Ohio | Office of Medical Assistance

John R. Kasich, Governor
John B. McCarthy, Director

House Finance Health Sub-Committee
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Chairwoman Gonzales, Ranking Member Foley and members of the committee, thank you for the opportunity to testify today before the House Finance Health Sub-Committee. 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 low-income Ohioans receiving health care coverage through the Medicaid program, as well as the state's 70,000+ Medicaid providers.

Since assuming office two years ago, Governor Kasich has outlined a vision for Medicaid that is grounded on bringing better health outcomes to Ohioans through a person-centered approach, while also implementing new efficiencies to taxpayers in our state.

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. The only reason we were able to accomplish so many of these is because of our great 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:

- Medicaid Information Technology System – After several years in the making, 2011 saw the launch of a new information system aimed at strengthening the state's ability to serve beneficiaries and providers alike. MITS is a browser-based administration platform that offers a streamlined, more efficient approach to reimbursing providers and resolving patient claims.

- Managed Care Procurement – Ohio Medicaid has reformed its approach to managed care by allowing more choice to residents across the state. Beginning on July 1, Medicaid beneficiaries will be able to select from five managed care plans for the coordination of their care needs. Those five plans are: Buckeye Community Health Plan, CareSource, Molina Healthcare of Ohio, Paramount Advantage, and United Healthcare Community Plan of Ohio. With this change all Ohioans will have access to all five plan options, making person-centered care coordination a higher priority.

- Integrated Care Delivery System – 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 hopes of combating this trend, 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 ICDS proposal is set

to launch later this year and will see 114,000 dual-eligible individuals in 29 Ohio counties be enrolled into coverage through managed care. I have to thank Harry Saxe, Christi Pepe, and Kim Donica. It was due in large part to their hard work and great ideas that we were able to obtain a signed MOU with CMS.

- Cost Savings – Administration of Ohio's Medicaid program continues to improve over recent years. 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.

Ascending to the Agency Level

In light of these recent reforms and successes, it only makes sense that Ohio Medicaid's next step is to become its own cabinet-level agency. Last year's Mid-Biennium Budget Review (MBR) set into motion the process for OMA to begin its transition into a state agency. I am happy to report that much progress has been made since the passage of that legislation and that we are far ahead of schedule in our efforts. With that said, the Governor's Executive Budget includes language to establish the Ohio Department of Medicaid effective July 1, 2013 – one full year before what was proposed in the MBR.

The move to create a stand-alone Medicaid agency in Ohio 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. Creation of a new Medicaid department will allow for our recent work and innovation to continue while also placing a renewed focus on the administrative aspects of daily operations.

As seen in the Executive Budget, the new Medicaid department will report higher administrative costs in FY 2014 than in FY 2013. This increase arises from a number of factors such as:

- first and foremost, the necessary structural accounting changes aimed at boosting transparency;
- the costs associated with shifting out of the Department of Job and Family Services and into a new executive agency; and
- new initiatives centered on our continuing commitment to modernize the Medicaid program in Ohio.

It is important to note that more than 80 percent of the administrative increase will occur with or without the separation from ODJFS. Furthermore, Ohio Medicaid shares the cost of its administrative overhead with the federal government. In fact, the state GRF share of Medicaid administrative costs in the budget is only 23.5 percent and the rest is paid from federal or special revenue funds. (Figures 1 and 2)

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. This inability of the current structure to support an enterprise view of the program compels state staff to resort to time-consuming, manual, ad hoc reporting using multiple data sources – and the resulting product generally fails to accurately and transparently deliver the information necessary to track and manage 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. It removes non-Medicaid spending from Medicaid lines, so there is no confusion about the source or purpose of funding. The new structure also splits services from administration and support, which at first makes it seem as if administration costs have increased when in fact it is similar – but now administrative and support costs are being shown for what they are, providing greater budget transparency and 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. (Figure 3)

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. The current system is not capable of meeting the processing standards for the conversion to the new Modified Adjusted Gross Income (MAGI) eligibility standard required by Obamacare to be implemented January 2014.

The Ohio Department of Administrative Services has contracted with a vendor to replace CRIS-E with a new, integrated, enterprise solution that will support both state and county operations. Maybe most importantly, the new system will provide the technology necessary for integrating eligibility across Ohio's health and human services agencies. The project will focus first on Medicaid eligibility, then expand to other programs that currently depend on CRIS-E (this phase will retire CRIS-E), and finally expand to support other health and human services programs. 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.

In addition to the CRIS-E replacement, DAS will release a request for proposals (RFP) in February 2013 to acquire an organizational change management (OCM) vendor to coordinate the transition from the current business environment to a new, more efficient and effective business environment. Combined with the simplification of eligibility policy, the new integrated eligibility system provides the opportunity to improve the business processes involved with enrolling Ohio citizens in health and human services programs. The Executive Budget includes funding for this project and leverages 90 percent in federal funds.

Fighting Fraud and Abuse

Of course, the end goal of launching a stand-alone Medicaid department is to provide a more efficient, higher quality program that remains accountable to Ohio's taxpayers. 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 efficiency and accountability in the management of services. The following is a breakdown of reforms 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 has proven to be a vital asset in providing accountability and honesty 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. Additionally, 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.

Long Term Care

Earlier this week the sub-committee heard from Director Kantor-Burman on budget initiatives regarding nursing facility payments and home- and community-based services. Among those items were:

- Update the quality incentive rate component
- Make changes in patient liability
- Implement a shared savings initiative for home health
- Limit the daily rate for a caregiver living with a consumer
- Increase rates for aide and nursing services
- Join the Balancing Incentive Program
- Consider some modifications in the nursing facility base rate methodology

If you have further questions on those initiatives, I will be happy to answer those at the end my testimony.

I would like to discuss, in more depth, provisions that are included in the budget regarding long-term care services. While some of the initiatives have costs to the state, the changes being made will help ensure individuals receiving long-term services and supports are receiving quality care in the setting of their choice.

Home- and Community Based Services

Ohio Medicaid has proposed to increase the budget for Medicaid aide and nursing services three percent 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. As part of the rate design, Ohio Medicaid will 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 are proposing to create unique daily rates for a caregivers living with a beneficiary rather than reimburse such a

provider on an 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 Medicaid home health benefits may be avoidable. Based on this evidence, 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. The incentive program will save $6 million over two years and allow Ohio Medicaid to distribute 50 percent of the savings back to participating providers, for net savings of $3.0 million ($1.1 million state share) over the biennium.

Medicaid will be submitting its application for the Balancing Incentive Payment Program (BIPP) this quarter. 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;
- 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.

The peer group change adds $40 million ($15 million state share) over the biennium and generates $4 million in franchise fee revenue.

The Executive Budget also modifies the method that is used to calculate the nursing facility franchise permit fee assessment rate. The proposal replaces actual fee amounts, which have to be recalculated based on projected net patient revenue each biennium and amended to statute to reflect revised rates. Instead, 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.

Nursing facility residents are required to contribute to their nursing facility costs, but may retain an amount of their personal funds for items not covered by Medicaid such as clothing, personal items, and newspapers. The current personal needs allowance is $40 per month and has not been increased since 1997. The budget proposes to increase the personal needs allowance to $45 per month in calendar year 2014 and $50 per month in calendar year 2015. This provision costs $6.4 million ($2.3 million state share) over the biennium.

After discussions with legislators regarding custom wheelchairs in the last General Assembly, we have proposed in the budget 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 have proposed to use alternative purchasing models for custom wheelchairs, including selective contracting, competitive bidding, or a manufacturer's rebate program.

Ohio's nursing homes have significant underutilized capacity. In some cases, these facilities could serve a population that is currently served in more expensive rehabilitation hospitals and long-term, acute-care hospitals (LTACHs). The Nursing Facility Reimbursement Subcommittee recommended and the budget includes payment changes that prioritize post-acute rehabilitation in nursing facilities, not hospitals. It creates a specialty nursing facility service category in Ohio for individuals who would otherwise be served in rehabilitation hospitals and LTACHs, and authorizes a new ventilator weaning program.

Currently, program integrity activities related to nursing facilities focus on accurate billings and payment, as well as 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.

Governor Kasich's budget includes a proposal that 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. They publish a list monthly identifying recently added facilities, those that remain on the list without improving, those that remain on the list but are improving, and those that recently graduated from the list. 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.

Reform Health Plans Payments

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

- Consolidating health plan regions from eight to three.
- Giving beneficiaries more choice by having two or three plans per region to five.

- Moving from plans being present in small sometimes non-contiguous regions to all plans operating statewide.
- 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 also provides health 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.

We continue to take steps to link payment with performance. The budget authorizes Ohio Medicaid to increase the amount of health plan payments it withholds pending the plan's ability to demonstrate 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. Because the ICDS involves Medicare services, the federal government will have input on the design of ICDS quality incentives.

Reform Hospital Payments

The budget proposal includes several provisions that impact hospitals. It reauthorizes temporary assessment programs and supplemental payment programs that would otherwise expire and makes several significant changes in hospital payment policy. (Figure 4)

The budget bill reauthorizes the hospital franchise permit fee program (which would otherwise sunset on June 30, 2013) and incorporates the franchise fee allocation methodology developed by the Ohio Hospital Association, which collects $524 million in annual fees that are used to draw federal funds and make payments back to hospitals totaling $840 million.

The Ohio Hospital Care Assurance Program (HCAP) is Ohio's primary means of implementing the federal disproportionate share hospital (DSH) payment program, which provides additional 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 Executive Budget 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.

The Executive Budget will allow the temporary five percent rate increase for hospitals 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.

Ensuring quality care at our children's hospitals remains a primary goal of our work. The Executive Budget redirects the temporary special children's hospital funding that was authorized in the last budget to financially support delivery system changes that improve outcomes for children enrolled in Medicaid. 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 will make strides toward reducing the problematic levels of hospital readmissions seen across our state. The proposal limits Medicaid payments to hospitals for readmissions within 30 days by establishing percentage-based benchmarks for readmission reductions. These readmission reductions will be 25 percent of total readmissions based on stays for all non-psychiatric hospitals per fiscal year. Hospitals will be provided with a report that tracks their readmission rates over a seven-year period and will have the responsibility to implement hospital-developed approaches to reducing their readmission rates by 25 percent. Failure to achieve this will result in the state recovering 25 percent of the value of Medicaid payments to the hospital for readmissions from the base year. The base year will be the prior year's readmissions and payments for readmissions. If hospitals meet the benchmark each year, readmissions will be reduced by 44 percent in total and result in substantially fewer program payments for readmissions. This provision is expected to save $103 million ($38 million state share) over the biennium. Over the long term, Ohio Medicaid will incorporate "potentially preventable readmissions" and "potentially preventable complications" into the inpatient hospital all payer diagnosis related grouper reimbursement (APDRG) system. These groupers use clinical information from historical claims to determine the appropriateness of paying a current claim if it is related to a readmission.

Today, Medicaid direct medical education payments are made as an add-on to inpatient hospital claims. The Governor's budget does not change the current level of Medicaid direct graduate medical education funding, but it does propose to target those funds to support health sector workforce priorities such as primary care, 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. Beginning January 1, 2012, Ohio Medicaid set specific Medicaid managed care capital rates for hospitals and, as a result of that process, determined that further adjustment to the capital rates is needed to reduce the extent to which Ohio 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, and eliminate fee-for-service capital cost settlement. This provision will save $58 million ($21 million state share) over the biennium.

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 will adjust 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 a few services, such as unlisted surgeries, drugs administered with IV therapy, and independently billed drugs and medical supplies that are reimbursed at cost. This results in large variations in payment for these services. 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

The Executive Budget makes other provider payment changes that 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 will see their Medicaid payments increase 82 percent on January 1, 2013, and 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.

Currently, Medicaid 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 in hospitals, ambulatory surgery centers, and nursing facilities – these facilities bill the practice expense separately. Medicaid currently enforces "site differential payments" when some services are performed in a hospital. The Executive Budget 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.

Currently, Medicaid reimburses imaging services the same amount, regardless of whether single or multiple procedures are performed at the same session. The practice expense cost 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, preventing further disability and other medical costs. 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 Ohio Medicaid the tools it needs 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.

In January 2012, Ohio joined Catalyst for Payment Reform, an independent, national non-profit organization that leverages the collective strength of private- and public-sector health-care purchasers to achieve better value and quality in health care. We were the first state Medicaid program to participate in the organization's efforts.

Governor Kasich has also established The Governor's Advisory Council on Health Care Payment Innovation which includes:

- purchasers (Bob Evans, Procter & Gamble, GE Aviation, Council of Smaller Enterprises and Cardinal Health)
- plans (Aetna, Anthem, CareSource, Medical Mutual, UnitedHealthcare)
- providers (Akron Children's, Catholic Health Partners, Central Ohio Primary Care, Cleveland Clinic, North Central Radiology, Ohio Health, and ProMedica)
- Consumers (AARP, Legal Aid Society, Universal Health Care Action Network)
- Research (Health Policy Institute of Ohio)

In September of last year, Ohio submitted a grant application to CMS for a State Innovation Model Design Initiative (SIM). Initiative is providing nearly $300 million to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance for residents of participating states. Just last week, Ohio was awarded $3 million to develop and implement evidence-based health care strategies that improve the health of individuals rather than simply treat disease.

Ohio will use the SIM grant to develop a comprehensive plan to expand the use of patient-centered medical homes (PCMH) and episode-based payments for acute medical events to most Ohioans who receive coverage under Medicaid, Medicare and commercial health plans. The Governor's Office of Health Transformation will lead the design team in partnership with the Governor's Advisory Council on Payment Innovation. The design phase will last six months and conclude with a plan to implement both models statewide.

Conclusion

While I did not cover our decision to extend Medicaid coverage to individuals under 138 percent of poverty, I must stress the importance of how extending coverage will offer health coverage to 245,000 low-income Ohioans. Additionally, such a move will help in supporting a workforce that is attractive to job creators – those same job creators who may have to face detrimental effects due to Obamacare.

It is also important to note that should Medicaid coverage not be extended, further cuts will need to be made to the Medicaid budget. Over the next two years, Ohio taxpayers would need to pay an additional $404 million in state general revenue ($690 million all funds).

Throughout this process, we have to remember that 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 expertise and innovation offered by the private sector. 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.

The initiatives in this budget, as well as the payment reform initiatives outlined by Director Moody, will allow the State of Ohio to continue its work in reforming Medicaid.

Thank you again Chairwoman Gonzales, Ranking Member Foley and members of the Sub-committee for the opportunity to discuss Ohio Medicaid's budget initiatives. I believe that these initiatives will help us continue our efforts to modernize Medicaid to control costs and ensure Ohioans received quality care. I am happy to answer any questions you may have.

Figure 1.

ODJFS and Medicaid Operating Budget Summary

Administrative Cost	FY 2013 ODJFS with Medicaid	FY 2014 ODJFS Only	FY 2014 Medicaid Only	FY 2014 Combined	FY 2013-14 Change	FY 2013-14 % Change
Baseline Request:	***$755.0***	***$514.6***	***$250.1***	***$764.7***	***$9.7***	***1.2%***
Payroll	*$328.5*	*237.2*	*$77.5*	*$314.7*	*-$13.8*	
Contracts		*89.1*	*$144.1*	*$233.1*	*$26.4*	
$206.7		*177.7*	*$26.6*	*$204.2*	*-$5.6*	
Maintenance						
$209.8						
Equipment	*$9.9*	*10.6*	*$1.9*	*$12.5*	*$2.6*	
Add: New Items	***$171.9***		***$311.2***	***$311.2***	***$139.3***	***81.0%***
IT projects including eligibility	*$97.2*		*$170.3*	*$170.3*	*$73.1*	
ACA implementation (Woodwork)	*$0.0*		*$0.9*	*$0.9*	*$4.9*	
ACA implementation (Expansion)	*$0.0*		*$1.3*	*$1.3*	*$1.3*	
ACA implementation (Staff)	*0.0*		*$3.5*	*$3.5*	*$3.5*	
Balancing Incentive Program	*$0.0*		*$26.7*	*$26.7*	*$26.7*	
Accounting changes-volume contracts	*$74.7*		*$76.7*	*$76.7*	*$2.0*	
Staffing Increase	*$0.0*		*$3.0*	*$3.0*	*$4.0*	
New Department Contingency	*$0.0*		*$28.8*	*$28.8*	*$28.8*	
Total	***$926.9***	***$514.6***	***$561.4***	***$1076.0***	***$149.1***	***16%***

Source: OAKS Budget and Planning Module – Payroll/Contract/Maintenance/Equipment account codes only. SFY 2013 is adjusted to include accounting changes planned for SFY 2014-2015

Figure 2.
Medicaid Operating Budget Summary by Funding Source

Administrative Cost	FY 2014 All funds	FY 2014 GRF	FY 2014 SSR	FY 2014 FED	GRF%	SSR%	FED%
Baseline Request:	***$250.1***	***76.1***	***$18.3***	***$155.5***	***30.4%***	***7.3%***	***62.2%***
Payroll	*$77.5*	*$32.6*	*$2.5*	*$42.3*	*42.1%*	*3.2%*	*54.7%*
Contracts	*$144.1*	*$30.8*	*$14.0*	*$99.3*	*21.4%*	*9.7%*	*68.9%*
Maintenance	*$26.6*	*$11.7*	*$1.8*	*$13.0*	*44%*	*6.8%*	*48.9%*
Equipment	*$1.9*	*$1.0*	*$0.0*	*$0.9*	*52.6%*	*0.0%*	*47.4%*
Add: New Items	***$311.4***	***$55.8***	***$31.4***	***$224.2***	***17.9%***	***10.0%***	***72.1%***
IT projects including eligibility	*$170.4*	*$4.2*	*$18.6*	*$147.6*	*2.4%*	*10.9%*	*86.7%*
ACA implementation	*$2.2*	*$1.0*	*$0.0*	*$1.2*	*45.4%*	*0.0%*	*54.6%*
Balancing Incentive Program	*$26.7*	*$10.0*	*$3.4*	*$13.3*	*37.5%*	*12.7%*	*49.8%*
Accounting changes-Volume	*$76.7*	*$34.6*	*$0.0*	*$42.1*	*45.1%*	*0.0%*	*54.9%*
Staffing Increase	*$6.6*	*$0.8*	*$0.4*	*$5.4*	*12.2%*	*6%*	*81.8%*
Contingency/Elevation	*$28.8*	*$5.2*	*$9.0*	*$14.6*	*18.0%*	*31.2%*	*50.8%*
Total	***$561.4***	***$131.9***	***$49.7***	***$379.7***	***23.5%***	***8.9%***	***67.6%***

Updated January 31, 2013

Figure 3.
Medicaid Budget Crosswalk from Current to Proposed Appropriation Line Item Structure

	CURRENT STRUCTURE						PROPOSED STRUCTURE				
	Fund Group	Current Fund	Current ALI	Current ALI Name	Full or Partial Medicaid?	Service, Admin or Both?	Proposed Fund	Proposed ALI	Proposed ALI Name	Double Counting?	Service or Admin?
Office of Medical Assistance/ Department of Medicaid	GRF	GRF	600525	Health Care / Medicaid	Partial	Both	GRF	651525	Medicaid / Health Care Services	N	S
	GRF	~~GRF~~	~~600537~~	~~Children's Hospital~~	F	S					S
	GRF	GRF	600526	Medicare Part D		S	GRF	651526	Medicare Part D	N	S
	FED	3F00	600623	Health Care Federal	F	Both	3F00	651623	Medicaid Services - Federal	N	S
	FED	~~3F00~~	~~600650~~	~~Hospital Care Assurance - Federal~~	F	S	3F00	651624	Medicaid Program Support - Federal	N	A
	GSF	5DL0	600639	Health Care / Medicaid Support - Recoveries	F	Both	5DL0	651639	Medicaid Services - Recoveries / Rebates	N	S
	GSF	~~5P50~~	~~600692~~	~~Health Care / Medicaid Support - Drug Rebates~~	F	Both					
	GSF	5FX0	600638	Medicaid Payment Withholding	F	S	5FX0	651638	Medicaid Services - Payment Withholding	N	S
	SSR	5GF0	600656	Health Care / Medicaid Support - Hospital / UPL	F	S	5GF0	651656	Medicaid Services - Hospital / UPL	N	S
	SSR	5R20	600608	Long Term Care Support	F	Both	5R20	651608	Medicaid Services - Long Term Care	N	S
	~~SSR~~	~~4J50~~	~~600613~~	~~Nursing Facility Bed Assessment~~	F	Both					
	SSR	4K10	600621	DDD Support - Franchise Fee	F	S	4K10	No ALI	DDD Support - Franchise Fee	N	S
	SSR	6510	600649	Hospital Care Assurance Program Fund	F	S	6510	651649	Medicaid Services - HCAP	N	S
	GSF	5KW0		Managed Care Performance Payments	F	S	5KW0	651612	Managed Care Performance Payments	N	S
	SSR	~~4Z10~~	~~600625~~	~~HealthCare Compliance~~	F	Both					
	GRF	GRF	600425	Health Care Programs	F	A	GRF	651425	Medicaid Program Support - State	N	A
	GRF	GRF	600321	Program Support	Partial	A					
	GRF	GRF	600416	Information Technology Projects	Partial	A					
	GRF	GRF	600417	Medicaid Provider Audits	F	A					
	FED	3ER0	600603	Health Information Technology	F	Both	3ER0	651603	Medicaid Health Information Technology Grant	N	A
	SSR	5U30	600654	Health Care Program Support	F	A	5U30	651654	Medicaid Program Support	N	A
	SSR	~~5S30~~	~~600629~~	~~Health Care Program and DDD Support~~	F	A				N	
	FED	3G50	600655	Interagency		Both	3G50	651655	Medicaid Interagency Pass-Through	Yes	Trans
	SSR	5AJ0	600631	Money Follows the Person		Both	5AJ0	651631	Money Follows the Person	N	A
	SSR	4E30	600605	Resident Protection Fund		S	4E30	651605	Resident Protection Fund	N	A
							R055	651644	Refunds and Reconciliation	N	Trans
	FED	3FA0	600680	Health Care Grants Federal		Both	3FA0	651680	Health Care Grants - Federal	N	S
	SSR	5KC0	600682	Health Care Grants State		Both	5KC0	651682	Health Care Grants - State	N	A
Mental Health and Addiction Services	GRF	GRF	333321	Central Administration	Partial	A	GRF	652507	Medicaid Program Support	N	A
	GRF	GRF	333403	Pre-Admission Screening Expenses	Partial	A					
	GRF	GRF	335501	Mental Health Medicaid Match	F	S					
	GRF	GRF	038501	Medicaid Match	F	S					
	SSR	5JW0	038615	Board Match Reimbursement	F	S					
	FED	3B10	333635	Comm Medicaid Expansion	Partial	A	3B10	652636	Community Medicaid Legacy Costs	N	A
	FED	3B10	335635	Comm Medicaid Expansion	F	S	3B10	652635	Community Medicaid Legacy Support	Yes	S
	FED	3J80	038610	Medicaid	F	S	3J80	652609	Medicaid Legacy Costs Support	N	A
Department of Developmental Disabilities	GRF	GRF	320321	Central Administration	F	A	GRF	653321	Medicaid Program Support	N	A
	GRF	GRF	322407	Medicaid State Match	F	S	GRF	653407	Medicaid Services	N	S
	GSF	1520	323609	DC & Residential Operating Services	F	S	1520	653609	DC & Residential Operating Services	N	S
	FED	3G60	322639	Medicaid Waiver - Federal	F	Both	3G60	653639	Medicaid Waiver Services	N	S
							3G60	653640	Medicaid Waiver Program Support	N	A
	FED	3M70	322650	CAFS Medicaid	F	S	3M70	653650	CAFS Medicaid	N	S
	FED	3A40	323605	DC and Res Facility Svcs and Support	F	Both	3A40	653605	DC and Res Facility Svcs and Support	N	S
							3A40	653604	DC & ICF/IID Program Support		A
	FED	3A40	322653	ICF Federal	F	S	3A40	653653	ICF/IID	N	S
	SSR	5GE0	320606	Operating and Services	Partial	Both	5GE0	653606	ICF/IID & Waiver Match	N	S
	SSR	5CT0	322632	Intensive Behavioral Needs	F	S	5CT0	653607	Intensive Behavioral Needs	N	S
	SSR	5DJ0	322626	Targeted Case Management Services	F	S	5DJ0	653626	Targeted Case Management Services	Yes	S
	SSR	5EV0	322627	Program Fees	F	A	5EV0	653627	Medicaid Program Support	N	A
	SSR	5Z10	322624	County Board Waiver Match	F	S	5Z10	653624	County Board Waiver Match	N	S
	SSR	4890	323632	DC Direct Care Support	F	S	4890	653632	DC Direct Care Services	N	S
	SSR	5S20	590622	Medicaid Admin & Oversight	F	A	5S20	653622	Medicaid Admin & Oversight	N	A
Department of Health	GRF	GRF	440453	Health Care Quality Assurance	Partial	A	GRF	654453	Medicaid - Health Care Quality Assurance	N	A
	GSF	1420	440646	Agency Health Services	Partial	A					
	FED	3910	440606	Medicare Survey and Certification	Partial	A	3GD0	654601	Medicaid Program Support	N	A
	FED	3920	440618	Federal Public Health Programs	Partial	A					
Aging	GRF	GRF	490423	Long Term Care Budget - State	F	A	GRF	656423	Long Term Care Program Support - State	N	A
	FED	3C40	490623	Long Term Care Budget	F	A	3C40	656623	Long Term Care Program Support - Federal	N	A
Job and Family Services	GRF	GRF	600521	Family Assistance Local	Partial	A	GRF	655522	Medicaid Program Support - Local	N	A
	GRF	GRF	600525	Health Care/ Medicaid	Partial	Both	GRF	655523	Medicaid Program Support - Local Transportation	N	A
	FED	3F00	600623	Health Care Federal	Partial	A	3F01	655624	Medicaid Program Support	N	A

Figure 4.

Executive Budget Medicaid Impact on Hospitals			
All funds in millions	**SFY 2014**	**SFY 2015**	**SFY 2014-2015**
Hospital Baseline (FFS + MCO)	$ 3,999	$ 4,235	$ 8,235
- Total Hospital Franchise Fee	$ (524)	$ (524)	$ (1,048)
Hospital Baseline (FFS + MCO) minus Franchise Fee	$ 3,476	$ 3,711	$ 7,187
Supplemental Payments Supported by the Franchise Fee			
- Upper Payment Limit Program	$ 502	$ 502	$ 1,003
- Managed Care Incentive	$ 162	$ 162	$ 324
- Support of 5% Rate Increase	$ 177	$ 177	$ 353
Subtotal	$ 840	$ 840	$ 1,681
Baseline Plus Supplemental Payments Supported by Franchise Fee	$ 4,316	$ 4,552	$ 8,868
Hospital SFY 14/15 Budget Initiatives (All Funds)			
- Eliminate hospital 5% inpatient and outpatient rate update	$ (83)	$ (177)	$ (260)
- Reduce readmissions by 25%	$ (34)	$ (69)	$ (103)
- Cap Capital to 85% of Cost with No FFS Settlement	$ (19)	$ (38)	$ (58)
- Pay DRG exempt hospitals at 90% of cost with no FFS settlement	$ (4)	$ (8)	$ (12)
- Modify outpatient fee schedule	$ (22)	$ (44)	$ (67)
Subtotal	$ (163)	$ (337)	$ (500)
Estimated Reimbursement	$ 4,153	$ 4,215	$ 8,368
Percent Change	-3.8%	-7.4%	-5.6%
ACA Mandates			
- Woodwork (all) now enrolled	$ 218	$ 408	$ 627
- Expansion (all) now enrolled	$ 211	$ 788	$ 999
Subtotal	$ 430	$ 1,196	$ 1,626
Net Change between ACA Mandates and Budget Initiatives	$ 266	$ 859	$ 1,126
Total Executive Budget for Hospitals	**$ 4,582**	**$ 5,411**	**$ 9,993**
Dollar Change from Baseline	$ 583	$ 1,176	$ 1,759
Percent Change	14.6%	27.8%	21.4%

Figure 5.

Ohio Medicaid Spending (All Funds in millions)

All Funds	SFY2012	SFY 2013	%	SFY 2014	%	SFY 2015	%	SFY 2014/15
Initial Trend in 2011	$ 19,342	$ 20,797						
HB 153 Appropriations [1]	$ 19,154	$ 20,298						
Actual /Estimate	$ 18,438	$ 19,768						
Initial Program Trend in 2013	**$ 18,438**	**$ 19,666**	**6.7%**	**$ 20,723**	**5.4%**	**$21,477**	**3.6%**	**$ 42,200**
Health Transformation Initiatives In Progress (HB 153)								
ICDS		$ -		$ 493		$ 298		$ 791
Health Homes		$ 25		$ 215		$ 303		$ 519
ABD Kids MCP Expansion		$ -		$ 87		$ 41		$ 128
Balancing Incentive Program		$ -		$ 27		$ 25		$ 52
Subtotal		**$ 25**		**$ 822**		**$ 667**		**$ 1,490**
ACA Mandates								
Woodwork		$ -		$ 531		$ 996		$ 1,527
Physician Fee Increase		$ 77		$ 321		$ 262		$ 583
Subtotal		**$ 77**		**$ 852**		**$ 1,258**		**$ 2,110**
Baseline Total	**$ 18,438**	**$ 19,768**	**7.2%**	**$ 22,397**	**13.3%**	**$23,402**	**4.5%**	**$ 45,799**
Savings & Cost Avoidance								
Health plan changes				$ (270)		$ (376)		$ (646)
Hospital changes				$ (163)		$ (337)		$ (500)
Nursing Facility changes				$ 15		$ 21		$ 36
HCBS changes				$ 4		$ 27		$ 31
Fight Fraud and Abuse				$ (33)		$ (41)		$ (74)
Other Provider Changes				$ (70)		$ (95)		$ (165)
Subtotal				**$ (517)**		**$ (801)**		**$ (1,318)**
Baseline Less Savings & Cost Avoidance		**$ 19,768**	**7.2%**	**$ 21,880**	**10.7%**	**$22,601**	**3.3%**	**$ 44,481**
Simplify Eligibility/ACA								
Eligibility Changes				$ (62)		$ (184)		$ (246)
Newly Eligible Enrollment (Pre Rebate)				$ 562		$ 2,111		$ 2,673
Newly Eligible Enrollment (Net)				**$ 500**		**$ 1,927**		**$ 2,426**
Executive Budget	**$ 18,438**	**$ 19,768**	**7.2%**	**$ 22,380**	**13.2%**	**$24,528**	**9.6%**	**$ 46,907**

[1] *Note: Amounts adjusted from $18.8B in SFY12 and $19.8B in SFY13 to include the budget for Medicare Part D and UPL appropriations*

Figure 6.

Ohio Medicaid Spending (State Share of General Revenue Funds in millions)

GRF - State Share	SFY2012	SFY 2013	%	SFY 2014	%	SFY 2015	%	SFY 2014/15
Initial Trend in 2011	$ 5,336	$ 5,680						
HB 153 Appropriations [1]	$ 5,108	$ 5,293						
Actual /Estimate	$ 4,936	$ 5,079						
Initial Program Trend in 2013	**$ 4,936**	**$ 5,081**	**2.9%**	**$ 5,520**	**8.6%**	**$ 5,733**	**3.9%**	**$ 11,253**
Health Transformation Initiatives In Progress (HB 153)								
ICDS		$ -		$ 182		$ 110		$ 292
Health Homes		$ (3)		$ (17)		$ 10		$ (7)
ABD Kids MCP Expansion		$ -		$ 32		$ 15		$ 47
Balancing Incentive Program		$ -		$ (60)		$ (60)		$ (120)
Subtotal		**$ (3)**		**$ 136**		**$ 76**		**$ 212**
ACA Mandates								
Woodwork		$ -		$ 186		$ 335		$ 521
Physician Fee Increase		$ -		$ -		$ -		$ -
Subtotal		**$ -**		**$ 186**		**$ 335**		**$ 521**
Baseline Total	**$ 4,936**	**$ 5,079**	**2.9%**	**$ 5,842**	**15.0%**	**$ 6,144**	**5.2%**	**$ 11,986**
Savings & Cost Avoidance								
Health plan changes				$ (100)		$ (139)		$ (239)
Hospital changes				$ (60)		$ (125)		$ (185)
Nursing Facility changes				$ 6		$ 8		$ 13
HCBS changes				$ 2		$ 10		$ 11
Fight Fraud and Abuse				$ (12)		$ (15)		$ (28)
Other Provider Changes				$ (26)		$ (35)		$ (61)
Subtotal				**$ (191)**		**$ (296)**		**$ (487)**
Baseline Less Savings & Cost Avoidance		**$ 5,079**	**2.9%**	**$ 5,652**	**11.3%**	**$ 5,847**	**3.5%**	**$ 11,499**
Simplify Eligibility/ACA								
Eligibility Changes				$ (23)		$ (68)		$ (91)
Newly Eligible Enrollment (Pre Rebate)				$ -		$ -		$ -
Newly Eligible Enrollment (Net)				**$ (23)**		**$ (68)**		**$ (91)**
Executive Budget	**$ 4,936**	**$ 5,079**	**2.9%**	**$ 5,629**	**10.8%**	**$ 5,779**	**2.7%**	**$ 11,408**

[1] *Note: Amounts adjusted from $4.8B in SFY12 and $5.0B in SFY13 to include the budget for Medicare Part D*