Provider Reimbursement

**Primary Care Rates are Increased:**

- Increases Medicaid primary care rates $151 million over two years

- Applies to:
  - Physicians
  - Optometrists
  - Physician Assistants
  - Advanced Practice Registered Nurses

- Estimated increases in rates:
  - Non-facility – 19% (as a % of Medicare 53.6% to 65.4%)
  - Facility – 30% (as a % of Medicare 45.6% to 60.2%)

- Increases Medicaid dental provider rates $5 million over two years
Reform Non-Institutional Provider Reimbursement

From Rationalization of Reimbursement Policy:

• Applies Medicaid maximum payment to Medicare crossover claims (saves $129 million over two years)

• Normalizes payments that are made to only one health system from 140% of FFS to 100% of FFS to align the health system with other providers in the same geographic area (saves $1.5 million)
Fight Fraud, Waste, and Abuse
Fight Fraud, Waste and Abuse

*Electronic Visit Verification:*

- The Executive Budget calls for Electronic Visit Verification (EVV) technology to assist with ensuring the proper delivery and reporting of home care services.

- Several states have already adopted state-of-the-art systems that ensure that necessary services are being rendered in accordance with the proper time, manner, and scope designated in the service plan.

- EVV systems may incorporate various forms of technology such as, GPS, biometrics, tablets, and smartphones.
Fight Fraud, Waste and Abuse

- Releasing an RFP to procure a vendor to use advanced analytics to mine existing data for fraud

- Recoup related physician payments when a hospital claim has denials after it is reviewed by our utilization review vendor
Payment Innovation
## 5-Year Goal for Payment Innovation

**Goal**
80-90 percent of Ohio’s population in some value-based payment model (combination of episodes- and population-based payment) within five years

**State’s Role**
- Shift rapidly to PCMH and episode model in Medicaid fee-for-service
- Require Medicaid MCO partners to participate and implement
- Incorporate into contracts of MCOs for state employee benefit program

### Patient-centered medical homes

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Episode-based payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>In 2014 focus on Comprehensive Primary Care Initiative (CPCi)</td>
<td></td>
</tr>
<tr>
<td>Payers agree to participate in design for elements where standardization and/or alignment is critical</td>
<td>State leads design of five episodes: asthma acute exacerbation, perinatal, COPD exacerbation, PCI, and joint replacement</td>
</tr>
<tr>
<td>Multi-payer group begins enrollment strategy for one additional market</td>
<td></td>
</tr>
<tr>
<td>Payers agree to participate in design process, launch reporting on at least 3 of 5 episodes in 2014 and tie to payment within year</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 3</th>
<th>20 episodes defined and launched across payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model rolled out to all major markets</td>
<td></td>
</tr>
<tr>
<td>50% of patients are enrolled</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 5</th>
<th>50+ episodes defined and launched across payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale achieved state-wide</td>
<td></td>
</tr>
<tr>
<td>80% of patients are enrolled</td>
<td></td>
</tr>
</tbody>
</table>
Patients and providers continue to deliver care as they do today

Patients seek care and select providers as they do today

Providers submit claims as they do today

Payers reimburse for all services as they do today

Patients and providers continue to deliver care as they do today

Providers may:
- Share savings: if average costs below commendable levels and quality targets are met
- Pay part of excess cost: if average costs are above acceptable level
- See no change in pay: if average costs are between commendable and acceptable levels

Calculate incentive payments based on outcomes after close of 12 month performance period

Review claims from the performance period to identify a ‘Principal Accountable Provider’ (PAP) for each episode

Payers calculate average cost per episode for each PAP

Compare average costs to predetermined “commendable” and “acceptable” levels
Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average episode cost per provider)

- **Risk sharing**: Pay portion of excess costs
- **No change**: Payment unchanged
- **No Change**: Eligible for gain sharing based on cost, but did not pass quality metrics
- **Gain sharing**: Eligible for incentive payment

NOTE: Each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost.
Questions