



Medicaid Budget

Senate Finance Committee Testimony
Tuesday, May 10, 2011

Health Transformation Team

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Ohio's Health System Performance

Health Outcomes – 42nd overall¹

- 42nd in preventing infant mortality (only 8 states have higher mortality)
- 37th in preventing childhood obesity
- 44th in breast cancer deaths and 38th in colorectal cancer deaths

Prevention, Primary Care, and Care Coordination¹

- 37th in preventing avoidable deaths before age 75
- 44th in avoiding Medicare hospital admissions for preventable conditions
- 40th in avoiding Medicare hospital readmissions

Affordability of Health Services²

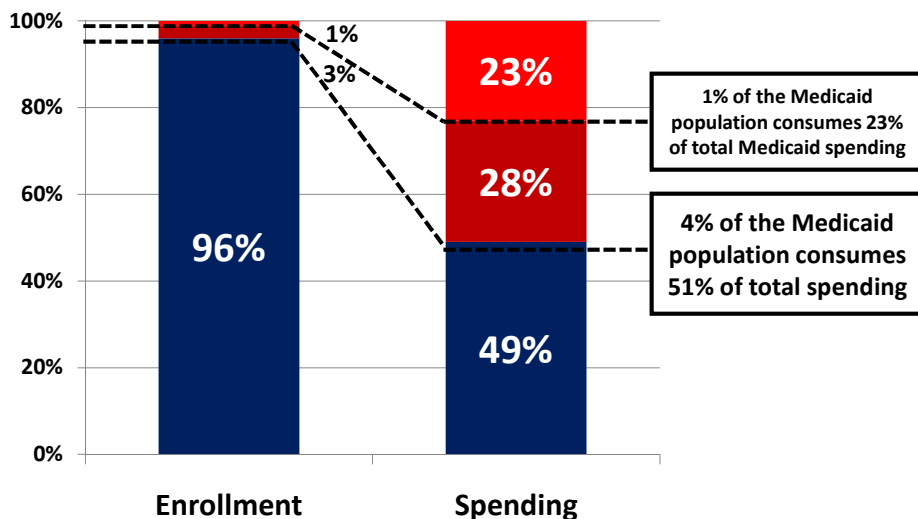
- 37th most affordable (Ohio spends more per person than all but 13 states)
- 38th most affordable for hospital care and 45th for nursing homes
- 44th most affordable Medicaid for seniors



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Sources: (1) Commonwealth Fund 2009 State Scorecard on Health System Performance, (2) Kaiser Family Foundation State Health Facts (updated March 2011)


A few high-cost cases account for most Medicaid spending



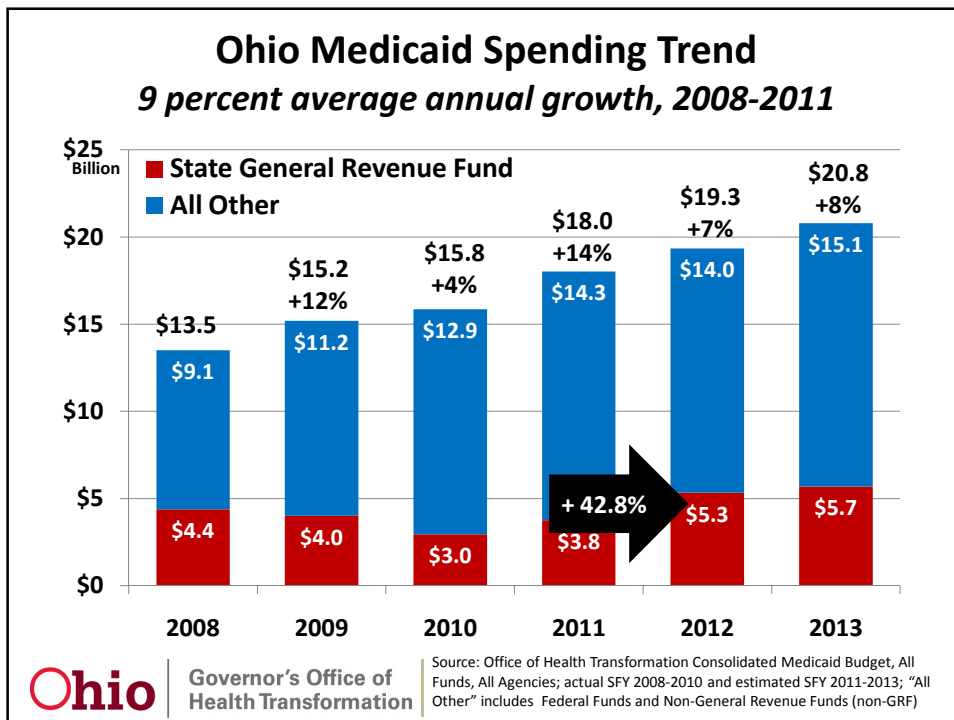
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Source: Ohio Department of Job and Family Services; SFY 2010 for all Medicaid populations and all medical (not administrative) costs

Fragmentation	vs.	Coordination
<ul style="list-style-type: none"> • Multiple separate providers • Provider-centered care • Reimbursement rewards volume • Lack of comparison data • Outdated information technology • No accountability • Institutional bias • Separate government systems • Complicated categorical eligibility • Rapid cost growth 		<ul style="list-style-type: none"> • Accountable medical home • Patient-centered care • Reimbursement rewards value • Price and quality transparency • Electronic information exchange • Performance measures • Continuum of care • Medicare/Medicaid/Exchanges • Streamlined income eligibility • Sustainable growth over time


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SOURCE: Adapted from Melanie Bella, *State Innovative Programs for Dual Eligibles*, NASMD (November 2009)



Health Transformation Priorities

- Improve Care Coordination
- Integrate Behavioral/Physical Health Care
- Rebalance Long-Term Care
- Modernize Reimbursement
- Balance the Budget

Improve Care Coordination

Coordinate care to achieve better health and cost savings through improvement

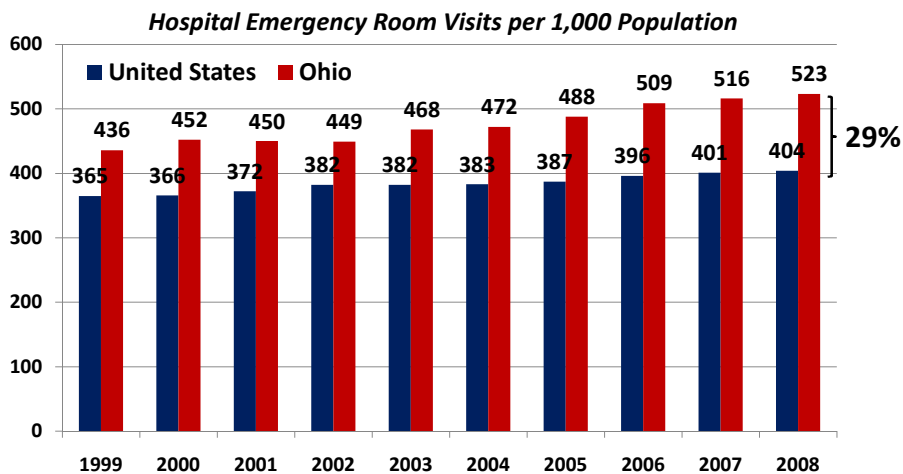
RECOMMENDATIONS:

- Promote Health Homes
- Provide accountable care for children
- Create a single point of care coordination

The Vision for Better Care Coordination

- The vision is to create a person-centered care management approach – not a provider, program, or payer approach
- Services are integrated for all physical, behavioral, long-term care, and social needs
- Services are provided in the setting of choice
- Easy to navigate for consumers and providers
- Transition seamlessly among settings as needs change
- Link payment to person-centered performance outcomes

Medical Hot Spot: Emergency Department Utilization: Ohio vs. US



Source: American Hospital Association Annual Survey (March 2010) and population data from Annual Population Estimates, US Census Bureau: <http://www.census.gov/popest/states/NST-ann-est.html>.

RECOMMENDATION:

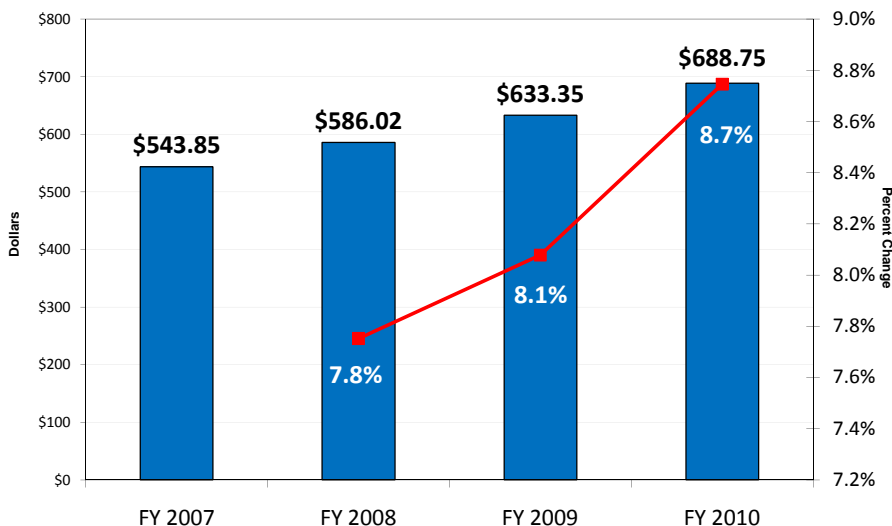
Promote Health Homes

HB 153 directs the Director of the Ohio Department of Health to define Medicaid Health Homes to ensure consistency in delivery of care and set a standard for reimbursement (3701.032)

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings
- Patient and family support (including authorized reps)
- Referral to community and social support services
- Use of health information technology to link services
- \$900,000 in FY 2012 and \$46,350,000 in FY 2013



**Children with Disabilities Eligible for Managed Care Expansion
Average Per Member Per Month Cost**



Based on claims incurred in FY 2010 and paid through January 2011. Prescription drug rebates not included. Includes children not institutionalized, retroactive, backdated, spend down, dual eligible, or enrolled in waivers. 12

RECOMMENDATION:

Provide Accountable Care for Children

- 37,544 children with disabilities in Medicaid fee-for-service
- Complicated cases but no care coordination
- Pediatric Accountable Care Organizations (ACOs) show promise – but few are ready to take risk and responsibility
- Create a path toward better care coordination
- \$87.1 million in FY 2013 (\$28.6 million in utilization savings are offset by one-time costs of moving from FFS to managed care)

RECOMMENDATION (continued):

Provide Accountable Care for Children

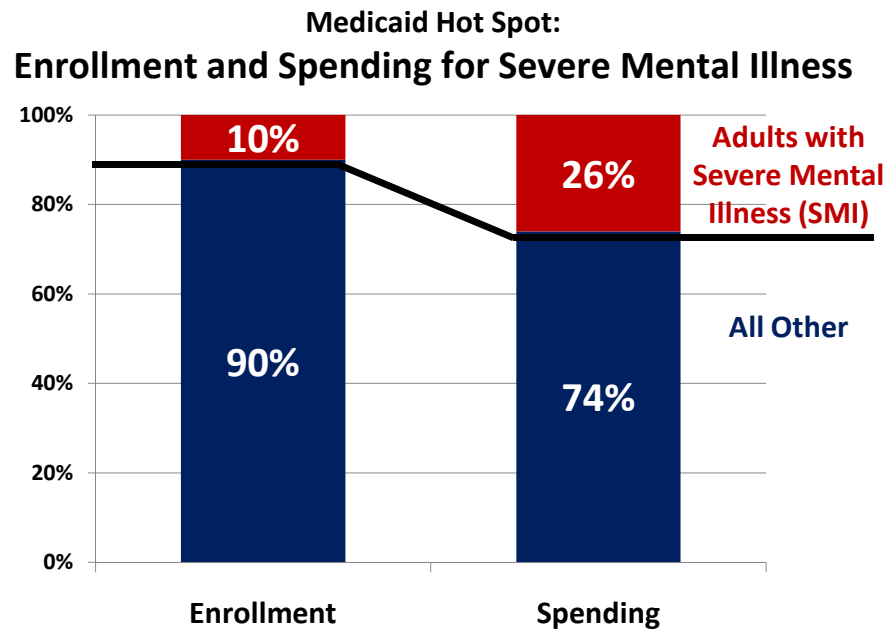
Responsibility	Current	Option I	Option II	Option III
Medicaid Contract	FFS	MCP	MCP	ACO
Care Coordination	None	MCP	ACO	ACO
Financial Risk	Medicaid	MCP	MCP	ACO
Savings	None	Medicaid	MCP & ACO	ACO & Medicaid

RECOMMENDATION:

Create a Single Point of Care Coordination

Implement an Integrated Care Delivery System:

- Focus first on 113,000 dual eligibles in nursing homes and on waivers, and individuals with severe mental illness
- Explore options for delivery models, including managed care, accountable care organizations, health homes, and other
- Require providers to have one point of care coordination
- Triple aim: improve the experience of care, enhance the health of populations, and reduce costs through improvement
- Seek the necessary federal waivers
- Budget neutral (with potential for significant future savings)



Integrate Behavioral/Physical Health

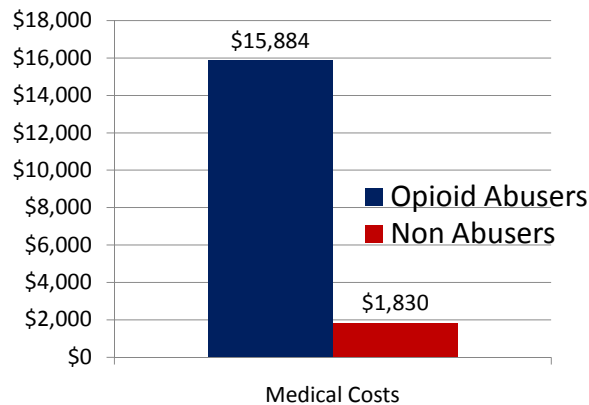
Treat the whole person, including physical and behavioral health care needs

RECOMMENDATIONS:

- Integrate behavioral and physical health benefits
- “Elevate” behavioral health financing to the state
- Manage behavioral health service utilization through a variety of strategies to avoid across-the-board rate cuts (saves \$243 million over the biennium)
- Consolidate housing programs

The National Medical Costs of Opiate Addiction

“The high cost of opioid abuse were driven primarily by high prevalence rates of costly co-morbidities and high utilization of medical services and prescription drugs.”
 – Journal of Managed Care Pharmacy



Rebalance Long Term Care

Enable seniors and people with disabilities to live with dignity in the settings they prefer

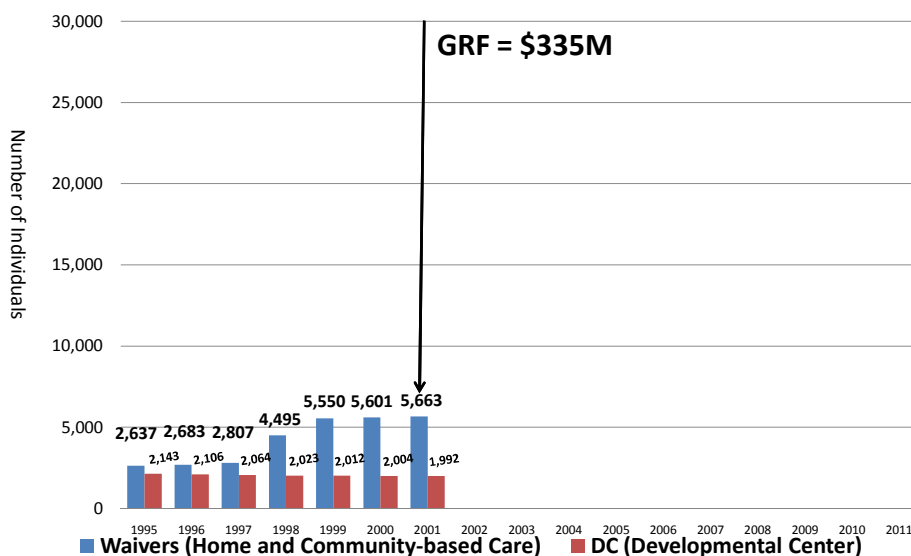
RECOMMENDATIONS:

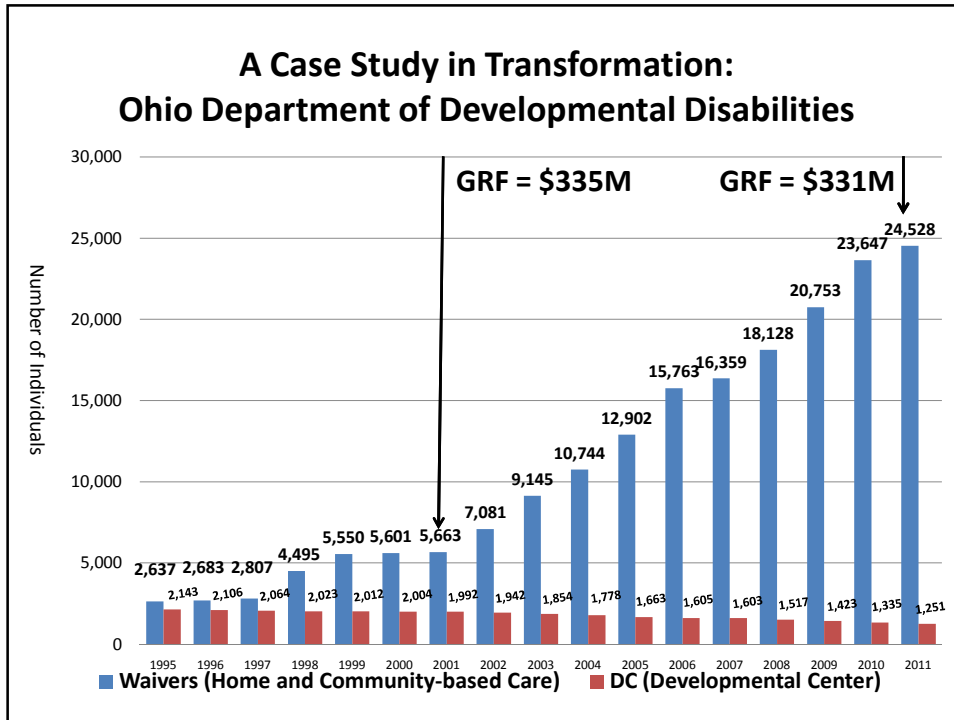
- Align programs for people with developmental disabilities
- Create a Unified Long Term Care System
- Reform nursing facility payment



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A Case Study in Transformation: Ohio Department of Developmental Disabilities





RECOMMENDATION:

Align Programs for People with DD

- Continue the transformation already underway
- Transfer Intermediate Care Facilities (ICFs) from ODJFS to DODD
- Transfer Transitions waiver from ODJFS to DODD
- Consolidate DODD Medicaid funding into one line item
- Utilization management
- Continued institution/community realignment
- Saves \$62.0 million over the biennium

RECOMMENDATION:**Create a Unified Long-Term Care System**

- Make services seamless for consumers and families
- Create a single point of access by consolidating PASSPORT, Ohio Home Care, Transitions/Aging, Choices, Assisted Living
- Transfer Medicaid waiver funding to ODJFS 600-525
- Create a clear “front door” into the delivery system
- Budget neutral

Reform Nursing Facility Payments

- Payment reform is needed to rebalance long-term care
- Ohio's Medicaid reimbursement per bed per day for nursing homes is \$4.75 higher than the national average¹
- Ohio has more nursing homes than all but 2 states.²
- Ohioans are more likely to live near a nursing home than a public high school³
- 15% of Ohio nursing home beds are empty on average
- Medicaid reforms in FY 2007 began the process of addressing these issues by transitioning to a price-based payment system

Sources:

1. Ohio Health Care Association.
2. <http://www.statehealthfacts.org/comparemaptable.jsp?ind=411&cat=8>
3. There are 962 nursing homes and 897 public high schools in Ohio ²⁴

Ohio has more nursing home beds than any neighboring state

State	Population Age 65+ Compared to 1,515,900 in Ohio ¹	Nursing Facility Beds Compared to 92,789 in Ohio ²	NF Beds Per 1,000 Pop. Compared to 8.0 in Ohio ²
Michigan	18% fewer seniors	50% fewer beds	4.7
Tennessee	43% fewer seniors	61% fewer beds	5.8
West Virginia	80% fewer seniors	88% fewer beds	5.9
Kentucky	63% fewer seniors	72% fewer beds	5.9
Pennsylvania	23% more seniors	4% fewer beds	7.0
Indiana	45% fewer seniors	48% fewer beds	7.5



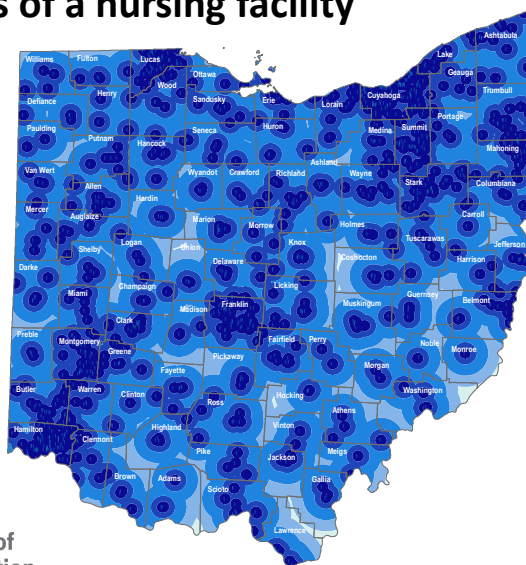
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Source:
 1. <http://www.statehealthfacts.org/comparable.jsp?typ=1&ind=2&cat=1&sub=1>
 2. <http://www.statehealthfacts.org/comparable.jsp?ind=413&cat=8&sub=97&yr=92&typ=1>

98.6% of Medicaid enrollees live within 10 miles of a nursing facility

Percent of Medicaid enrollees within distance of a nursing facility

- 0 - 2.5 miles: 78.6%
- 2.5 - 5 miles: 11.8%
- 5 - 10 miles: 8.2%
- 10 - 15 miles: 1.3%
- more than 15 miles: 0.07%
- Nursing Homes



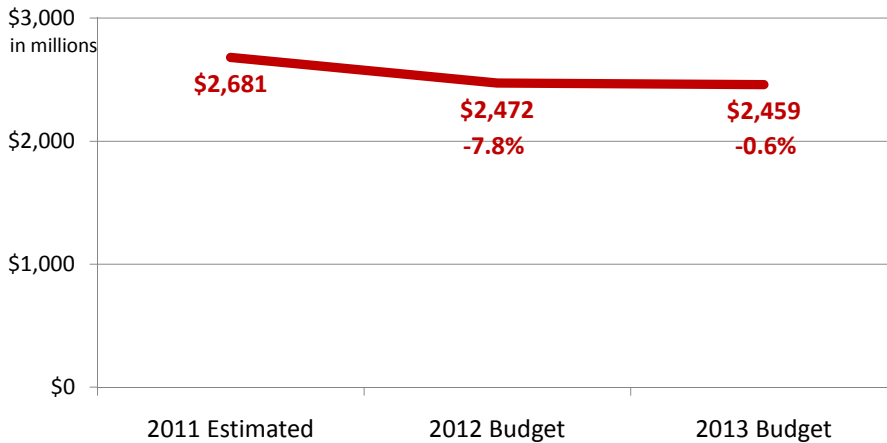
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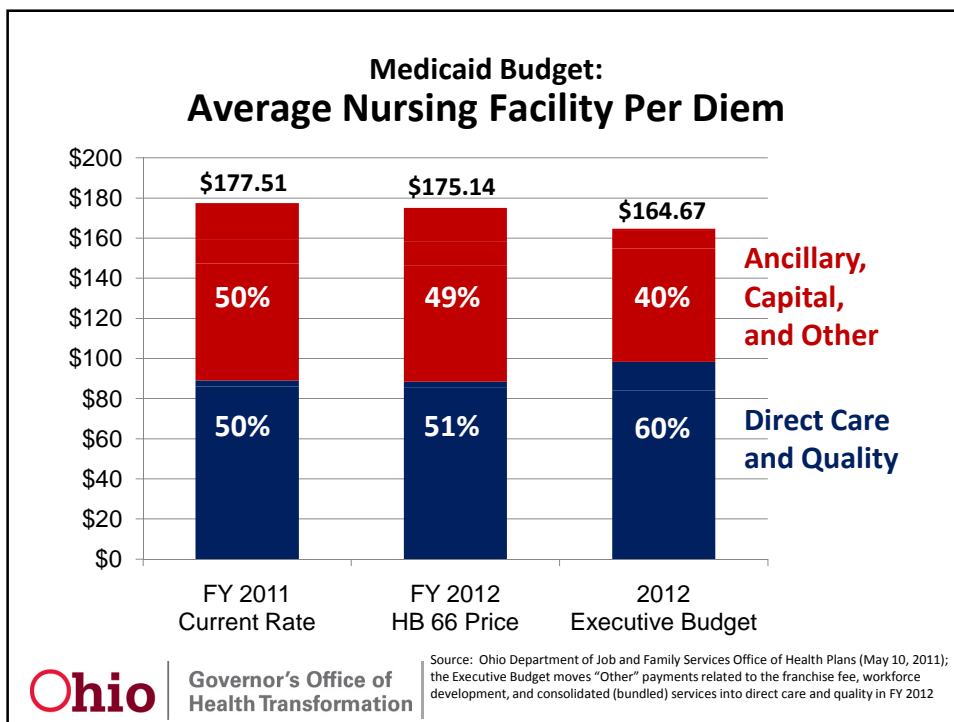
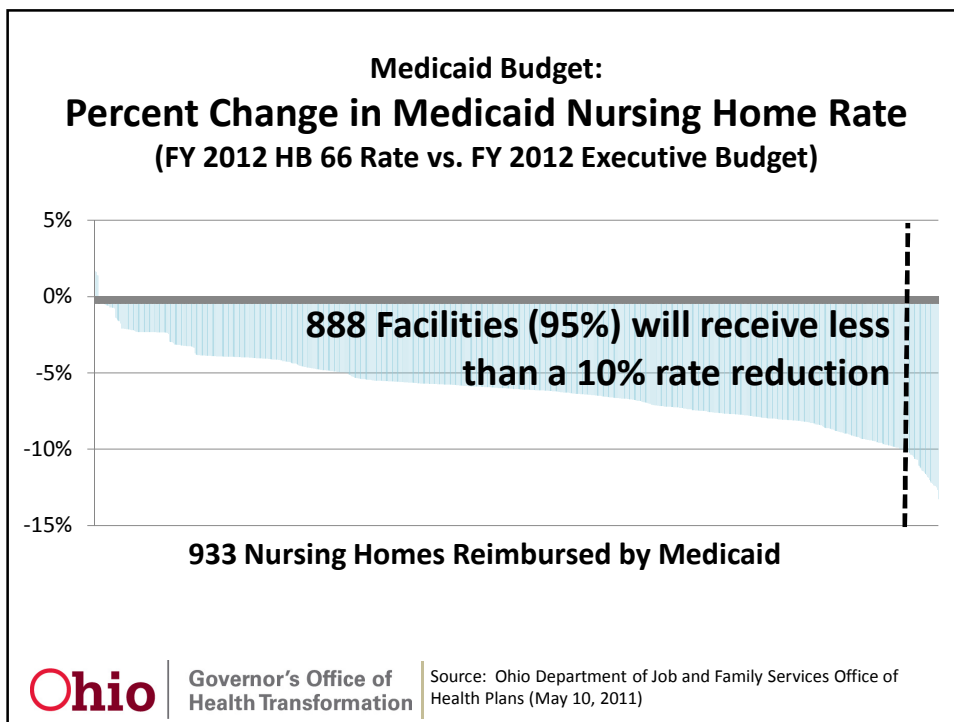
RECOMMENDATION:

Reform Nursing Facility Payments

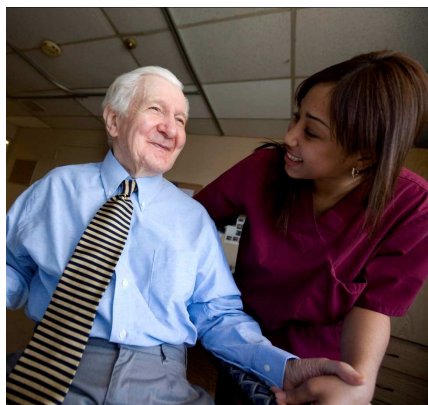
- Complete the transition to a price-based system enacted in 2005 (keep price at the 25th percentile for direct care and ancillary/support services)
- Eliminate the statutory add-on and set capital at the 25th percentile
- Increase the quality incentive payment from 1.7 to 8.75 percent
- Increase the portion of the rate that is related to direct care and quality from 50% to 60%
- Limit Medicare cost sharing obligations to no more than Medicaid
- Decrease Medicaid payments to “hold” empty beds from 50% of the facilities rate for 30 days to 25% of the rate for 15 days
- Reduce the nursing home franchise fee from \$11.95 per bed to \$11.38 in FY 2012 and \$11.60 in FY 2013

**Medicaid Budget:
Ohio Medicaid Spending on Nursing Homes**





Quality Incentives in Nursing Homes



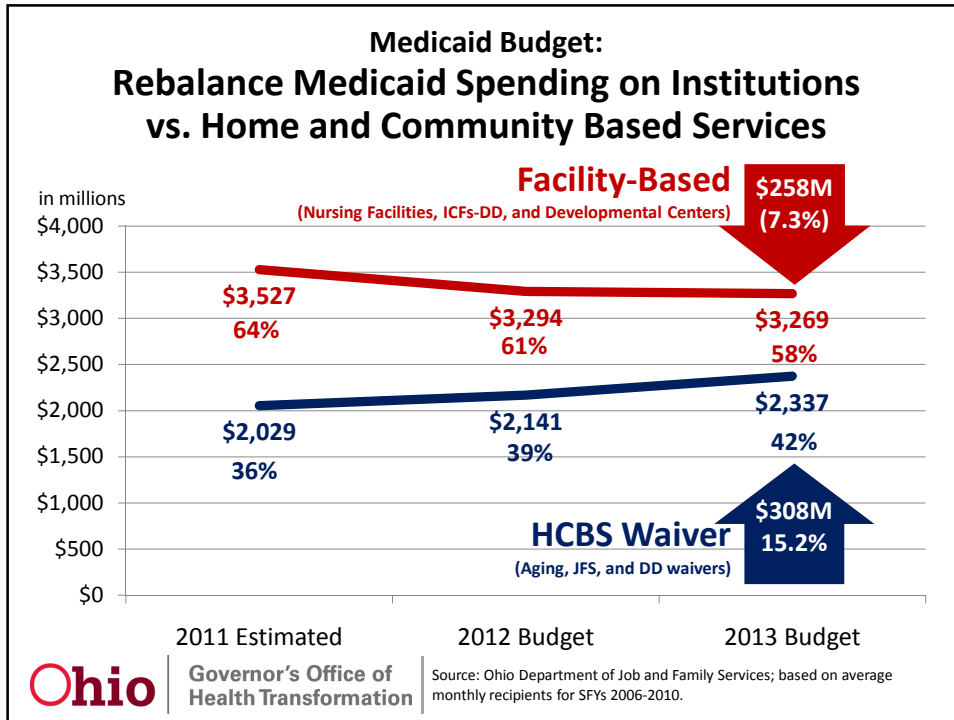
“Research suggests that person-centered care is associated with improved organizational performance including higher resident and staff satisfaction, better workforce performance and higher occupancy rates.”

2010 Annual Quality Report,
Alliance for Quality Nursing Home Care
and American Health Care Association

RECOMMENDATION:

Reward Person-Centered Outcomes

- Nursing facility payments currently include a small (1.7 percent) quality incentive payment that averages \$3.03 per day
- The current incentive is linked to business process measures and results in winners and losers and will be phased out
- Focus instead on person-centered performance measures that emphasize resident control and choice
- Increase the quality incentive to 8.75 percent and make it available for every facility to earn based on performance
- Timing issues need to be resolved
- Budget neutral



Medicaid Budget: PASSPORT/Choices Waiver

- Provides home and community based services to delay or prevent nursing facility placement for low-income Ohioans over age 60
- Not clear why administrative costs varied 77% across the state and spending for PASSPORT services, which federal law requires to be uniform statewide, varied 56% in FY 2010

All Funds	FY 2011 Estimated	FY 2012 Budget	Percent Change	FY 2013 Budget	Percent Change
Caseload	32,158	34,570	7.5%	36,958	6.9%
Executive	\$518,685,418	\$499,788,037	-3.6%	\$499,992,491	0.0%
PMPM	\$1,344	\$1,205	-10.4%	\$1,127	-6.4%
House	\$518,685,418	\$513,692,375	-1.0%	\$527,886,494	2.8%
PMPM	\$1,344	\$1,238	-7.9%	\$1,190	-3.9%

Source: Office Department of Aging. "Executive" and "House" includes spending on PASSPORT/Choices waiver services and Administrative Agency case management and administration; "caseload" and "PMPM" are monthly averages statewide.

Modernize Reimbursement

Reset Medicaid payment rules to reward value instead of volume

RECOMMENDATIONS:

- Nursing facility payments
- Managed care plan payments
- Hospital payments

RECOMMENDATION:

Reform Managed Care Plan Payments

- Create a pay-for-performance program, linked to nationally recognized performance measures, and withhold 1 percent of payment for plans to earn back as an incentive for performance
- Reduce the administrative burden on plans and reduce the administrative component of the capitation rate
- Include pharmacy in the managed care benefit
- Require Medicaid reimbursement to default to FFS rates for hospitals that will not contract with Medicaid managed care
- Eliminate the Children's Buy-In Program (but allow the five children currently enrolled to continue to receive care)
- Saves \$159 million over the biennium

RECOMMENDATION:**Modernize Hospital Payments**

- Outdated reimbursement system dates to the 1980s and rewards more care not better care
 - Update the diagnosis-related group (DRG) system to make more accurate and efficient payments
 - Limit payments for health acquired conditions (errors)
 - Limit outlier payments
 - Set specific Medicaid managed care capital rates
 - Bring outpatient payment policy in line with Ohio's Medicaid State Plan Amendment
 - Limit Medicare Part B cost sharing to no more than Medicaid
 - Eliminate supplemental payments for children's hospitals
- Saves \$478 million over the biennium



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**Medicaid Budget:
Children's Hospitals**

Children's Hospital	A. Franchise Fee Net Impact 2012-2013	B. Payment Reductions 2012-2013	C. Net Impact (A + B) 2012-2013	D. Discontinue Supplemental 2012-2013	E. Total Impact (A + B + D) 2012-2013
Cincinnati	\$3,225,464	\$(9,492,592)	\$(6,267,127)	\$(8,729,444)	\$(14,996,571)
Akron	\$12,375,029	\$(8,823,439)	\$3,551,590	\$(4,717,571)	\$(1,165,982)
Dayton	\$6,780,528	\$(7,078,499)	\$(297,971)	\$(2,873,978)	\$(3,171,949)
Columbus	\$13,600,060	\$(17,296,279)	\$(3,696,218)	\$(10,176,341)	\$(13,872,559)
Toledo	\$2,648,082	\$(2,648,219)	\$(137)	\$(1,571,658)	\$(1,571,795)
Cleveland	\$14,278,382	\$(2,241,733)	\$12,036,649	\$(5,352,617)	\$6,684,033
TOTAL	\$52,907,546	\$(47,580,760)	\$5,326,786	\$(33,421,608)	\$(28,094,822)

SOURCE: Ohio Department of Job and Family Services. Amounts are biennial totals and include Ohio Medicaid Fee-for-Service and Managed Care Program spending. "Payment Reductions" includes Outlier Payments (\$32.0 million), Medicare Crossover Payments (\$163,825), and Inpatient Capital Rates (\$17.7 million). "Payment Reductions" also includes a net gain for Children's Hospitals related to Outpatient Service Payments (\$2.3 million increase). Children's Hospitals estimate Outlier Payment savings may exceed the ODJFS estimate based on managed care contract data available to the hospitals but not the state (the state has offered to recalculate Outlier savings if the hospitals choose to share that information).

- House restored \$4 million (\$11.1 million all funds) 2012-2013



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Source: Ohio Department of Job and Family Services.

Balance the Budget

Contain Medicaid program costs in the short term and ensure financial stability over time

RESULTS:

- A sustainable system
- \$1.4 billion in net savings over the biennium
- Align priorities for consumers (better health outcomes) and taxpayers (better value)
- Challenge the system to improve performance (better care and cost savings through improvement)



Ohio Medicaid All Funds Total

All Funds	SFY 2011	SFY2012	%	SFY 2013	%	SFY 2012-2013
Initial Trend	\$18,020,279,696	\$19,342,184,313	7.3%	\$20,796,914,822	7.5%	\$40,139,099,135
<i>Revised Baseline</i>	\$ (157,570,224)	\$ (379,813,566)		\$ (454,545,028)		\$ (834,358,593)
<i>Additional Costs</i>		\$ 959,811,555		\$ 1,849,269,574		\$ 2,809,081,129
<i>Franchise Fee Revenue</i>		\$ 449,395,358		\$ 438,657,744		\$ 888,053,102
<i>Savings and Cost Avoidance</i>		\$ (1,530,847,617)		\$ (2,779,029,597)		\$ (4,309,877,214)
<i>Subtotal</i>		\$ (501,454,269)		\$ (945,647,307)		\$ (1,447,101,576)
Budget	\$17,862,709,472	\$18,840,730,044	5.4%	\$19,851,267,515	5.4%	\$38,691,997,559
<i>525 All Funds</i>	<i>\$10,480,554,867</i>	<i>\$11,814,893,179</i>	<i>12.7%</i>	<i>\$13,171,301,005</i>	<i>11.5%</i>	<i>\$24,986,194,184</i>



**Governor's Office of
Health Transformation**

Revised Baseline updated February 28, 2011; Savings and Cost Avoidance updated May 10, 2011; includes all departments; does not include Medicare Part D

Ohio Medicaid State Share Total

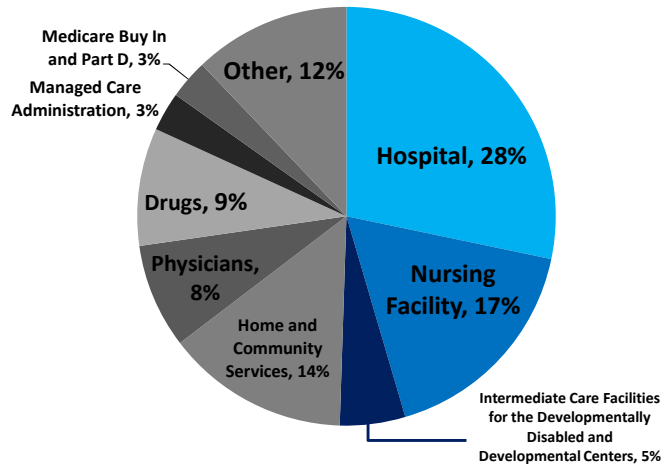
GRF State	SFY 2011	SFY2012	%	SFY 2013	%	SFY 2012-2013
Initial Trend	\$ 3,737,265,147	\$ 5,335,729,055	42.8%	\$ 5,680,339,444	6.5%	\$11,016,068,499
<i>Revised Baseline</i>	\$ 18,796,793	\$ (82,727,222)		\$ (103,091,587)		\$ (185,818,809)
<i>Additional Costs</i>		\$ 343,728,971		\$ 649,428,780		\$ 993,157,751
<i>Franchise Fee Revenue</i>		\$ (294,997,317)		\$ (313,730,704)		\$ (608,728,021)
<i>Savings and Cost Avoidance</i>		\$ (488,673,323)		\$ (904,666,724)		\$ (1,393,340,047)
<i>Subtotal</i>		\$ (522,668,892)		\$ (673,106,887)		\$ (1,194,729,126)
Budget	\$ 3,756,034,940	\$ 4,813,460,258	28.1%	\$ 5,008,279,210	4.1%	\$ 9,821,339,373
<i>525 State Share</i>	<i>\$3,143,279,568</i>	<i>\$4,301,495,337</i>	<i>36.8%</i>	<i>\$4,705,852,933</i>	<i>9.4%</i>	<i>\$9,007,348,270</i>



**Governor's Office of
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Revised Baseline updated February 28, 2011; Franchise Fee Revenue and Savings and Cost Avoidance updated May 10, 2011; includes all departments; does not include Medicare Part D

Total Ohio Medicaid Expenditures, SFY 2010

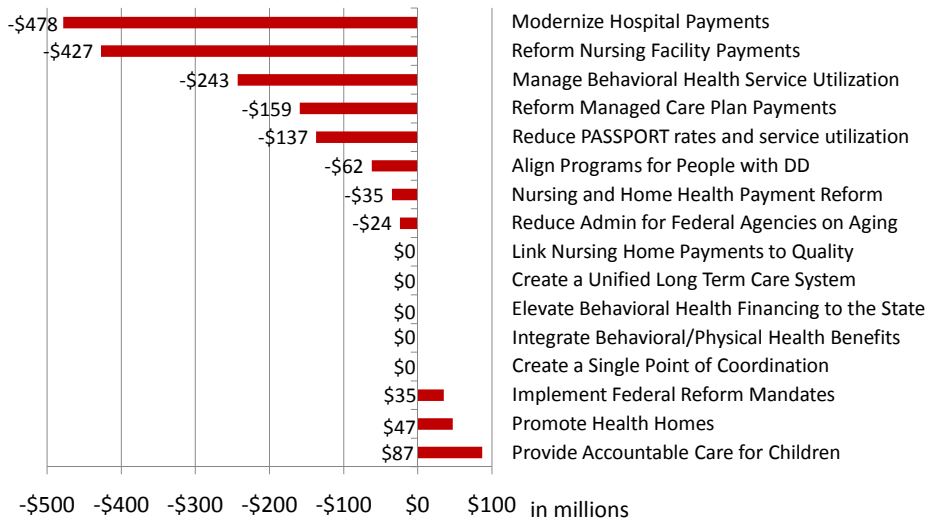


Source: Ohio Department of Job and Family Services and the Governors Office of Health Transformation. Managed care expenditures are distributed to providers according to information from Milliman. Hospitals include inpatient and outpatient expenditures as well as HCAP Home and community services include waivers as well as home health and private duty nursing.



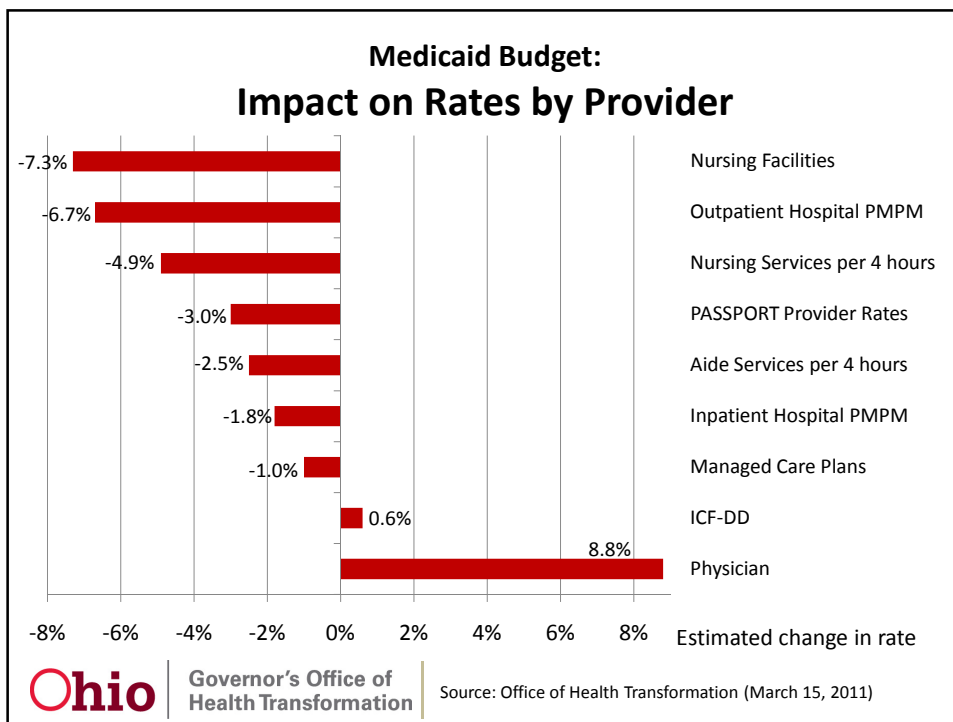
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Medicaid Budget: Savings and Investments



Source: Office of Health Transformation (March 15, 2011); savings are measured from the Ohio Department of Job and Family Services February 28, 2011 estimate of baseline growth absent change






Governor's Office of Health Transformation

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