



Governor's Office of
Health Transformation

Health Transformation Priorities

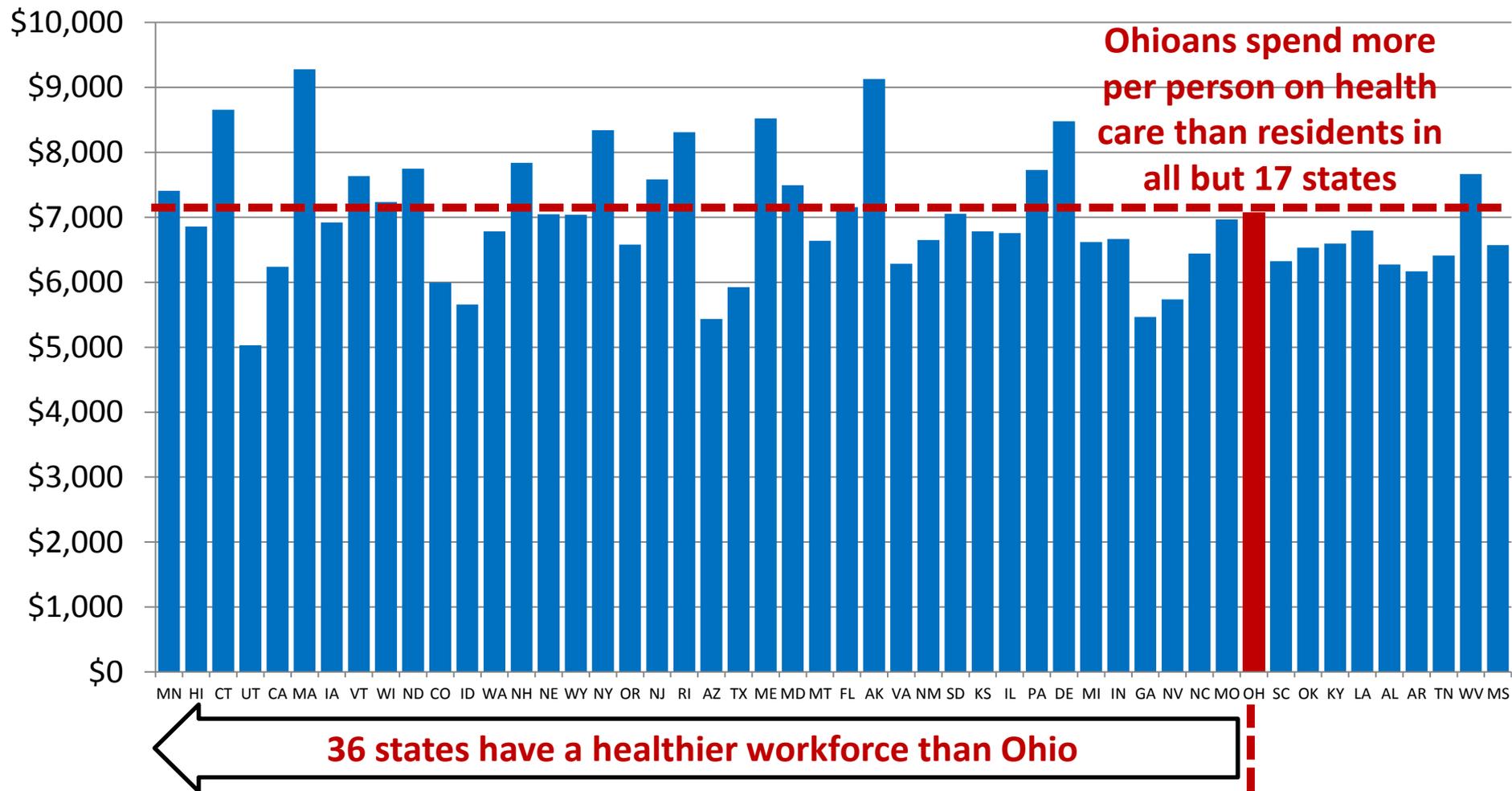
Greg Moody, Director

Governor's Office of Health Transformation

DD Superintendents Winter Conference

March 11, 2013

Health Care Spending per Capita by State (2011) in order of resident health outcomes (2009)



Governor's Office of
Health Transformation

Sources: CMS *Health Expenditures by State of Residence* (2011); The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (October 2009).

Governor Kasich's First Jobs Budget:

“Repeal and Replace” Old Medicaid

Inherited a program that grew 33% over 3 prior years

- Created the Office of Health Transformation
- Linked nearly 10% of nursing home reimbursement to quality
- Increased access to home and community based services
- Freed local behavioral health from Medicaid match
- Created health homes for people with serious mental illness
- Consolidated health plan regions to be more efficient
- Linked 1% of health plan payments to performance
- 3rd state approved to integrate Medicare-Medicaid services
- Implemented a new Medicaid claims payment system

Saved Ohio taxpayers \$2 billion over two years

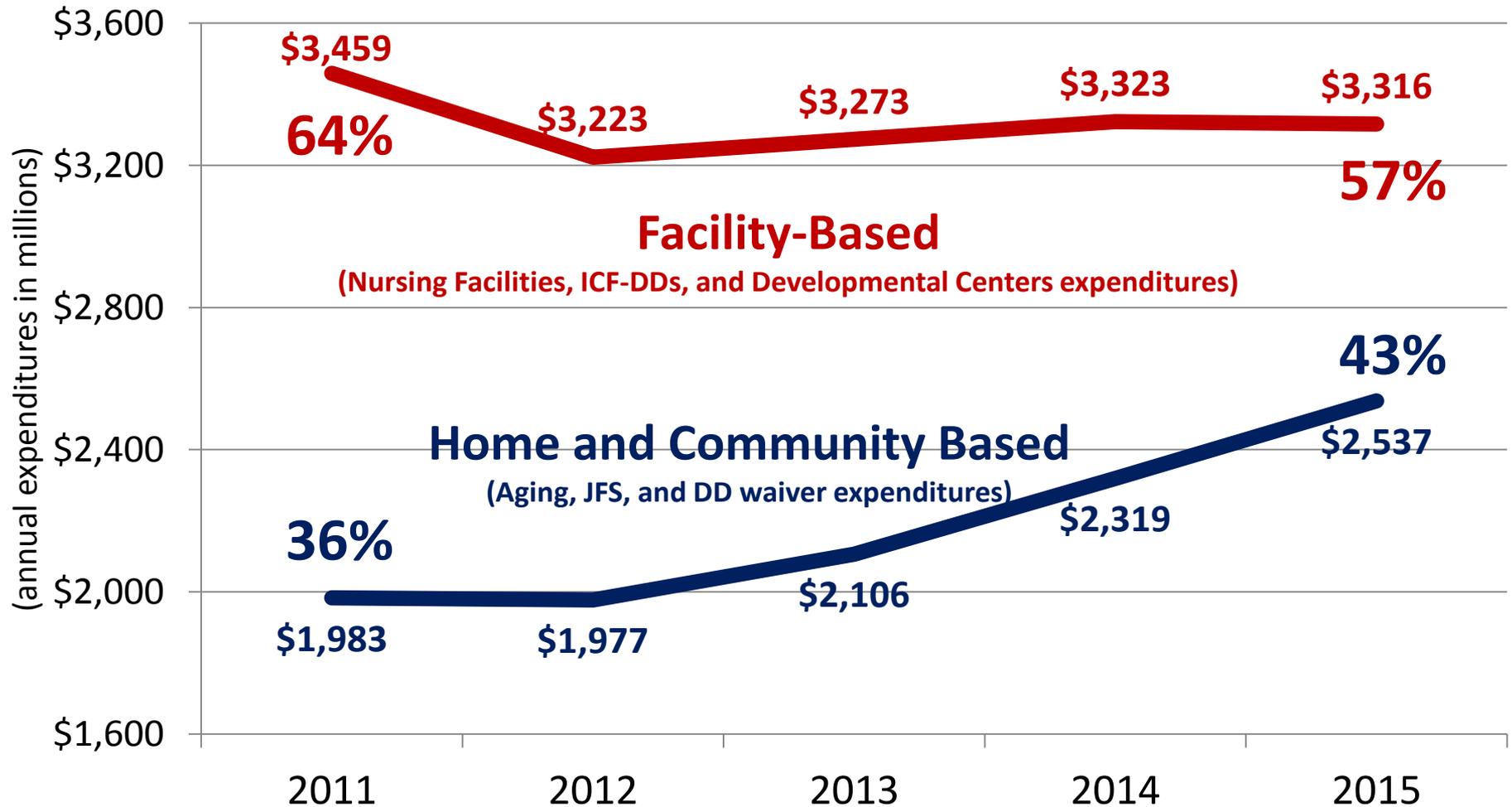
Rebalance Long-Term Care:

Prioritize Home and Community Services

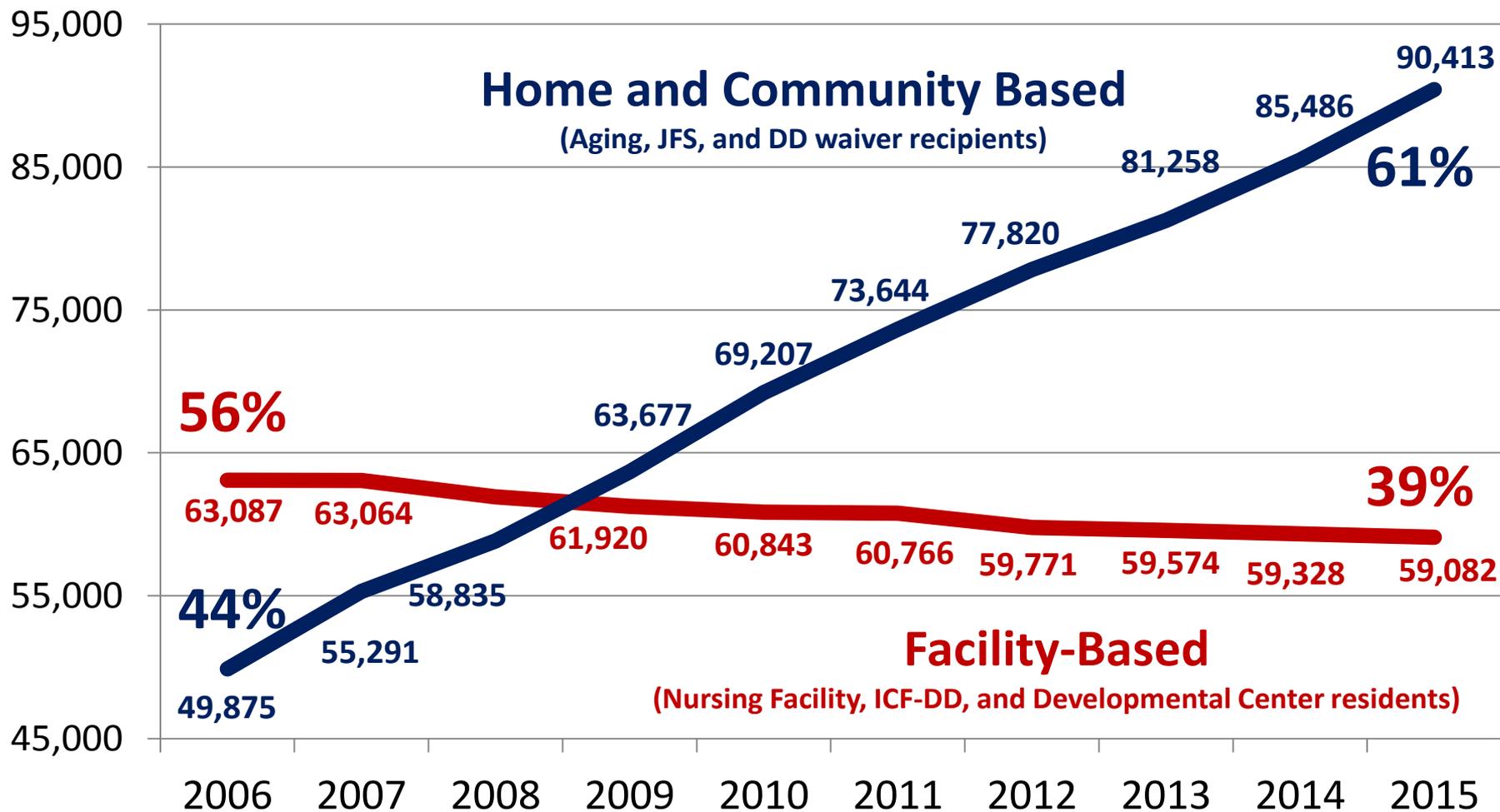
Jobs Budget 2.0

- Medicaid payment changes
 - Increase rates for aide & nursing services, adult day care, assisted living
 - Increase the nursing home resident personal needs allowance
 - Limit the daily rate for a caregiver living with a consumer
 - Implement a shared savings initiative for home health
 - Medicaid net cost is \$31 million (\$11 million state) over two years
- Join the Balancing Incentive Program
 - Commit to 50/50 institutional vs. community long-term care spending
 - No wrong door, standard assessments, conflict-free case management
 - Enhanced federal funds free up \$120 million state share over two years
- Ensure core competencies in the direct care workforce

Ohio Medicaid Spending on Institutions Compared to Home and Community Based Services



Ohio Medicaid Residents of Institutions Compared to Recipients of Home and Community Based Services



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Source: Ohio Medicaid based on agency surveys; 2006-2012 actual and 2013-2015 estimated.

Rebalance Long-Term Care:

Enhance Developmental Disabilities Services

Jobs Budget

- Expanded home and community based services options
- Continued downsizing state-run developmental centers

Jobs Budget 2.0

- Convert institutional placements into community settings
 - Flat rate for residents who are less profoundly disabled
 - Financial incentive to convert institutional beds to community services
 - Increase rates for providers serving former residents of institutions
- Support Employment First
- Increase access to autism services

Streamline Health and Human Services:

Organize Government to be More Efficient

Jobs Budget

- Created the Office of Health Transformation
- New Medicaid claims payment system (MITS)
- Reorganized Medicaid programs and budgets

Jobs Budget 2.0

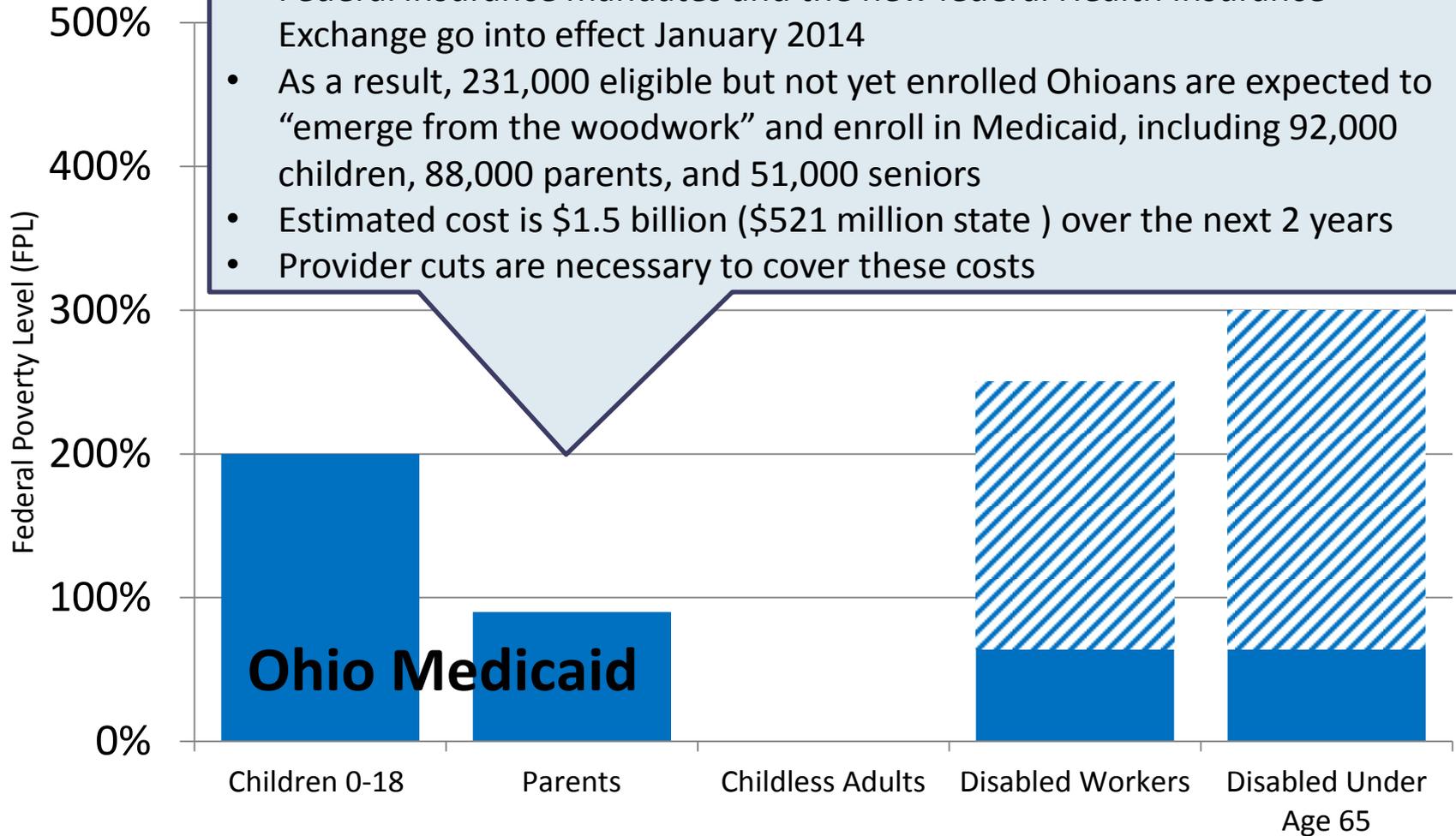
- Consolidate Mental Health and Addiction Services (July 2013)
- Create a unified Medicaid budgeting/accounting system
- Create a Cabinet-Level Department of Medicaid (July 2013)
- Replace Ohio's 34-year-old eligibility system (CRIS-E)
- Coordinate health sector workforce programs

Jobs Budget 2.0 Medicaid Plan

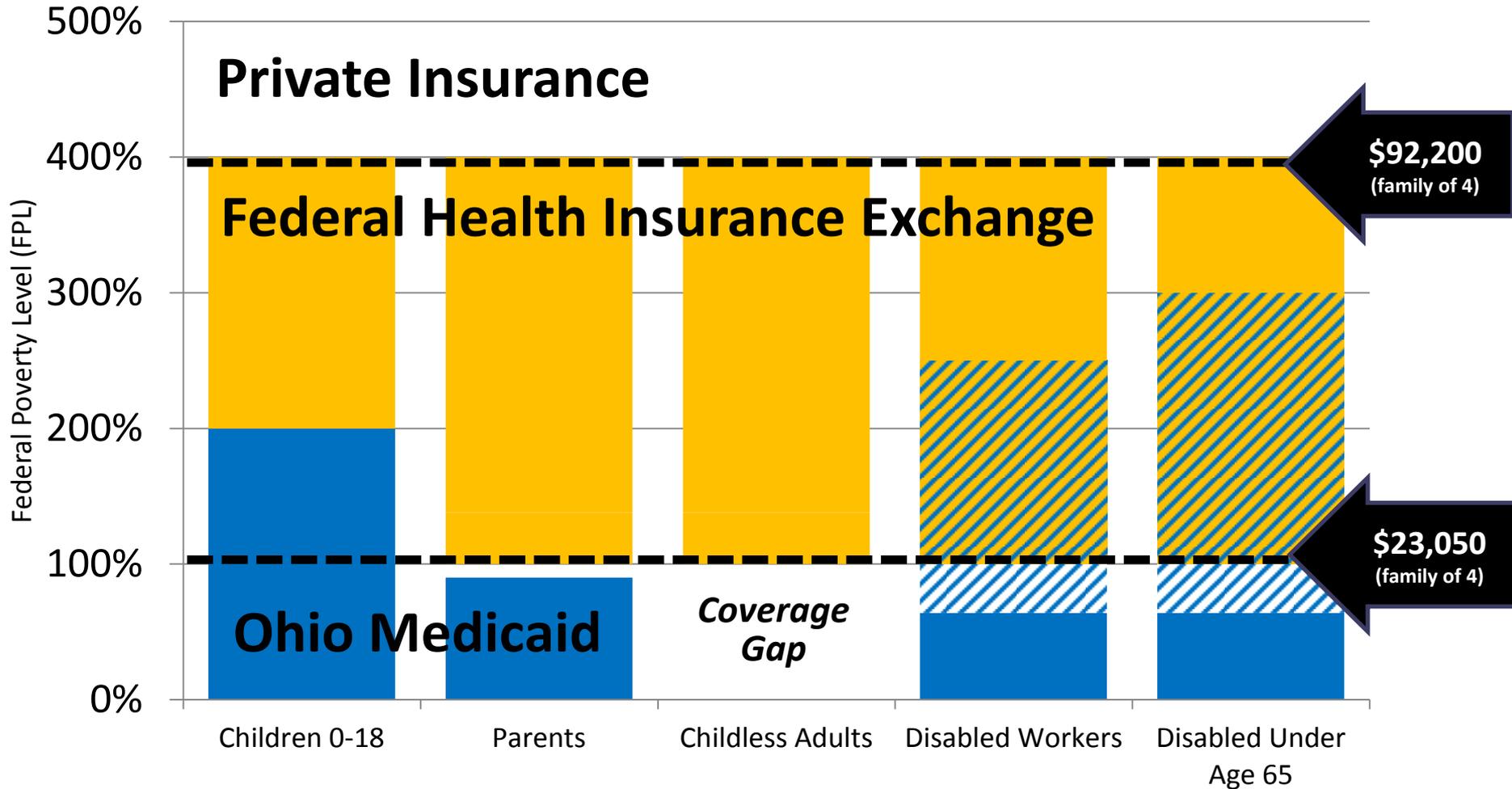
- Obamacare is not the path Governor Kasich would have chosen for Ohio, but it is – for now – the law of the land
 - In March 2010, Congress mandated that every state expand Medicaid to adults with annual income below \$15,415 (138% of poverty)
 - In June 2012, the United States Supreme Court ruled the federal government cannot penalize a state that chooses not to expand
- After weighing the options, Governor Kasich decided that extending coverage to more low-income Ohioans makes sense
 - Ohio has the legal authority and will automatically roll back the extension if the federal government changes the rules

Woodwork Effect

- Federal insurance mandates and the new federal Health Insurance Exchange go into effect January 2014
- As a result, 231,000 eligible but not yet enrolled Ohioans are expected to “emerge from the woodwork” and enroll in Medicaid, including 92,000 children, 88,000 parents, and 51,000 seniors
- Estimated cost is \$1.5 billion (\$521 million state) over the next 2 years
- Provider cuts are necessary to cover these costs



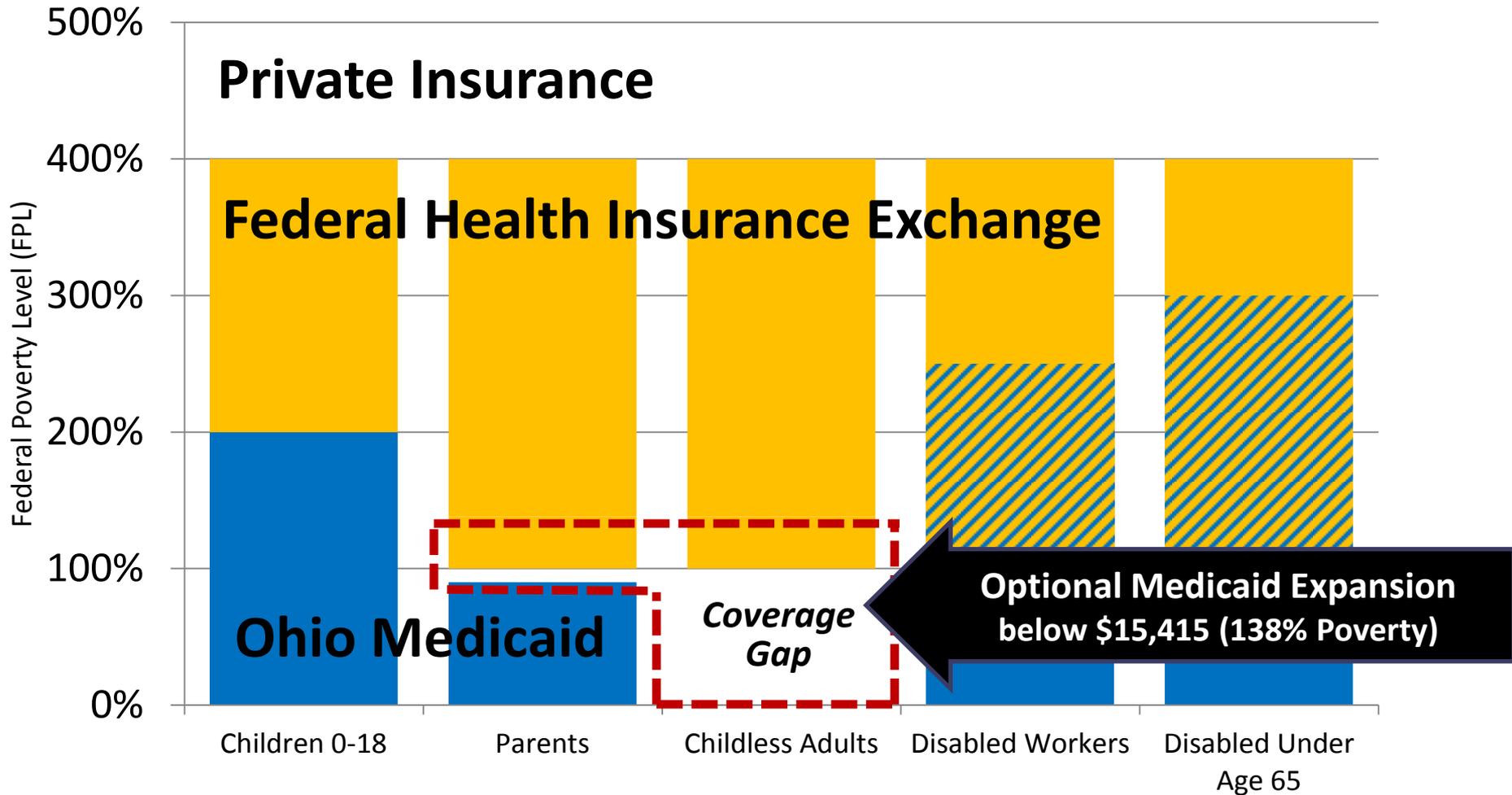
Ohio Medicaid and Insurance Exchange Eligibility in 2014



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SOURCE: Ohio Medicaid; Medicaid eligibility as of February 2013; Federal Health Insurance Exchange eligibility as of January 2014; 2012 poverty level is \$11,170 for an individual and \$23,050 for a family of 4; over age 65 coverage is through Medicare, not the exchange.

Lowest-Income Ohioans Face a Coverage Gap in 2014



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SOURCE: Ohio Medicaid; Medicaid eligibility as of February 2013; Federal Health Insurance Exchange eligibility as of January 2014; 2012 poverty level is \$11,170 for an individual and \$23,050 for a family of 4; over age 65 coverage is through Medicare, not the exchange.

Extend Medicaid Coverage:

Who Is Caught in Ohio's Coverage Gap?

- Individuals with income less than 138% of poverty
 - \$15,415 for an individual or \$23,050 for a family of four
- About half work, but their employer doesn't offer or they can't afford health insurance
- Many work as health care providers for others but don't themselves have coverage
- Some are unable to work because of mental illness or addiction, but have no regular source of care to recover
- 594,000 Ohioans with annual income below 138% of poverty lack health insurance (6.9% of Ohio's total population)

Extend Medicaid Coverage: Put Ohio's Federal Taxes to Work in Ohio

Federal Funds Impact (in millions)	FY 2014	FY 2015	FY 2014-15
Newly eligible populations (100% federal*)	\$562	\$2,000	\$2,561
Previously eligible population (64% federal)	<u>(\$39)</u>	<u>(\$116)</u>	<u>(\$155)</u>
TOTAL FEDERAL FUNDS INTO OHIO	\$523	\$1,884	\$2,407

*

Calendar Year	Federal Match for Newly Eligible Populations
2014, 2015, 2016	100%
2017	95%
2018	94%
2019	93%
2020+	90%



Extend Medicaid Coverage: Give Ohio Taxpayers Relief in This Budget

GRF State Share Impact (in millions)	FY 2014	FY 2015	FY 2014-15
Newly eligible enrollees state cost	--	--	--
Previously eligible enrollees state cost	(\$23)	(\$68)	(\$91)
Prison costs that shift to Medicaid	(\$9)	(\$18)	(\$27)
Eliminate hospital 5% rate add-on*	(\$31)	(\$65)	(\$96)
Reduce hospital capital payments*	(\$7)	(\$14)	(\$21)
Health plan administrative savings*	(\$25)	(\$27)	(\$52)
Sales and HIC tax revenue offsets	<u>(\$18)</u>	<u>(\$97)</u>	<u>(\$117)</u>
TOTAL STATE BENEFIT	\$114	\$290	\$404

* These cuts are made possible by increased enrollment through woodwork/expansion and represent GRF state share only (all funds include \$220 million in SFY 2014 and \$470 million in SFY 2015, or \$690 million over two years).



Extend Medicaid Coverage: Free Up Local Funds to Meet Local Needs

Local Funds Impact (in millions)	FY 2014	FY 2015	FY 2014-15
Sales tax revenue	\$4	\$21	\$25
Behavioral health services to Medicaid	<u>\$35</u>	<u>\$70</u>	<u>\$105</u>
TOTAL LOCAL BENEFIT	\$39	\$91	\$130

Extend Medicaid Coverage:

Improve Health Outcomes

- Extend life and reduce health disparities – expansion states reduced mortality and improved outcomes, particularly among older adults, non-whites, and residents of poorer counties
- Improve health outcomes for children – children are 3 times more likely to be uninsured if their parents are uninsured
- Help children make a healthy transition to adulthood – young adults are dropped from Medicaid on their 19th birthday
- Restore community mental health capacity – free up at least \$70 million annually in local behavioral health funding
- Improve care through better coordination – extend Ohio's nationally-recognized Medicaid reforms to more Ohioans

Extend Medicaid Coverage:

Mitigate the Harmful Effects of Obamacare

- Keep the doors open to Ohio's hospitals – federal payments for uncompensated care shrink as a result of Obamacare
- Hold the line on health insurance premium increases – prevent an uncompensated care cost-shift to private-sector premiums
- Protect Ohio taxpayers from federal decisions – codify an automatic opt-out if the federal government changes the rules
- Protect Ohio employers from Obamacare penalties – avoid employees triggering employer penalties on the Exchange

Modernize Medicaid:

Who Supports Extending Medicaid?

- Ohio Chamber of Commerce
- Ohio Right to Life
- Catholic Conference of Ohio
- County Commissioner's Association of Ohio
- Ohio Hospital Association
- Ohio Children's Hospital Association
- Ohio Association of Health Plans
- National Alliance on Mental Health (NAMI Ohio)
- Ohio State Medical Association
- Columbus Dispatch, Cleveland Plain Dealer, Toledo Blade, Akron Beacon Journal, Cincinnati Enquirer, Youngstown Vindicator

Complete List: www.healthtransformation.ohio.gov/Budget/ExtendMedicaidServices.aspx

Extend Medicaid Coverage:

Consequences of Not Extending Coverage

Over the next two years, Ohio taxpayers would need to pay an additional \$404 million in state general revenue (\$690 million all funds) to:

- NOT extend coverage to 275,000 more low-income Ohioans
- NOT keep \$2.4 billion in Ohioans' federal tax dollars in Ohio (\$13 billion over seven years)
- NOT strengthen local mental health and addiction services
- NOT free up \$130 million in local funds to meet local needs
- NOT protect local hospitals from federal cuts



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Current Initiatives

Modernize Medicaid

- Reform nursing facility reimbursement
- Integrate Medicare and Medicaid benefits
- Rebalance spending on long-term services and supports
- Create health homes for people with mental illness
- Restructure behavioral health system financing
- Improve Medicaid managed care plan performance

Streamline Health and Human Services

- Consolidate mental health and addiction services
- Create a cabinet-level Medicaid department
- Modernize eligibility determination systems
- Integrate HHS information capabilities
- Coordinate programs for children
- Share services across local jurisdictions

Improve Overall Health System Performance

- Pay for health care based on value instead of volume
- Encourage Patient-Centered Medical Homes
- Accelerate electronic Health Information Exchange

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