Ohio | Office of Medical Assistance

John R. Kasich, Governor
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Chairman Burke, Ranking Member Cafaro and members of the committee, thank you for the opportunity to testify today before the Senate Finance Sub-Committee on Medicaid. My name is John McCarthy, and I serve as Director of the Office of Medical Assistance, commonly referred to as Ohio Medicaid. Today, OMA's daily operations directly impact the lives of 2.3 million Ohioans receiving health care coverage through the Medicaid program, as well as the state's 70,000+ Medicaid providers.

Over the course of the last two years, Governor Kasich's vision for Medicaid has been grounded on bringing better health outcomes to Ohioans through a person-centered approach, while also implementing new efficiencies aimed at keeping the program honest Ohio's taxpayers.

Recent Accomplishments

The current biennium has been marked by a series of accomplishments that have helped to drive this work forward and change the way that Medicaid is administered across Ohio. This was only made possible by the great work of our staff. A few that I have to thank because of all their hard work over the last two years include Patrick Beatty, Mel Borkan, Cynthia Calendar Dungy, and Dr. Mary Applegate. Examples of these recent reforms include:

- The successful launch of the ***Medicaid Information Technology System*** **(MITS)** in 2011. This new information system has strengthened the state's ability to serve beneficiaries and providers alike through a browser-based administration platform that offers a streamlined, more efficient approach to provider reimbursements and patient claims.

- Ohio Medicaid has reformed its approach to ***managed care*** by providing residents across the state with more choice. Beginning on July 1, beneficiaries will be able to select from five managed care plans for the coordination of their care needs. Those plans include: Buckeye Community Health Plan, CareSource, Molina Healthcare of Ohio, Paramount Advantage, and United Healthcare Community Plan of Ohio.

- Ohio is home to 182,000 individuals who are covered by both Medicaid and Medicare. However, a lack of coordination between the two programs often results in inefficiencies and poor health outcomes for the individual. In December 2012, Ohio became only the third state in the nation to reach an agreement with the Centers for Medicare and Medicaid Services (CMS) on how to better coordinate care for this population. Ohio's ***Integrated Care Delivery System*** is set to launch later this year as 114,000 dual-eligible individuals in 29 Ohio counties will be enrolled into managed care coverage.

- Ohio's Medicaid program has continued to see cost savings and improvement recently. Thus far in State Fiscal Year 2013, Medicaid expenditures have come in $380.7 million under projections – 4.2%. Most recently, total expenditures for the month of January came in at $86.6 million, or 6.4%, under projections.

Extending Medicaid Coverage to More Low-Income Ohioans

On February 4, Governor Kasich announced his state operating budget for Fiscal Years 2014-15. The proposal included a plan to bring Medicaid benefits to 275,000 more Ohioans beginning on January 1, 2014.

The plan would see Ohio extending Medicaid eligibility to those individuals living at or below 138 percent of federal poverty. For the first three years following implementation, this new population would be covered entirely by federal funding. At the conclusion of year three, incremental reductions would begin before leveling-off at 90/10 federal-state match by 2020.

Expansion of this nature is greatly needed to compensate for coverage gaps created through the Affordable Care Act and not addressed by the launch of the new federally-administered health care exchange. Without expansion, parents living from 90-100 percent of federal poverty and childless adults at or below 100 percent poverty would be ineligible for coverage - either through Medicaid or the exchange. Many of the individuals believed to be in this new coverage gap are over 55 years of age - and while looking for work - are finding it difficult to gain employment. Others are unable to work due to mental illness or addiction, and an estimated 26,000 military veterans are also among the uninsured that will fall into the coverage gap.

Meanwhile, it is expected that up to 231,000 Ohioans who are currently eligible for Medicaid - but not yet enrolled - will enroll next year as a result of mandates put forth by the federal health care law. Known as the "woodwork effect," this population includes 92,000 children, 88,000 parents, and 51,000 seniors and carries an estimated cost $1.5 billion ($521 million state share) over the next two years.

From a dollars-and-cents standpoint, Medicaid expansion as it was presented in the "as introduced" House version of the budget would put Ohio's federal tax dollars to work in Ohio. For fiscal years 14-15, more than $2.4 billion in federal funds would find its way into Ohio rather than being spent on bringing health care to the residents of other states. In fact, the Governor's plan for expansion would present $404 million in savings to Ohio's budget over the next two years. Savings would have included:

- DRC/prison costs shifting to Medicaid ($27M)
- State cost of previously eligible enrollees ($91M)
- Elimination of a hospital 5% add-on rate ($96M)
- Reduction to hospital capital payments ($21M)
- Health plan administrative savings ($52M)
- Sales and HIC tax revenue offsets ($117M)

Medicaid expansion would also free up local funds that could then be used to meet local needs. Local mental health and addiction services boards will be able to utilize local dollars that are currently being spent to meet the physical health needs of individuals who are suffering from a mental illness or addiction on services such as housing.

- Sales tax revenue ($25M over the biennium)
- behavioral health services to Medicaid ($105M over the biennium)

As you know, the Governor's proposal to expand Medicaid in Ohio was omitted from the executive budget bill that was reported out of House Finance. In turn, House Bill 59 in its current form lacks the $404 million in savings that would have occurred through the Governor's initial plan. The House also included additional funding for FY14-15 to address mental health and addiction services, with $60 million going for mental health needs and $40 million being directed toward addiction-related services.

While excluding expansion from their budget plan, the House did amend the bill with language that appears to leave the door open to expansion. That language provides Ohio with the opportunity to seek an 1115 waiver or submit a state plan statement to extend Medicaid benefits to more Ohioans. However, the plan must be agreed to with the federal government and submitted to the General Assembly no sooner than September 15, 2013 and not later than October 1 - a mere five months from now. The General Assembly then has until the end of 2013 to enact legislation authorizing the implementation of the plan.

Last week before the Senate Finance Committee, Greg Moody and Ohio's Health and Human Services directors presented details on a revamped plan for expansion known as the "Ohio Health Insurance Option" (OHIO). This plan aims to create a private sector health insurance option in addressing the coverage gaps and mandates created by the federal health care law. The Ohio Option would be a three-year demonstration that enhances competition in Ohio's insurance marketplace while making coverage available to those who would benefit from expansion. The plan includes provisions to:

- create workforce linkages so that beneficiaries can find and keep better jobs;
- strengthen personal responsibility through cost-sharing (co-pays);
- increase access to primary care physicians and other providers; and
- evaluate the results of the three-year demonstration before making a decision to continue the program in the years to come.

From the start of this process, Governor Kasich, Director Moody, and I have continued to work with CMS to find room for innovation and flexibility in addressing the health care landscape of the future. We have made good on that word and have negotiated successfully and in good confidence throughout the past several months. Shutting the door on Medicaid expansion would not only stand in the way of bringing much-needed care to thousands of Ohioans, but may also have a negative effect on Ohio's economy. We hope that the Senate's viewpoint on expansion differs from that of the Ohio House and that - with your help - we may still be able to seek legislative approval to bring health care to more low-income Ohioans.

Ascending to the Agency Level

In light of these recent reforms and successes, Ohio Medicaid is preparing to become its own cabinet-level agency. OMA's transition into becoming its own state agency began with last year's Mid-Biennium Budget Review (MBR). Since then, much progress has been made and we are far ahead of schedule in our efforts to become a stand-alone agency. With that said, the Executive Budget includes language to establish the Ohio Department of Medicaid effective July 1, 2013 – one full year ahead of initial plans.

The creation of a stand-alone Medicaid agency is long overdue. Back-to-back Medicaid study committees in 2005 and 2006 recommended that the creation of a cabinet-level Medicaid department would improve program performance and rein in spending, while a 2006 performance audit by the Auditor of State held that reorganization of the office was necessary in moving forward. A cabinet-level Medicaid department will help in advancing our recent work and innovation while also placing a renewed focus on the administrative aspects of daily operations.

Unified Medicaid Budget

Currently, the Medicaid program spans multiple state agencies yet the accounting system and complex budget structure are not organized to track Medicaid budgets, expenditures, and performance across state agencies. Inefficiencies related to the current structure forces state staff to resort to time-consuming, manual, ad hoc reporting using multiple data sources. Furthermore, the resulting product generally fails to accurately deliver the information necessary to managing the program.

We have proposed to restructure Medicaid-related appropriations line items (ALIs) in a new way, so they can clearly roll up into an enterprise view of Medicaid for internal and external reporting purposes. The new structure captures ALL Medicaid spending across ALL agencies across ALL line items, while limiting confusion by removing non-Medicaid spending from Medicaid lines. The new structure also splits services from administration and support, which at first makes it seem as if administration costs have increased – but now administrative and support costs are being shown for what they are - providing a more accurate picture of how taxpayer dollars are actually being spent.

The new budget structure directly aligns with the Ohio Administrative Knowledge System (OAKS), which means actual spending can now be tracked, creating a real-time view of actual Medicaid spending statewide. The budgeting and accounting changes in this budget are a prelude to better performance tracking and reporting in the future. The new structure provides a foundation on which to build better analytic and reporting tools that will remake previously unusable data into business intelligence – the knowledge required to make better decisions about how to further modernize Medicaid and improve overall health system performance.

Automate Eligibility Determination Systems

Ohio's Client Registry Information System Enhanced (CRIS-E), which supports eligibility determination for Medicaid and the other primary public assistance programs, is more than 30 years old – and is no longer capable of meeting the processing standards for the conversion to the new Modified Adjusted Gross Income (MAGI) eligibility standard to be implemented in January 2014.

The Ohio Department of Administrative Services has contracted with a vendor to replace CRIS-E with a new integrated solution that will support both state and county operations. The new system will also provide the technology necessary for integrating eligibility across Ohio's health and human services agencies. The new system will give individuals and families seeking Medicaid coverage an option to apply online and provide real-time determination for most people who apply. The budget includes $230 million for this system ($26 million state share) over the biennium.

Fighting Fraud and Abuse

This budget reaffirms the State of Ohio's commitment to combating fraud and abuse whenever and wherever it may arise in the Medicaid program.

Budget proposals targeting Medicaid fraud and abuse are expected to save upwards of $74 million ($27.4 million state share), while also bringing about added accountability in the management of services. The following reforms are geared toward savings and efficiency:

- Five positions will be added to the Medicaid audit team to boost monitoring and recovery capabilities *[Savings: $1.5 Million ($554,000 state share)]*

- Through contracting with our vendor, Ohio Medicaid will be able to better identify overpayments and underpayments and will now be able to recoup any excess payments accordingly. [*Savings: $48 million ($18 million state share)]*

- We have also contracted with an outside vendor to perform pre- and post-payment review of hospital service and to advise the state regarding coverage and utilization management. *[Savings: $19 million ($7 million state share)]*. Our vendor has already identified a number of additional program integrity and efficiency measures *[Savings: $6 million ($2.2. million)]*.

While these measures are welcomed steps toward good government and fiscal responsibility, I must express our ongoing commitment to attack system abuse across Ohio. Our Surveillance and Utilization Review Section (SURS) works diligently to review provider's paid claims in order to identify any outliers and anomalies that may be indicative of potential abuse of the Medicaid program. SURS determines high risk areas for potential fraud and audit purposes by working with the OMA program area, the Attorney General's Medicaid Fraud Control Unit, and the Auditor of State's Medicaid audit area. These entities come together each month to coordinate and further stymie fraud, waste and abuse in Ohio.

SURS is often the starting point for identifying fraud and abuse and is a vital asset in keeping us accountable to Ohio's taxpayers. The section makes regular referrals to the Attorney General's Medicaid Fraud Control Unit for review and potential prosecution based on each Medicaid provider's individual circumstances. On a monthly basis, 1,500 inpatient and outpatient claims in the fee-for-service program are examined to review medical necessity, proper coding, place of service, and quality, with the intent of finding items that may have been billed inappropriately.

Audits conducted through SURS ensure that Medicaid providers are not only compliant with state rules and regulations, but also with those at the federal level. This is an important part of our work and will remain prominent in the years ahead.

Home- and Community Based Services

Ohio Medicaid has proposed a 3-percent increase for aide and nursing services in SFY 2015. The increase will take into account labor market data, education and licensure status of providers, whether providers are independent or home-health agencies, and the length of time of service visits. Ohio Medicaid will also create incentives to improve the quality of clinical care by paying in a way that better assures appropriate involvement of registered nurses when licensed practical nurses are providing care. This provision costs $23.0 million ($8.5 million state share) over the biennium.

It is not uncommon for a provider to be a relative or live-in friend of a consumer receiving services in their home or community setting. Operational and administrative expenses for a provider living with a consumer are lower than other providers of similar services, and it is difficult to administer a plan of care in such cases on an hourly basis. Thus, we plan to create unique daily rates for caregivers living with beneficiaries rather than reimburse such providers on hourly or quarter-hourly rates. This provision saves $1.0 million ($370,000 state share) over the biennium.

In late 2010, the Ohio Council for Home Care and Hospice began a campaign to reduce avoidable hospitalizations and participating agencies demonstrated that they in fact had the ability to make these reductions. Ohio Medicaid estimates that as much as 12 percent of the cost of hospital care provided to non-dual eligible recipients of home- and community-based services (HCBS) and other home health benefits may be avoidable. As a result, Ohio Medicaid will be implementing a quality incentive program based on their model to reduce the number of avoidable admissions to hospitals or nursing facilities. This provision will save $6 million over two years and allow Ohio Medicaid to distribute 50 percent of the savings back to participating providers for a net savings of $3.0 million ($1.1 million state share) over the biennium.

Medicaid submitted its application for the Balancing Incentive Payment Program (BIPP) on March 28, 2013. BIPP provides federal grants to states that make structural reforms to increase nursing home diversions and access to non-institutional long-term services and supports. The Executive Budget appropriates $20 million in state share over the biennium to make the structural changes necessary to qualify Ohio for $140 million in enhanced match, freeing up the same amount of state funds to reinvest in Medicaid. As a result, Ohioans will be able to access

home- and community-based services more easily. The process of rebalancing the system will accelerate, and taxpayers will save $120 million state share over the biennium.

Nursing Facility Payment Reforms

While the Executive Budget maintains the current nursing facility rate structure, three changes are being proposed to the current methodology:

- reclassify Stark and Mahoning Counties from peer group 3 to peer group 2 for the purposes of rate setting;
- shift the determination of the facility-specific leave day pricing percentage to a fiscal year;
- and extend the current five-percent enhanced rate to "critical access" nursing facilities, but adds an additional requirement that they earn the maximum quality incentive payment and at least one clinical quality point to qualify for the critical access rate add-on.

To further streamline, the budget sets the franchise fee per bed per day assessment amount to be calculated each year at the maximum percentage allowed by federal law (not to exceed six percent), eliminating the need for routine biennial budget amendments.

In follow-up to discussions we had with legislators regarding custom wheelchairs in the last General Assembly, we have proposed a definition for "custom wheelchairs" and removed them from the calculation of the nursing facility per diem (the per diem is reduced 32 cents). More importantly, we did not simply revert to the previous fee-for-service program to manage custom wheelchair purchasing. Instead, we are proposing to use alternative purchasing models that including: selective contracting, competitive bidding, or a manufacturer's rebate program.

The House moved the implementation date regarding the unbundling of wheelchairs and implementing a new purchasing strategy from FY 2015 to FY 2014. We do not support this change as it is administratively not possible to implement for the beginning of FY 2014.

Current program integrity activities regarding nursing facilities focus on accurate billings and payment and the quality of the services purchased. This budget aligns the Medicaid claims review process for nursing facilities with that applied to other provider types, streamlining the process and allowing nursing homes and Ohio Medicaid to resolve payment issues more quickly.

The budget also authorizes Ohio Medicaid to terminate the Medicaid provider agreement of nursing facilities with a history of providing poor quality care without improvement. The federal government operates a Special Focus Facility Program that identifies facilities with more deficiencies than most others, more serious deficiencies, and a pattern of serious deficiencies. The budget gives Ohio Medicaid another tool to ensure the quality of long-term services and supports in Ohio by terminating the provider agreement of a facility that either fails to improve within 12 months of being placed on the list or fails to graduate from the list within 24 months of being placed on the list.

The House added a provision requiring the Department of Aging to provide technical assistance to such a nursing facility through the Nursing Home Quality Initiative at least four months before ODM would be required to terminate the facility's Medicaid participation.

As Director Kantor-Burman will explain in her testimony, the House made a number of changes to the nursing facility quality incentive payment. Among those changes, the House added $30 million per year for the quality incentive bonus payments.

Reform Health Plans Payments

Over the last year, Ohio Medicaid initiated several significant changes to its managed care program.

- Consolidating health plan regions from eight to three.
- Giving beneficiaries by having five plans present in each region.
- Allowing each health plan to operate across the state.
- Requiring plans to pay for value instead of volume.
- Implementing a new Integrated Care Delivery System.
- Transitioning approximately 37,000 Ohio children from an uncoordinated and often difficult to navigate system to a coordinated care managed system.

This two-year plan continues Ohio Medicaid's commitment to using managed care as a core strategy to improve health outcomes for Medicaid beneficiaries and to reduce costs for taxpayers.

Given the maturity of Ohio's Medicaid managed care program and the economies of scale expected to result from increased enrollment due to the woodwork effect and the extension of Medicaid coverage, health plan administrative rates will reflect a one percent decrease. This change is expected to save $140 million ($52 million state share) over the biennium. The budget provides the plans with greater flexibility to manage pharmacy costs, which allows for a five percent adjustment in the component of the capitation rate that is driven by projected prescription drug costs. This is expected to save $136 million ($50 million state share) over the biennium. Additionally, the budget holds the trend of overall growth in capitation claims to three percent per year, which will save an estimated $370 million ($137 million state share) over the next two years.

The House restored this decrease in health plan administrative rates.

The budget also authorizes Ohio Medicaid to increase the amount of health plan payments it withholds pending a plan's ability to demonstrate that certain performance outcomes are met to two percent. The performance payment withhold will be implemented for both the current children and families program and the new Integrated Care Delivery System (ICDS) for Medicare-Medicaid enrollees.

Reform Hospital Payments

The budget proposal includes several provisions impacting hospitals. It reauthorizes temporary assessment programs and supplemental payment programs that would otherwise expire and makes several significant changes in hospital payment policy.

The Ohio Hospital Care Assurance Program (HCAP) is Ohio's primary means of implementing the federal disproportionate share hospital (DSH) payment program. This provides payments to hospitals that provide care to a disproportionate share of indigent patients. Ohio hospitals fund the state share of this program through a provider assessment. Ohio's program sunsets every two years and must be reauthorized. The budget bill reauthorizes HCAP until October 2015, which will result in hospitals receiving approximately (depending on federal allotments) $1.1 billion in DSH payments over the biennium, $726 million net of HCAP assessments.

After the Ohio Hospital Association raised concerns with the temporary language regarding the HCAP program, OMA worked with them to amend this language. However, the amendment that was included in the House bill was not the final agreed upon version and we will continue to work with OHA on this amendment.

The Executive Budget allows the temporary five percent rate increase for hospitals – that was authorized in the last budget – to expire on December 31, 2013. Ohio currently uses franchise fee proceeds to fund the rate add-on. Eliminating the add-on will save $260 million ($96 million state share) over the biennium.

The House restored the temporary five percent rate increase to hospitals, while also adding temporary language authorizing the continuing of the increase. We are concerned that the way this language is drafted may inhibit our ability to implement the new base prices with the new diagnosis related groupers that will be implemented on July 1, 2013. HB 153 directed Ohio Medicaid to update the DRG reimbursement system and earlier this spring Medicaid and the hospital associations came to an agreement on a new system.

Ensuring quality care at our children's hospitals remains a primary goal of our work. We have included a provision to redirect the temporary special children's hospital funding that was authorized in the last budget to financially support delivery system changes that improve health outcomes for children. As a result, $33 million ($12 million state share) over the biennium will be redirected (the provision is budget neutral) to support payments to children's hospitals for developing programs that achieve specific performance outcomes.

This budget meets problematic levels of hospital readmissions head on. Our proposal limits Medicaid payments to hospitals for readmissions within 30 days by establishing percentage-based benchmarks for readmission reductions. These reductions will be 25 percent of total readmissions based on stays for all non-psychiatric hospitals per fiscal year. OMA is working with the hospital associations to develop the implementing policy behind this initiative. The provision is expected to save $103 million ($38 million state share) over the biennium.

The House added language to implement a Hospital Readmissions Advisory Workgroup. However, we believe this workgroup is unnecessary as Medicaid is currently working with the hospital associations to draft the implementing policy.

Medicaid direct medical education payments are presently made as an add-on to inpatient hospital claims. The Governor's budget does not change the current level of direct graduate medical education funding, but it does propose targeting those funds to support health sector workforce priorities such as mitigating underserved areas in Ohio and recruiting minorities into health professions. While budget neutral, the opportunity to focus $200 million over the biennium to positively improve workforce priorities is significant.

Historically, Medicaid health plans have reimbursed hospitals using the same capital rate as calculated for fee-for-service inpatient capital costs. Last year, Ohio Medicaid began setting specific managed care capital rates for hospitals, and we have determined that further adjustments are needed to reduce the extent to which taxpayers subsidize hospital building campaigns through Medicaid. The budget will reduce inpatient capital rates from 100 percent of cost to 85 percent of cost for both fee-for-service and Medicaid managed care plans, while eliminating fee-for-service capital cost settlement. This provision will save $58 million ($21 million state share) over the biennium.

While the House retained the language from the as-introduced in 5167.10 – which prohibits managed care plans from paying more than the maximum rate established by the Medicaid director – they restored the savings this initiative would have realized.

Ohio Medicaid currently reimburses hospital services provided by DRG-exempt hospitals at 100 percent of cost, which is higher than what Medicaid pays for other inpatient hospital services through the DRG system. The Executive Budget adjusts reimbursement for DRG-exempt hospitals to pay 90 percent of cost. The budget also eliminates fee-for-service cost settlement. This provision will align reimbursement for DRG-exempt hospitals with Ohio Medicaid's strategic pricing goals and save $12 million ($5 million state share) over the biennium.

Ohio Medicaid reimburses most hospitals for outpatient services based on predetermined fee schedules. Although the majority of services have a set reimbursement rate, there are some that are reimbursed at cost (i.e., unlisted surgeries, drugs administered with IV therapy, and independently billed drugs and medical supplies). This results in large variations in payment. The budget bill sets fixed prices for all outpatient services currently reimbursed at cost, and the hospital laboratory fee schedule will be recalibrated to align payment rates to prescribed Medicare ceilings. These changes will save $67 million ($25 million state share) over the biennium.

Reform Other Provider Payments

Other proposed provider payment changes will save $165 million ($61 million state share) over the biennium. These savings are in addition to changes described separately for health plans, hospitals, nursing facilities, and home and community based long-term services and supports.

The federal government requires states to raise Medicaid fees at least to Medicare levels for family physicians, internists and pediatricians for certain primary care services. Physicians in both fee-for-service and managed care will get the enhanced rates. In Ohio, these primary care physicians should have seen their Medicaid payments increase 82 percent on January 1, 2013 and can expect to receive an estimated $700 million more in Medicaid payments over the two-year period ending December 31, 2014 - all of which is paid for by the federal government. The physician fee increase does not appear as an additional state share cost in the Executive Budget.

Medicaid currently reimburses physicians, advanced practice nurses and physician assistants the same amount for some services, regardless of where the service is delivered. The expenses actually incurred by the provider, however, vary depending on the site of the service. The provider bears the full practice expense for services performed in the office setting, but not elsewhere. Medicaid currently enforces "site differential payments" when some services are performed in a hospital. The budget bill extends site differential pricing to a greater number of settings and a broader array of covered services, consistent with federal Medicare policy. This provision will save $12.2 million ($4.5 million state share) over the biennium.

Since 1992, the Holzer Clinic has been reimbursed at 140 percent of the Medicaid physician fee schedule. The enhanced rate supported one rural clinic, but over time the Holzer Clinic expanded to ten new delivery sites and expansion continues, with every new site receiving enhanced reimbursement. Continuance of this payment methodology and the competitive advantage it provides cannot be justified in the current environment – no other physician group besides Holzer has ever qualified for this payment methodology since it was implemented. The Executive Budget eliminates the enhanced reimbursement rate for the Holzer Clinic Network and reverts payment to the standard Medicaid physician fee schedule beginning January 1, 2014. This provision will save $3.0 million ($1.1 million state share) over the biennium.

The House eliminated the requirement that OMA promulgate rules to no longer pay Holzer at 140% of the professional fee schedule and restored the funding.

At present, imaging services are reimbursed the same amount, regardless of whether single or multiple procedures are performed at the same session. The expense of providing multiple procedures to the same patient at the same time is less than the cost of providing these same procedures individually at different times to different patients. In recognition of this practice expense differential and consistent with federal Medicare policy, the budget reduces reimbursement amounts for physician offices and independent diagnostic testing facilities when two or more imaging procedures are performed by the same provider on the same patient on the same day. This provision will save $5.0 million ($1.9 million state share) over the biennium.

Ohio Medicaid will add a pharmacist to our staff to monitor utilization and implement cost containment strategies concerning specialty pharmaceuticals, which include high-cost biological medications for serious chronic conditions. Appropriate use of these products can slow or halt disease progression. Specialty pharmacies that dispense these drugs can provide additional clinical and administrative support to ensure the drugs are used at the proper point in therapy, administered in the best setting, and used consistently and correctly by the patient. The Executive Budget gives our agency the necessary tools to work with specialty pharmacies to contain costs,

including contracting with a limited number of pharmacies to ensure high quality service and clinical support or implementing minimum standards that current participating specialty pharmacies must follow. This provision will save $4.8 million ($1.8 million state share) over the biennium.

The Executive Budget provides resources to contract with a private sector vendor to update connections between the Medicaid pharmacy claims system and eligibility files to e-prescribing applications. By providing claims history to Medicaid providers, the prescriber can quickly find out what prescriptions the patient has filled to ensure that duplicative therapy and drug interactions can be avoided. Providing drug coverage information through the e-prescribing application will enable the prescriber to choose a medication that is covered without prior authorization so there is no delay in the patient beginning therapy. The resulting efficiency and improved quality in prescribing will save $2.2 million ($814,000 million state share) over the biennium.

Since 1986, the federal government has required states to conduct a survey of pharmacy cost of dispensing biennially. However, there is no requirement that pharmacy providers participate. Many pharmacies, particularly chain pharmacies, have said they only participate in surveys that are required by law. The 2011 survey had a 17 percent response rate. The information from the survey is important for any future changes in dispensing fees the state wants to consider, so the budget makes participation a requirement in law. This provision is budget neutral.

For consumers enrolled in Medicaid and Medicare, states have the option to pay the patient's Medicare cost sharing amount (typically 20 percent) or reimburse up to the Medicaid maximum amount. Ohio has elected to only reimburse up to the Medicaid maximum for institutional categories of services and for services paid by a Medicare Advantage plan. However, there is an exemption for non-institutional providers. These providers are paid the full Medicare cost sharing, which can result in the provider being paid more that the Medicaid maximum amount. The Executive Budget authorizes Ohio Medicaid to reimburse only up to the Medicaid maximum for all remaining Part B categories of service, not including physician services. This provision will save $97.2 million ($35.9 million state share) from non-institutional services and $40.0 million ($14.8 million state share) from dialysis clinics over the biennium.

Payment Innovation

In addition to the payment reforms included in the Jobs Budget and the Jobs Budget 2.0, Ohio is taking significant steps to engage public and private sector partners to design and implement systems of payment that signal powerful expectations for better care. The ultimate goal is to align public and private health care purchasing power to standardize and publicly report performance measures and reform the health care delivery payment system to reward the value of services, not the volume. Tomorrow you will hear from Director Moody regarding the work OHT has been doing around payment reform.

Conclusion

In order for any Medicaid program to be successful, it must develop strong and ongoing partnerships across the private sector. While here in Ohio and in my previous positions in Washington and Arizona, I have learned that it often proves beneficial to tap the private sector's expertise and innovation. In fact, much of our recent success has only been made possible through Ohio Medicaid's ability to become largely privatized.

For instance, we do not employ doctors to provide cookie-cutter methods of care to Ohioans, but rather we pay and entrust doctors in the private sector to care for those on the Medicaid rolls. We also contract with private companies to provide health care coverage to the 1.6 million people in managed care. Furthermore, we do not own any nursing homes. Instead, we pay nursing homes for the services they provide while assisting in the much-needed oversight that keeps them accountable to Ohio's taxpayers. We even went so far as to outsource our claims processing system. When I entered this job two years ago, the plan was to bring MITS in and have state employees run it. Frankly, that was not in the best interest of our state, nor did it fit our ongoing charge of modernizing Medicaid. So, we chose not do that, instead opting to contract with a private company to run MITS.

Thank you again Chairman Burke, Ranking Member Cafaro and members of the Sub-committee for the opportunity to discuss Ohio Medicaid's budget initiatives. I am happy to answer any questions you may have.