



**Governor's Office of
Health Transformation**

Medicaid Budget

House Finance Committee Testimony

Thursday, March 17, 2011

Health Transformation Team

- Greg Moody, Office of Health Transformation
- John Martin, Developmental Disabilities
- Bonnie Kantor-Burman, Aging
- John McCarthy, Medicaid
- Ted Wymyslo, MD, Health
- Tracy Plouck, Mental Health
- Orman Hall, Alcohol and Drug Addiction Services
- Michael Colbert, Job & Family Services

Medicaid is Ohio's Largest Health Payer

- Provides health coverage for low-income children, parents, seniors, and people with disabilities
- Covers 2.2 million Ohioans (1 in 5) including 2 in 5 births¹
- Spends \$18+ billion annually all agencies, all funds (SFY 2011)¹
- Accounts for 4.0% of Ohio's total economy and is growing²
- Funds are federal (63.69%) and state (36.31%)³
 - \$1.00 from Ohio draws \$1.75 federal = \$2.75 all funds
 - Must cut \$2.75 all funds to save \$1.00 state share (GRF)

SOURCES: (1) Ohio Department of Job and Family Services, (2) SFY 2011 estimate based on \$18.0 billion in Medicaid spending per ODJFS and \$498 billion Ohio gross domestic product per the State of Ohio Office of Budget and Management, and (3) Federal Register Vol. 76 No. 22 page 5811.

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

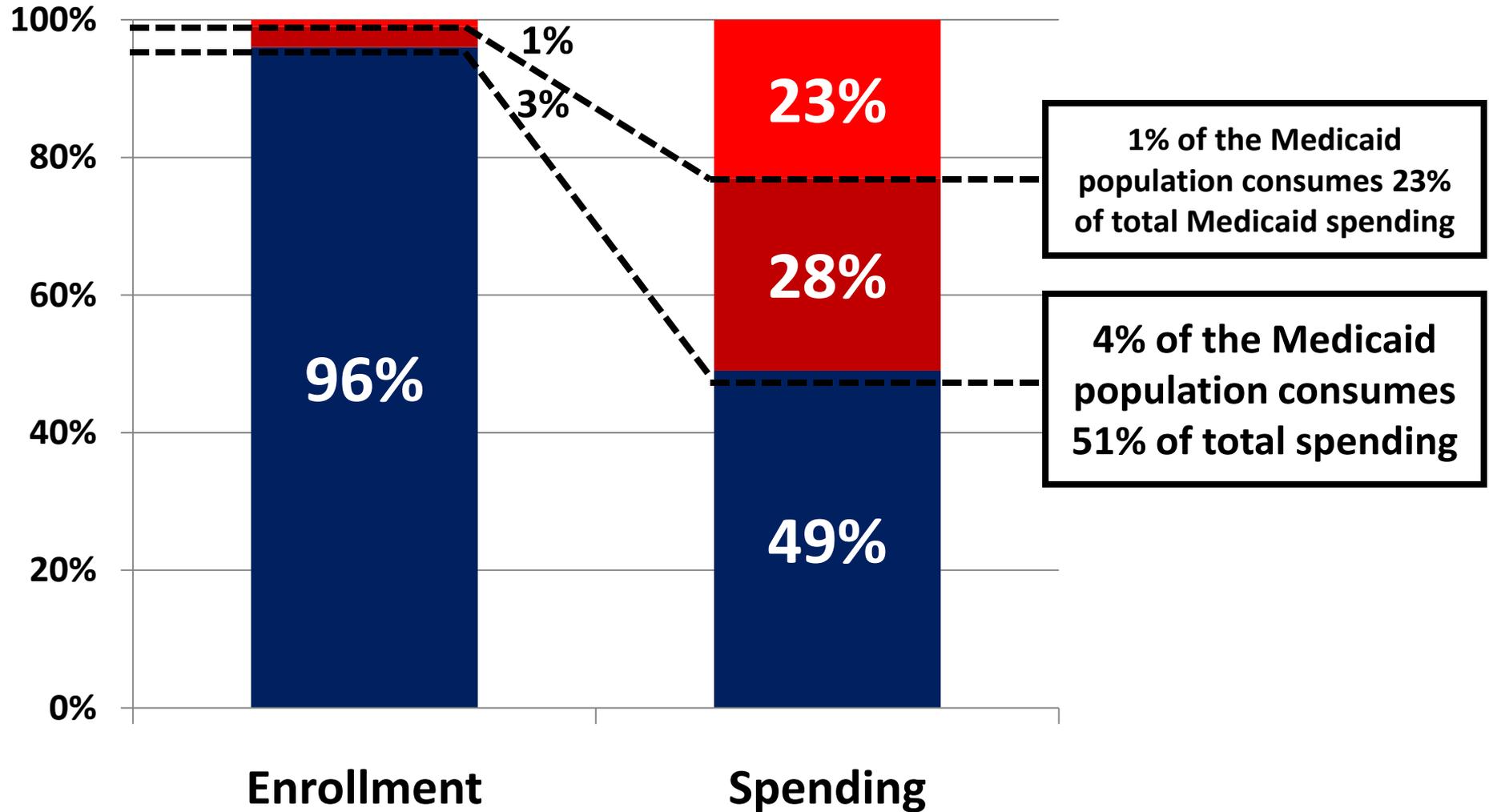
Prevention, Primary Care, and Care Coordination¹

- 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

A few high-cost cases account for most Medicaid spending



Fragmentation

vs.

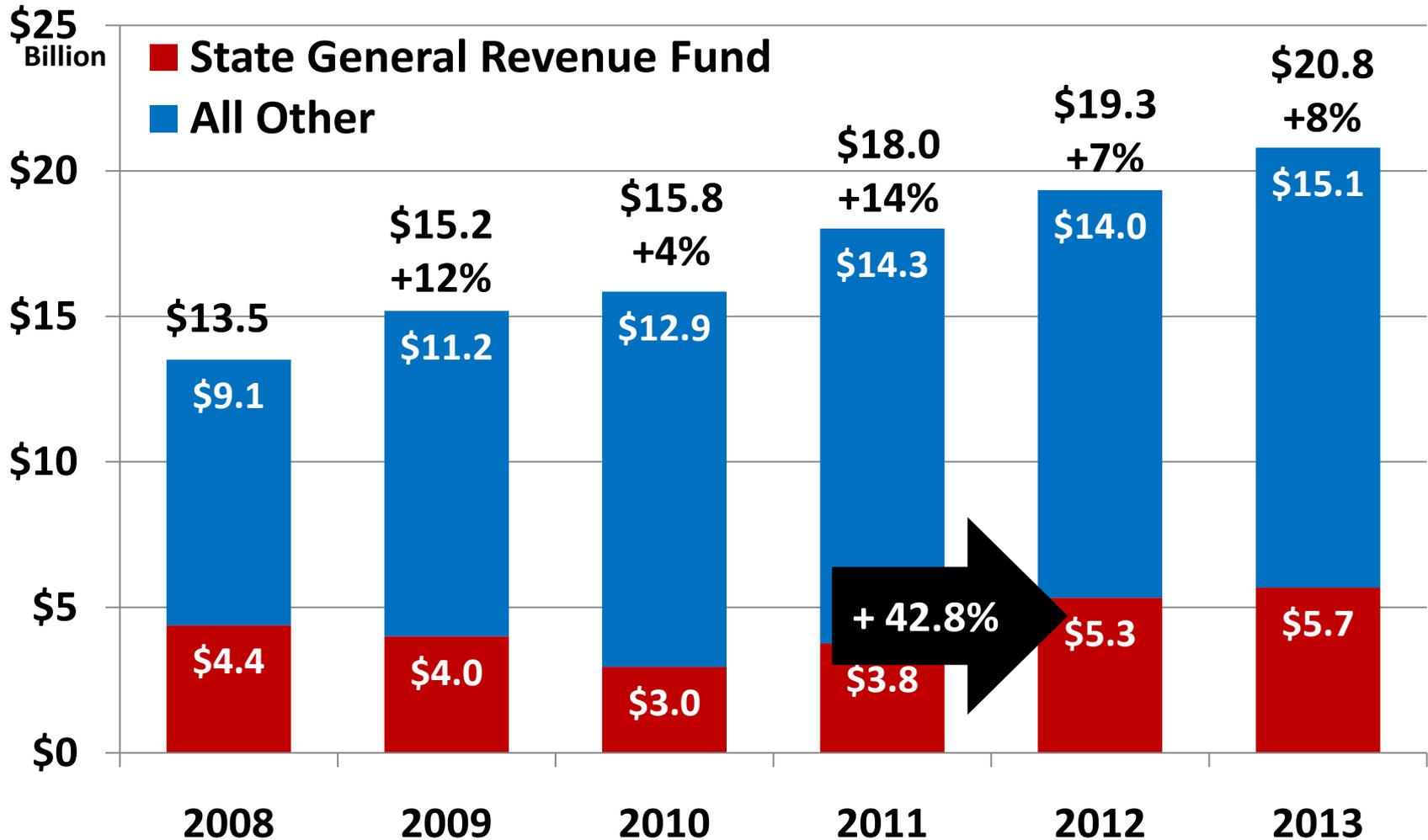
Coordination

- 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

- 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

Ohio Medicaid Spending Trend

9 percent average annual growth, 2008-2011



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Source: Office of Health Transformation Consolidated Medicaid Budget, All Funds, All Agencies; actual SFY 2008-2010 and estimated SFY 2011-2013; "All Other" includes Federal Funds and Non-General Revenue Funds (non-GRF)

ODJFS Medicaid Line Item 600-525

All Funds	SFY 2011	SFY2012	%	SFY 2013	%	SFY 2012-2013
Initial Trend	\$3,125,039,226	\$4,647,118,833	48.7%	\$4,977,637,741	7.1%	\$9,624,756,574
<i>Revised Baseline</i>	<i>\$3,751,798</i>	<i>(\$82,727,222)</i>		<i>(\$103,091,587)</i>		<i>(\$185,818,810)</i>
<i>Transfer for AGE</i>		<i>\$ 175,977,912</i>		<i>\$ 179,303,043</i>		<i>\$355,280,955</i>
<i>Transfer from ODMH</i>		<i>\$0</i>		<i>\$163,500,000</i>		<i>\$163,500,000</i>
<i>Transfer from ODADAS</i>		<i>\$0</i>		<i>\$26,163,729</i>		<i>\$26,163,729</i>
<i>Other Policy Changes</i>	<i>\$14,488,544</i>	<i>(\$438,874,186)</i>		<i>(\$537,659,993)</i>		<i>(\$976,534,179)</i>
<i>Subtotal</i>		<i>(\$262,896,274)</i>		<i>(\$168,693,221)</i>		<i>(\$431,589,495)</i>
525 State Share	\$3,143,279,568	\$4,301,495,336	36.8%	\$4,705,852,933	9.4%	\$9,007,348,270
<i>525 Federal Share</i>	<i>\$7,337,275,299</i>	<i>\$7,513,397,846</i>	<i>2.4%</i>	<i>\$8,465,448,071</i>	<i>12.7%</i>	<i>\$15,978,845,916</i>
<i>525 Total</i>	<i>\$10,480,554,867</i>	<i>\$11,814,893,182</i>	<i>12.7%</i>	<i>\$13,171,301,004</i>	<i>11.5%</i>	<i>\$24,986,194,186</i>

Revised Baseline updated February 28, 2011; includes all departments; does not include Medicare Part D



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>	\$ (157,440,366)	\$ (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>		\$ (1,526,660,553)		\$ (2,775,230,114)		\$ (4,301,890,667)
<i>Subtotal</i>		\$ (497,267,206)		\$ (941,847,823)		\$ (1,439,115,029)
Budget	\$17,862,839,330	\$18,844,917,107	5.5%	\$19,855,066,999	5.4%	\$38,699,984,106
<i>525 All Funds</i>	<i>\$10,480,554,867</i>	<i>\$11,814,893,182</i>	<i>12.7%</i>	<i>\$13,171,301,004</i>	<i>11.5%</i>	<i>\$24,986,194,186</i>

Revised Baseline updated February 28, 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
Revised Baseline	\$ 18,240,342	\$ (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>		\$ 161,602,571		\$ 157,258,801		\$ 318,861,372
<i>Savings and Cost Avoidance</i>		\$ (944,873,117)		\$ (1,376,702,881)		\$ (2,321,575,998)
<i>Subtotal</i>		\$ (522,268,797)		\$ (673,106,887)		\$ (1,195,375,684)
Budget	\$ 3,755,505,489	\$ 4,813,460,258	28.2%	\$ 5,007,232,557	4.0%	\$ 9,820,692,815
<i>525 State Share</i>	<i>\$3,143,279,568</i>	<i>\$4,301,495,336</i>	<i>36.8%</i>	<i>\$4,705,852,933</i>	<i>9.4%</i>	<i>\$9,007,348,270</i>

Revised Baseline updated February 28, 2011; includes all departments; does not include Medicare Part D



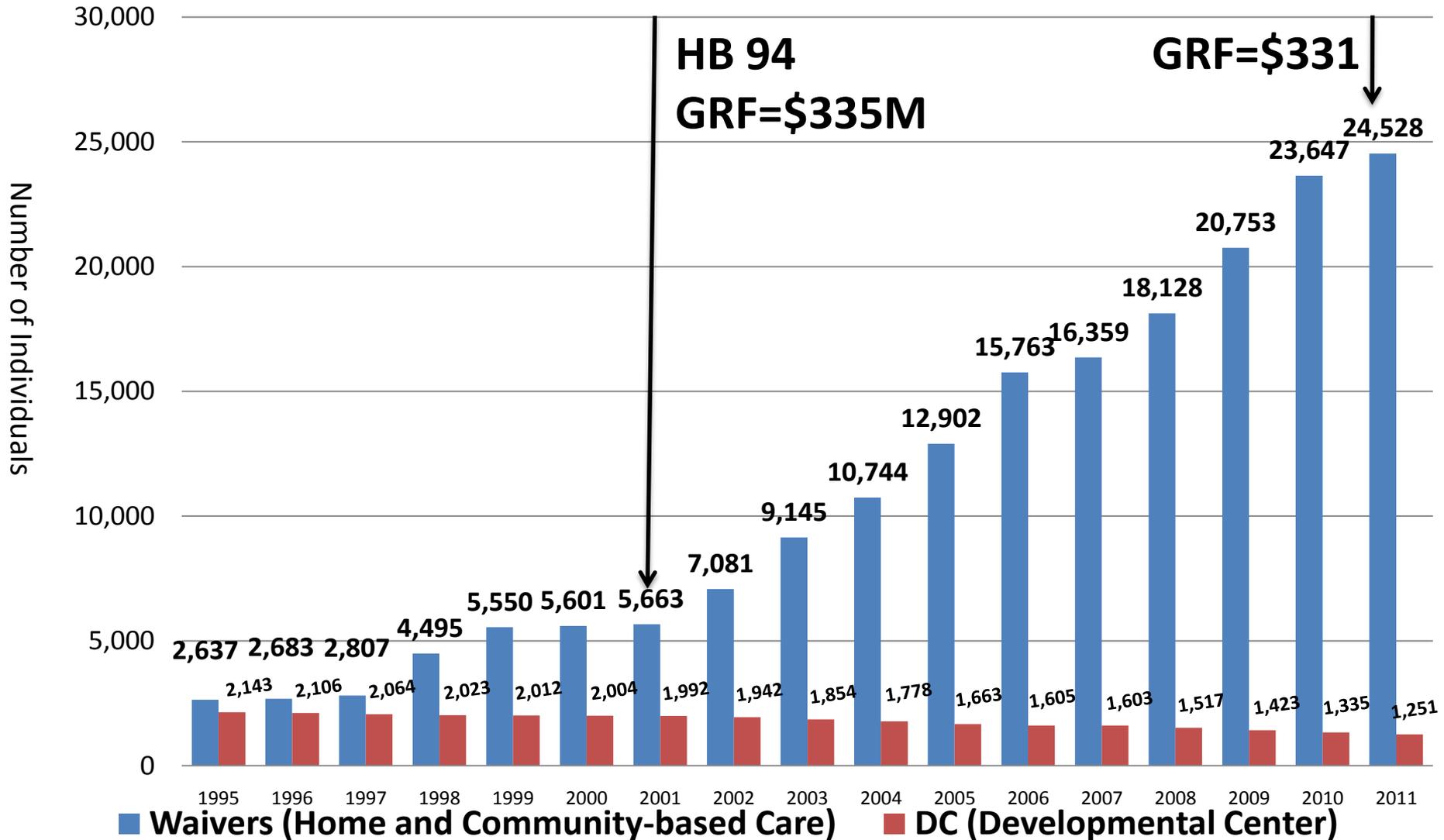
Budget Impact on Providers

	SFY2011	SFY2012	
Inpatient Hospital	\$1,054,701,001	\$1,060,574,329	0.6%
• Per Member Per Month	\$159.37	\$156.53	-1.8%
Outpatient Hospital	\$438,842,948	\$419,203,186	-4.5%
• Per Member Per Month	\$66.31	\$61.87	-6.7%
Physician	\$341,583,151	\$371,712,205	8.8%
Managed Care Plans	\$5,115,982,664	\$6,314,844,582	23.4%
• Administrative/Trend Changes			-1%

Budget Impact on Providers (continued)

	SFY2011	SFY2012	
Nursing Facility (inc. franchise fee)	\$2,680,915,522	\$2,472,669,990	-7.8%
• Statewide Average Rate	\$177.53	\$164.50	-7.3%
ICF-DD (inc. franchise fee)	\$552,471,835	\$553,899,675	0.3%
• Statewide Average Rate	\$278.15	\$279.81	0.6%
Nursing Services			
• Ohio HomeCare waivers	\$50,905,172	\$51,451,133	1.1%
• Private Duty Nursing	\$154,489,967	\$161,919,718	4.8%
• State Plan Home Health	\$105,554,710	\$107,166,358	1.5%
• Rate Per 4 hours	\$123.23	\$117.21	-4.9%
Aide Services			
• Ohio HomeCare waivers	\$281,046,409	\$294,378,627	4.7%
• State Plan Home Health	\$117,965,567	122,948,475	4.2%
• Rate Per 4 hours	\$59.98	\$58.50	-2.5%

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

Health Transformation Priorities

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

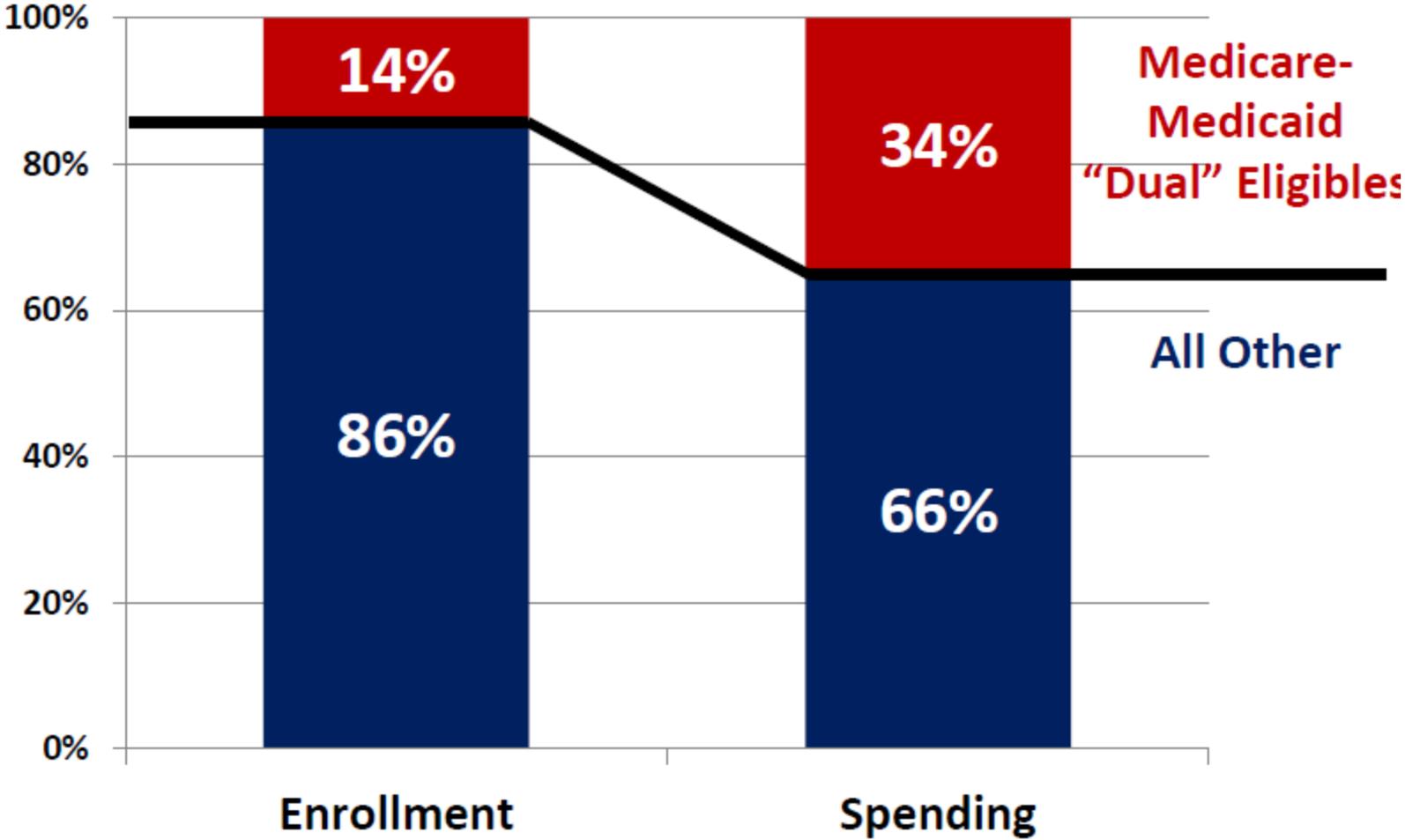
Improve Care Coordination

Coordinate care to achieve better health and cost savings through improvement

RECOMMENDATIONS:

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

Medicaid Hot Spot: Enrollment and Spending for Dual Eligibles



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

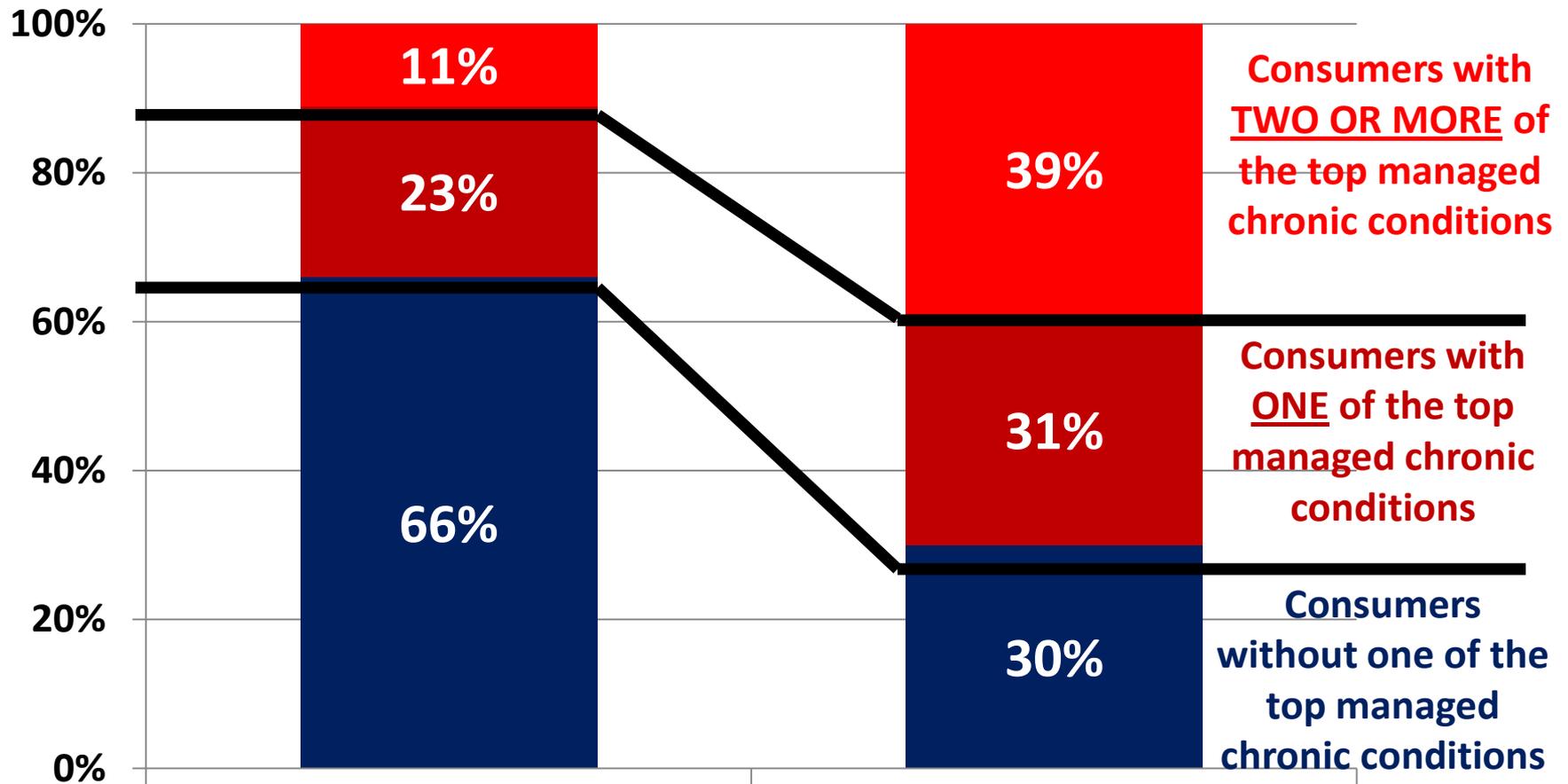
RECOMMENDATION:

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)

Medicaid Hot Spot: Enrollment Spending by Top Managed Chronic Conditions



Enrollment (2.3 million) Spending (\$10.3 billion)

Source: Ohio Department of Job and Family Services. Institutionalized consumers excluded. Based on SFY 2010 total medical cost either by ODJFS or Medicaid managed care plans. Top managed conditions = Diabetes, CAD, CHF, Hypertension, COPD, Asthma, Obesity, Migraine, HIV, BH, & Sub. Abuse.



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RECOMMENDATION:

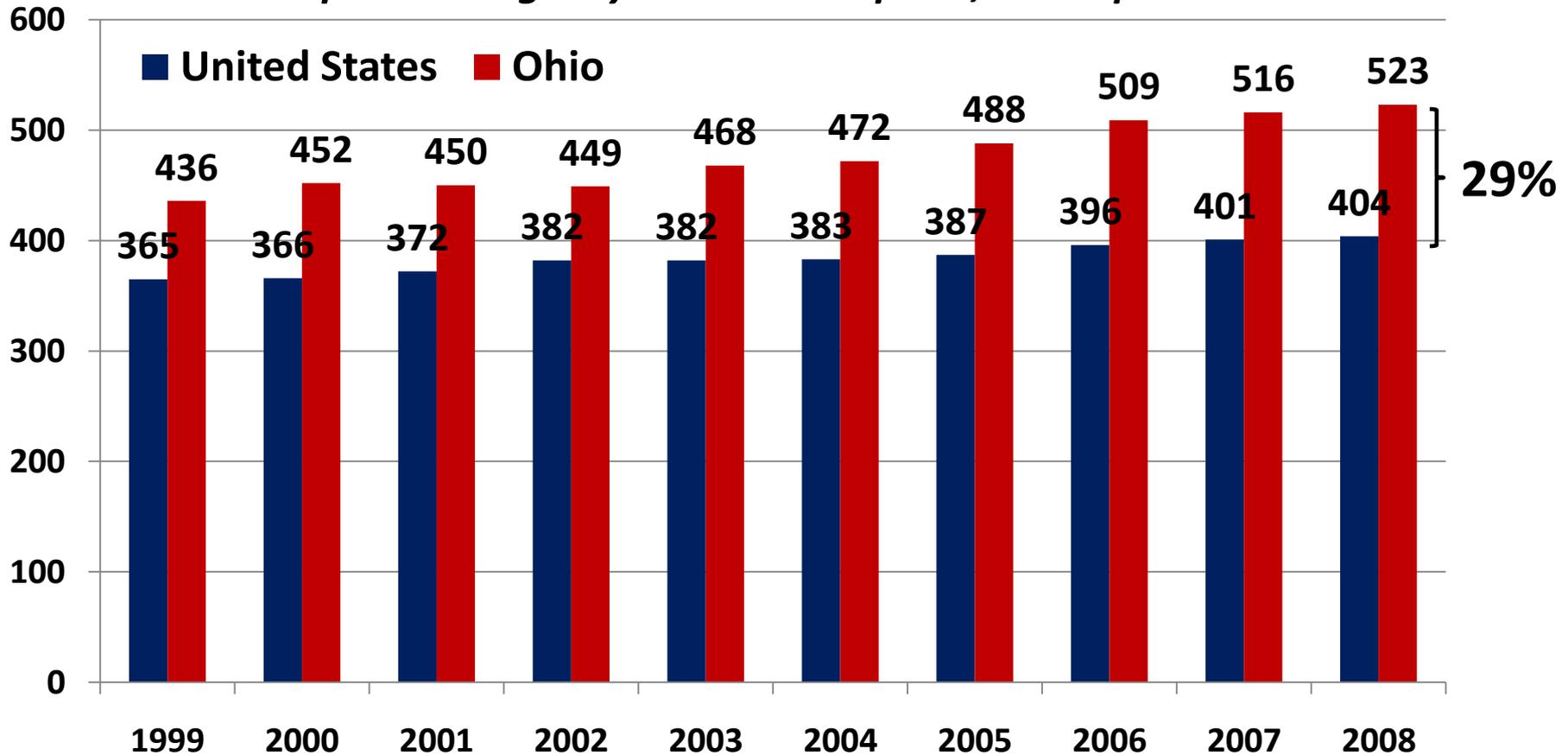
Promote Health Homes

Define Medicaid Health Homes to ensure consistency in delivery of care and set a standard for reimbursement

- 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

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

Hospital Emergency Room Visits per 1,000 Population



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>.



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Medicaid Hot Spot: Medicaid Enrollees Who Get Care Primarily from Hospitals*

** Indicating a lack of primary care and/or care coordination*

Non-Institutionalized Medicaid Population	Enrollment		Spending		Average Cost
	Number	%	Amount	%	
Children	29,552	1.3%	\$510 million	5%	\$17,300
Adults	12,530	0.5%	\$841 million	8%	\$67,100
Total	42,082	1.8%	\$1.35 billion	13%	\$32,100

Source: Ohio Department of Job and Family Services for SFY 2010. Note that medical costs include those incurred by MCPs and paid by FFS, excluding institutionalized consumers and their costs. Consumers may have been in both FFS and MC delivery systems within SFY 2010. This analysis includes consumers costs in both systems.



Medicaid Hot Spot: Avoidable Hospital Admissions for Children

Avoidable admissions are those conditions on admission claims that generally would not have resulted in inpatient admission if appropriate prior treatment had occurred.

Measurement	Admits	SFY 2009 Cost	Cost Per Admit
Asthma ¹	1,404	\$7,639,922	\$5,441
Urinary Tract Infection ²	759	\$4,270,681	\$5,626
Low Birth Weight ³	7,446	\$156,110,544	\$20,965

¹ Principal diagnosis code of asthma and no secondary diagnosis code of cystic fibrosis or respiratory anomaly, for patient aged 2 years and older.

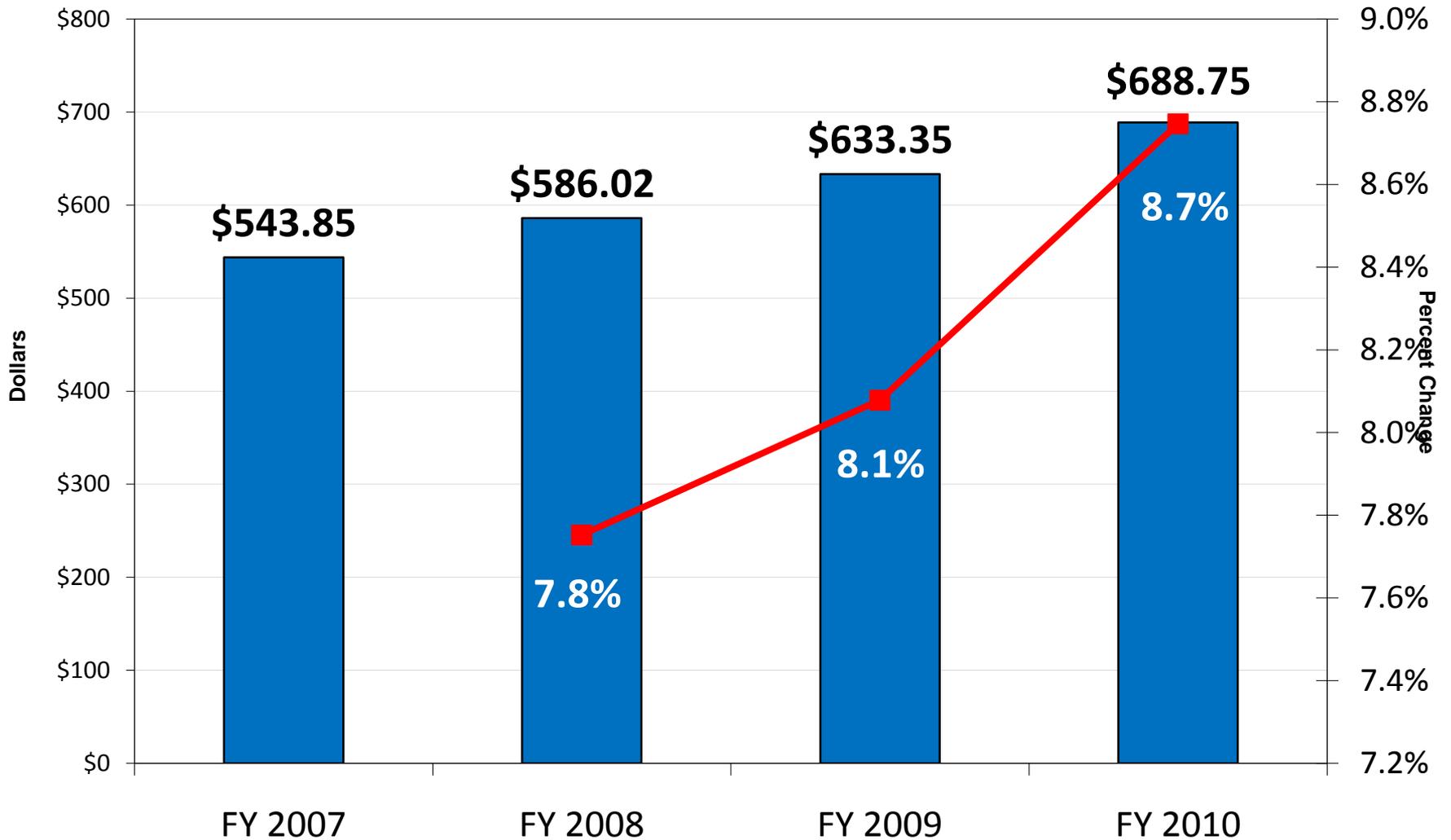
² Principal diagnosis code of urinary tract infection (UTI), for patients over the age of 90 days.

³ Diagnosis code of low birth weight, for neonates less than 2 months of age. Admissions for newborns with a missing age are included.



Children with Disabilities Eligible for Managed Care Expansion

Average Per Member Per Month Cost

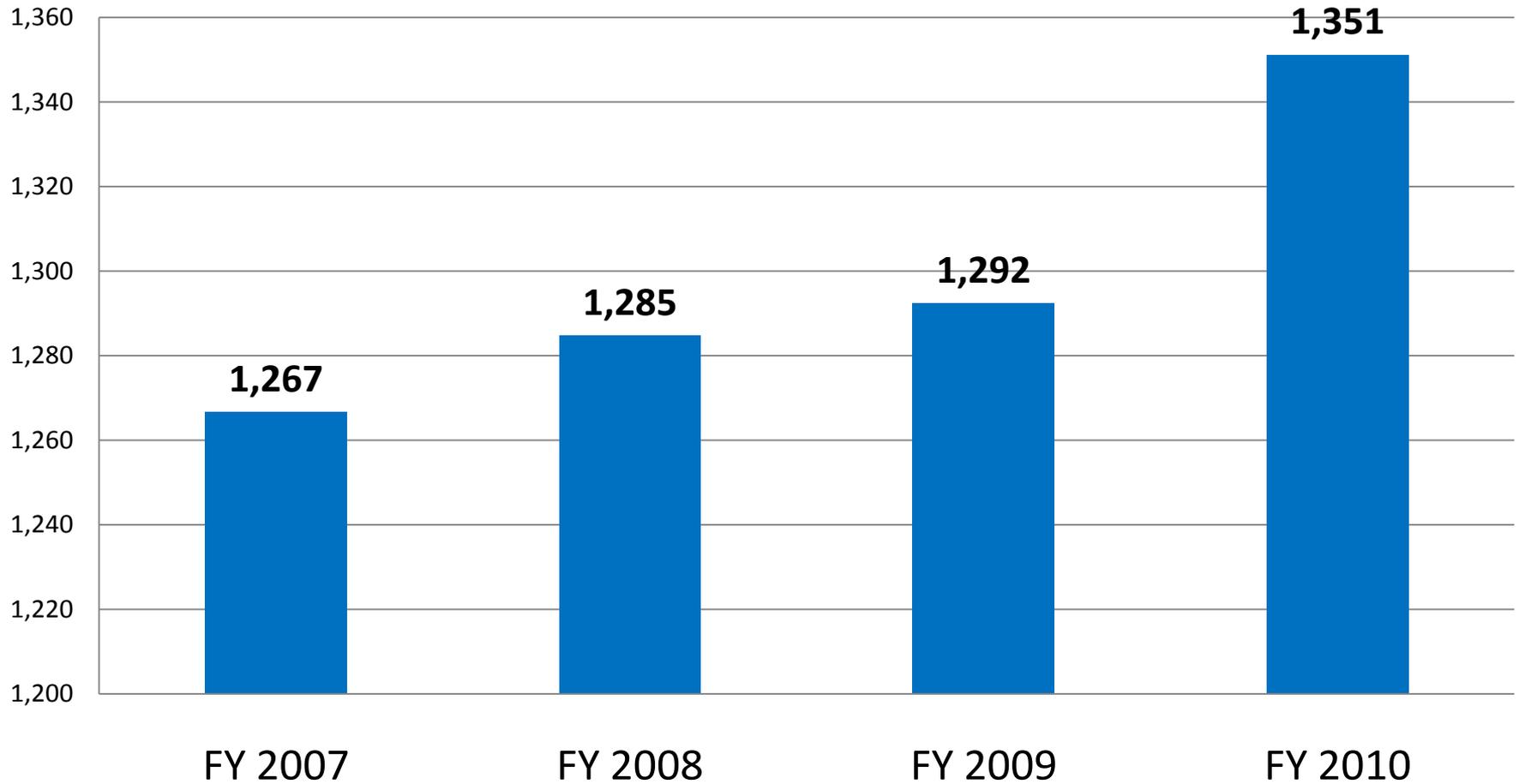


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Based on claims incurred in FY 2010 and paid through January 2011. Prescription drug rebates not included. Includes children not institutionalized, retroactive, backdated, spend down, dual eligible, or enrolled in waivers.

Children with Disabilities Eligible for Managed Care Expansion

Average Number of Prescriptions per 1000 Member Months



Based on claims incurred in FY10 and paid through January 2011. Prescription drug rebates are not included. Includes children not institutionalized, retroactive, backdated, spenddown, dual eligible, or enrolled in waivers.

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
- \$87,100,000 in FY 2013 (\$288 million in savings from better coordination and \$375 million in costs to exit fee-for-service)

RECOMMENDATION (continued):

Provide Accountable Care for Children

Responsibility	Current	Phase I	Phase II	Phase 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

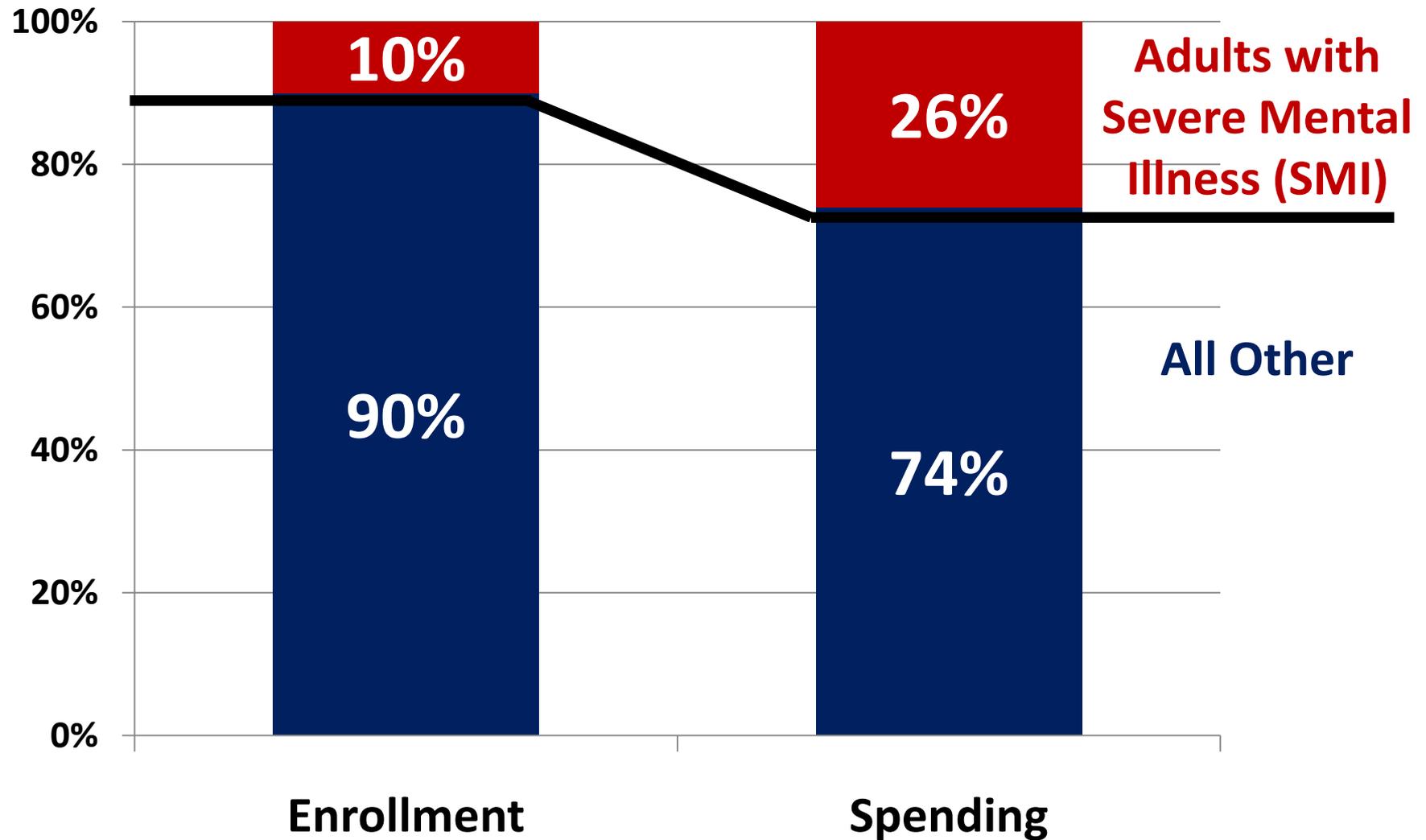
Integrate Behavioral/Physical Health

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

RECOMMENDATIONS:

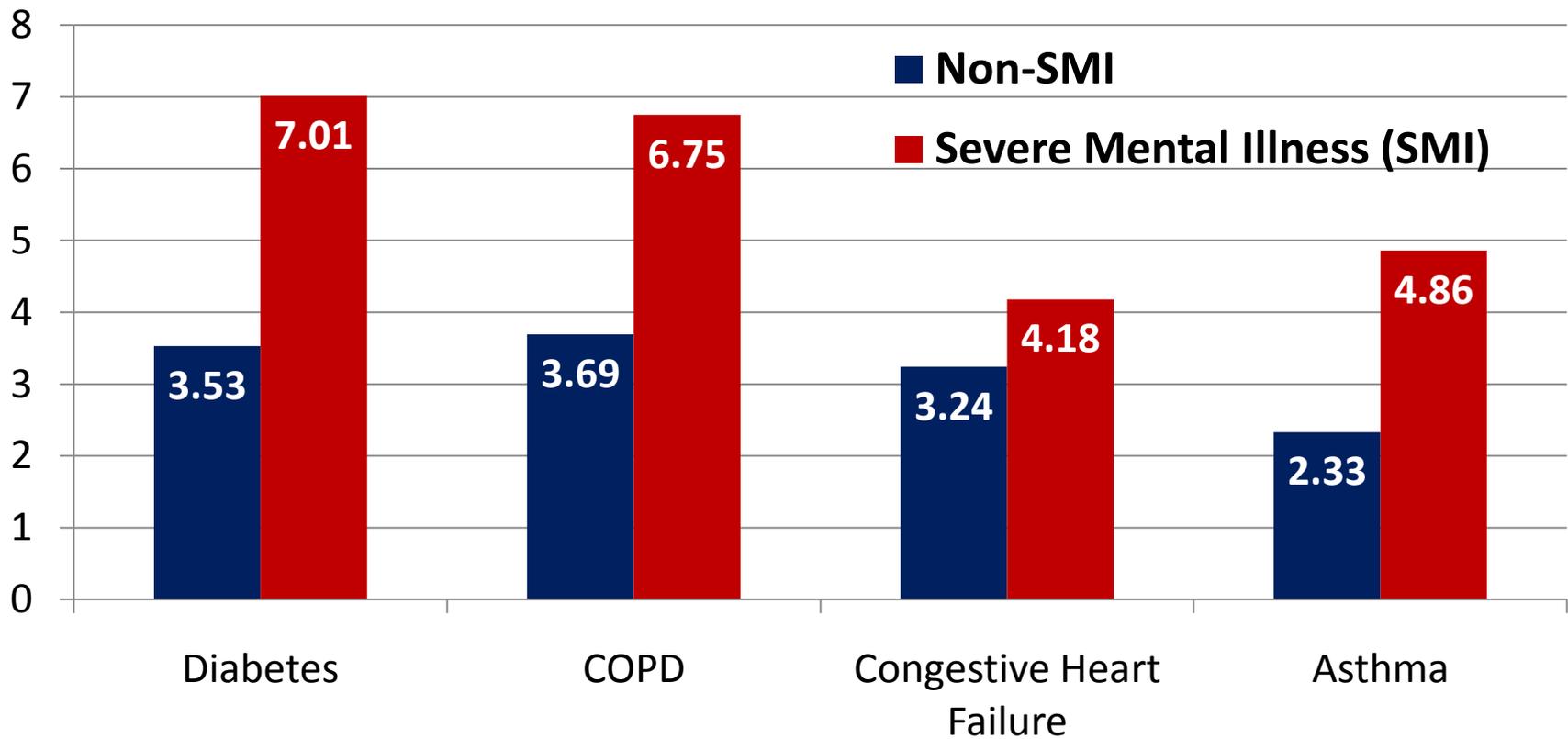
- Integrate behavioral and physical health benefits
- “Elevate” behavioral health financing to the state
- Manage behavioral health service utilization

Medicaid Hot Spot: Enrollment and Spending for Severe Mental Illness



Medicaid Hot Spot: Hospital Admissions for People with Severe Mental Illness

Avoidable hospitalizations per 1000 persons for ambulatory care sensitive conditions (avoidable with proper treatment)



RECOMMENDATION:

Integrate Behavioral/Physical Benefits

- Physical and behavioral health integration leads to better outcomes for individuals and less spending by taxpayers
- Care coordination opportunities led by Office of Health Transformation for planned implementation in FY 2013
- Focus populations: dual Medicare/Medicaid enrollees and individuals with severe and persistent mental illness
- Community Medicaid behavioral health services will be redesigned in conjunction with this project
- Budget neutral

RECOMMENDATION:

Elevate Behavioral Health Financing

- ODMH will allocate and commit sufficient dollars to meet each county board's Medicaid match obligation
- This will include cost containment rules to focus on high priority areas and reduce overall costs
- Boards will reimburse providers and process claims for Medicaid through MACSIS, as they have done in the past
- Boards will be held harmless from the effects of Medicaid match on other revenue (e.g., levy, non-Medicaid, block grant)
- Transition in FY 2012 then in FY 2013 then the appropriation shifts to ODJFS line item 600-525
- Budget neutral

RECOMMENDATION:

Manage Behavioral Health Service Utilization

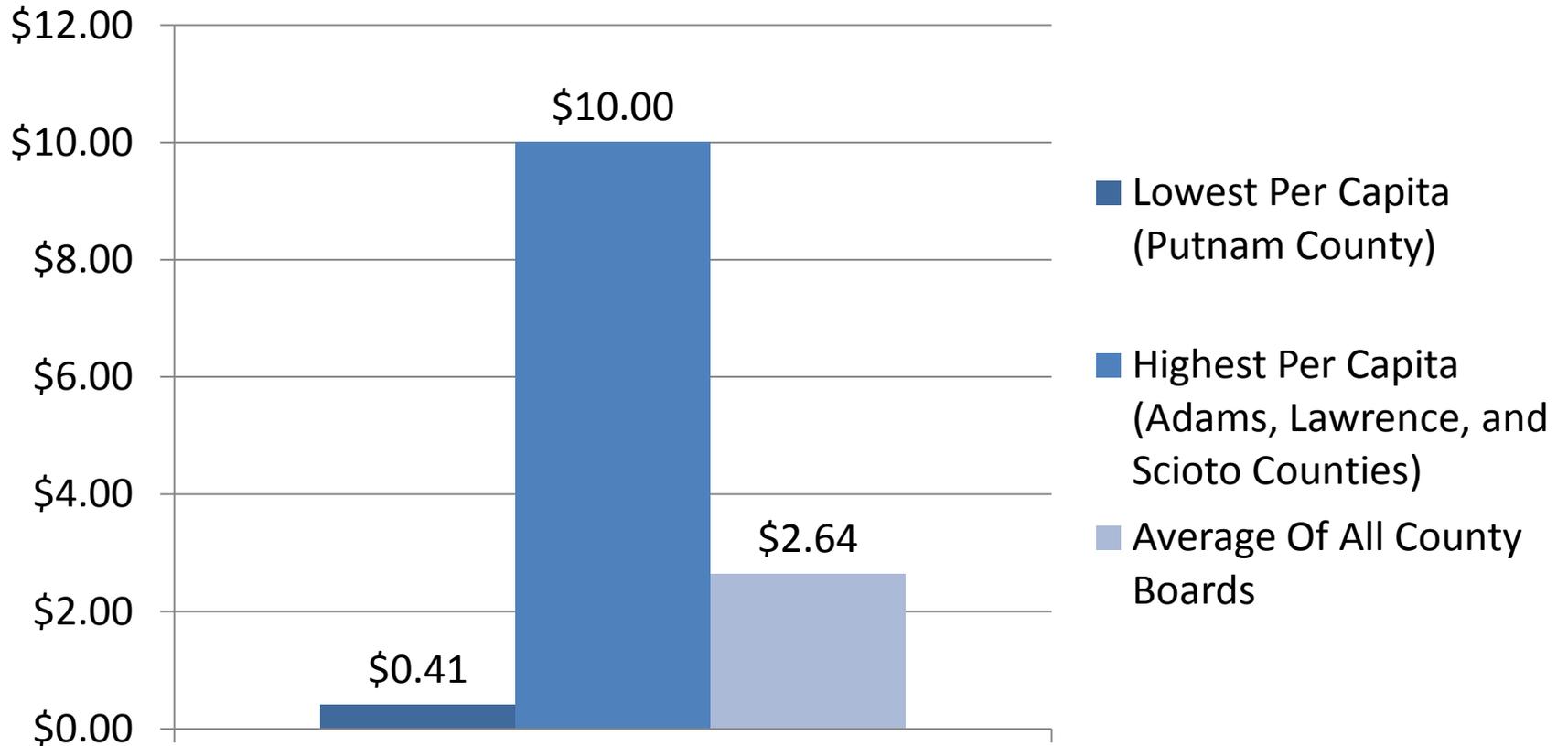
- Currently no limits on amount, frequency, or duration
- Utilization control strategies developed with consumer, provider, and board input but no consensus
- Recommendation is data-informed, preferable to across the board cuts, and based on experience in other states
- Effective July 1, 2011: service utilization limits, payment modifications, and limits on community mental health benefits for long-term nursing facility stays
- Children entitled to all medically necessary services consistent with Medicaid EPSDT requirements
- Saves \$243 million over the biennium

RECOMMENDATION (continued):

Manage Behavioral Health Service Utilization

Service	Workgroup	Proposed	% of clients not impacted
Community psychiatric supportive treatment	130 hours	104 hours	96%+
Pharmacy management	24 hours	24 hours	98%+
Counseling	100 hours	52 hours	97%
Diagnostic assessment by an MD	4 hours	2 hours	95%
Diagnostic assessment	10 hours	4 hours	90%+
Partial hospitalization	90 days	30 days	50%

Variation in Per Capita ODADAS Medicaid Spending By County Board

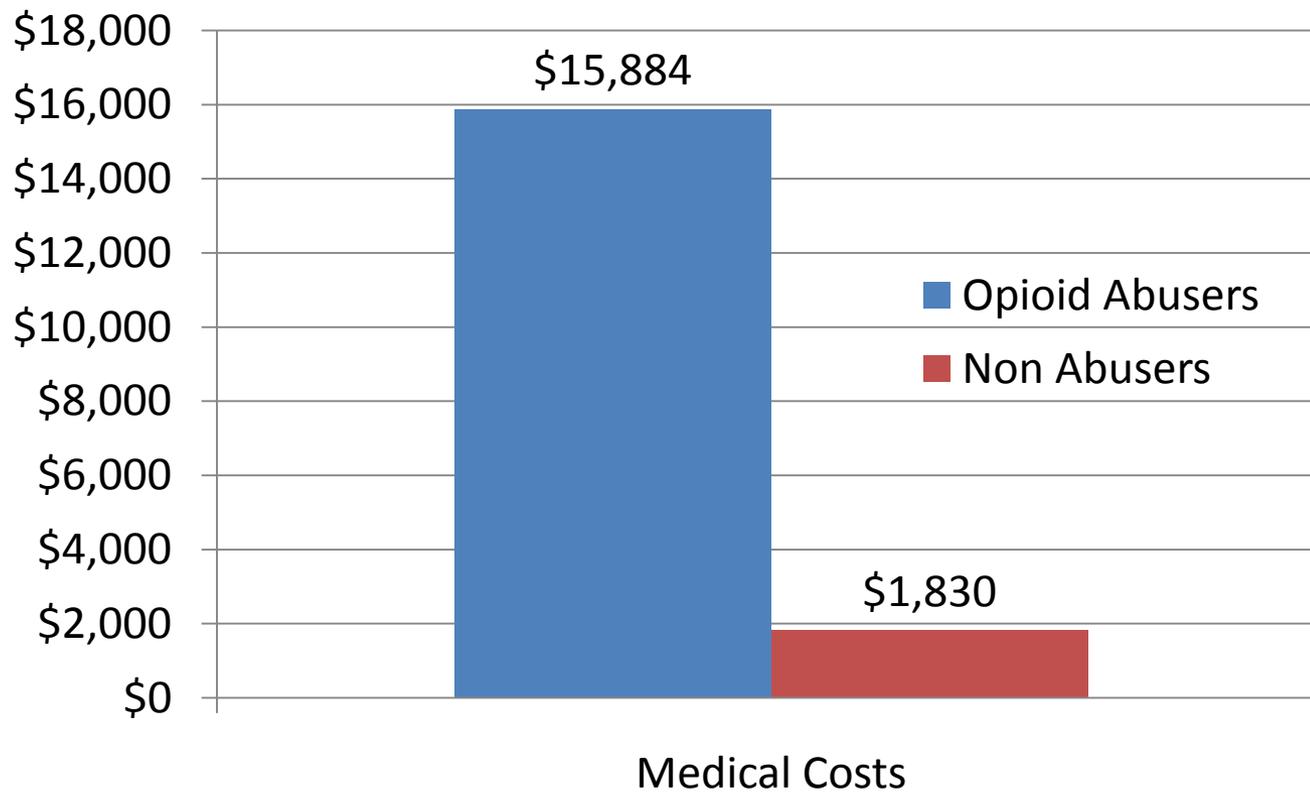


County Board Per Capita MCD Projection 2012

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



Solving the Problem

- By resolving fragmentation in the system, we can:
 - Provide Ohioans with addiction issues with more patient based care, leading to improved health outcomes
 - Reduce the cost per capita for those on Medicaid with alcohol and other drug addictions
 - See a reduction in opiate abuse and addiction

Rebalance Long Term Care

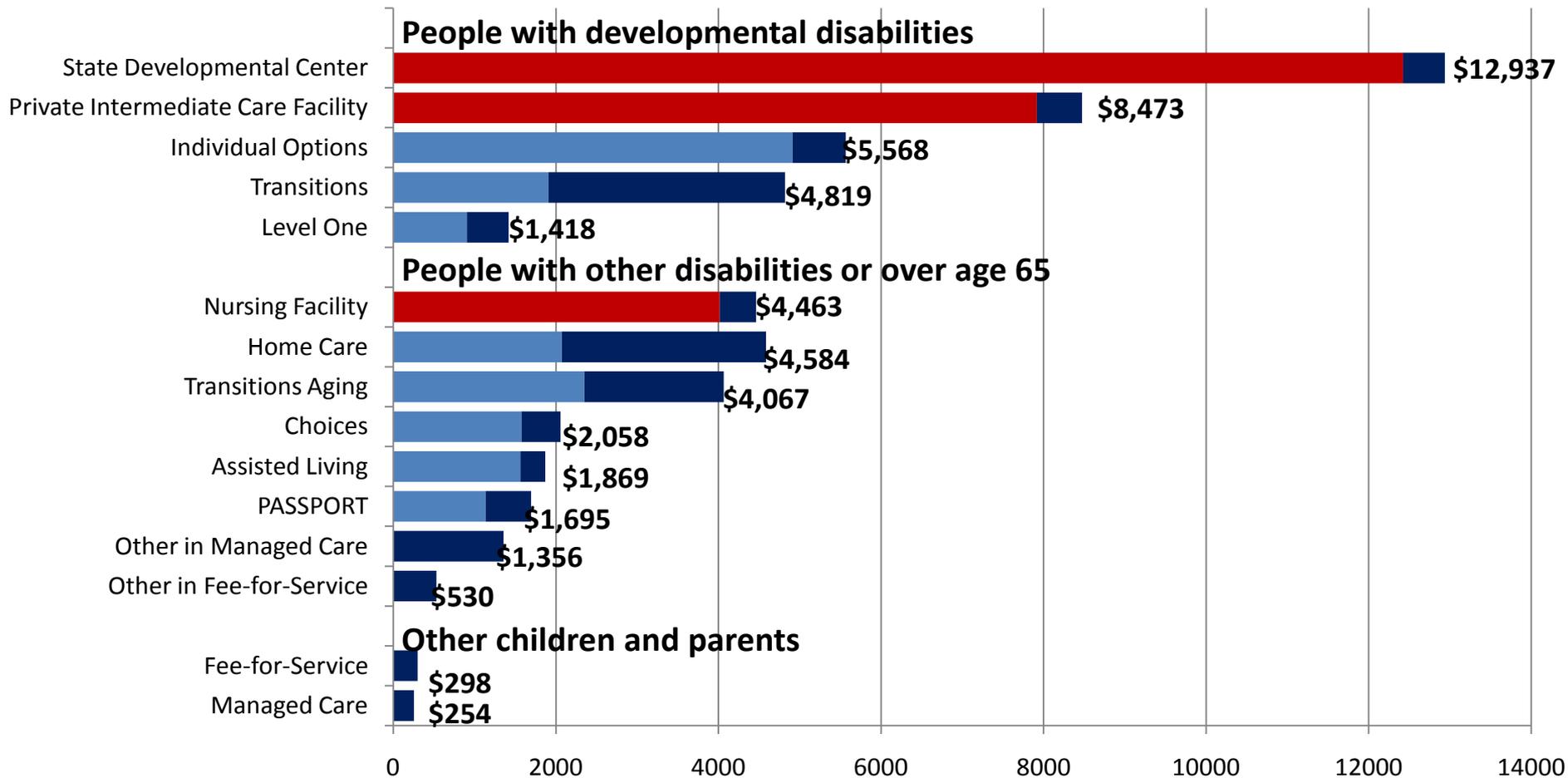
Enable seniors and people with disabilities to live with dignity in the settings they prefer

RECOMMENDATIONS:

- Align Programs for People with Developmental Disabilities
- Create a Unified Long-Term Care System
- Evaluate PACE
- Link Nursing Facility Payments to Person-Centered Outcomes

Ohio Medicaid Spending per Member per Month by Setting

■ Institutional Services
 ■ Waiver Services
 ■ All Other Medicaid

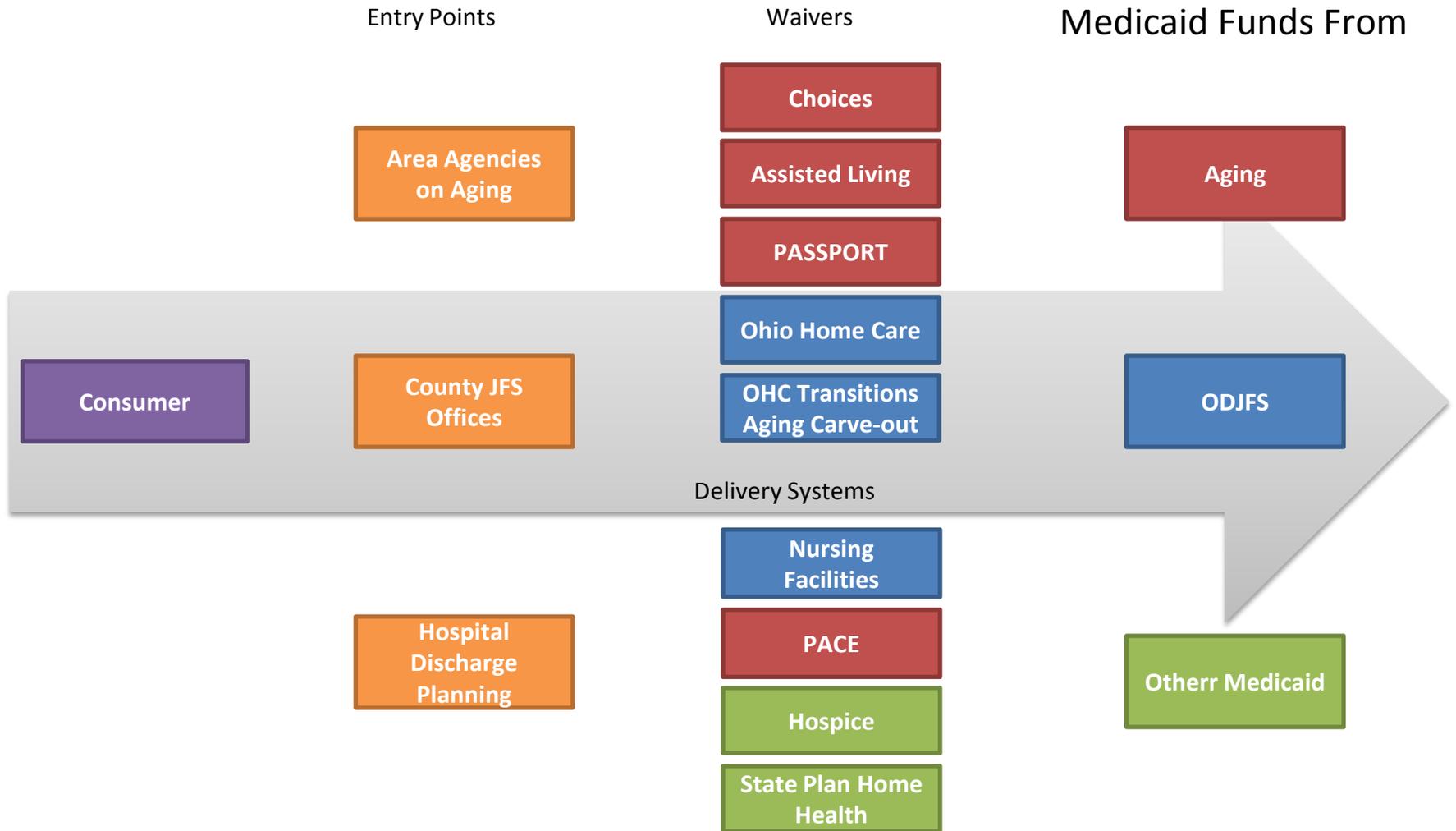


Source: Ohio Department of Job and Family Services. Includes claims incurred from July 2009 through June 2010 and paid through October 2010; cost differences between institutional and waiver/community alternatives do not necessarily represent program savings because population groups being compared may differ in health care needs.



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Current Long-Term Care Delivery System

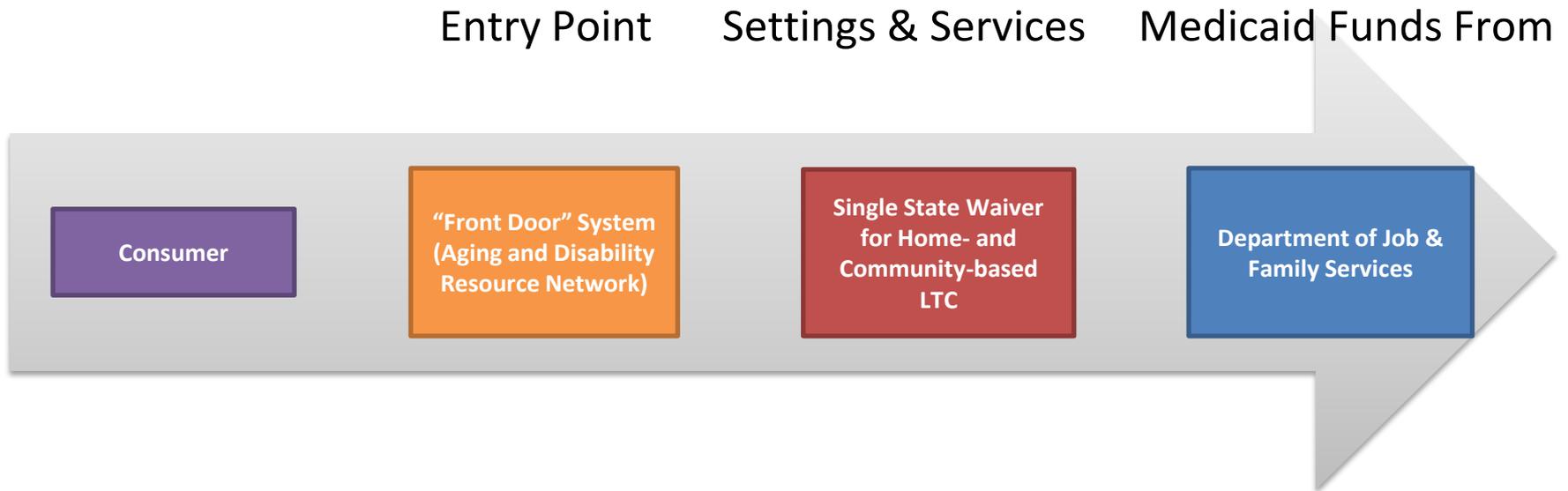


RECOMMENDATION:

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

Unified Delivery System



RECOMMENDATION:

Evaluate PACE

- Program of All-Inclusive Care for the Elderly (PACE) serves 750 people in two sites (Cleveland and Cincinnati)
- Most expensive community-based option – twice as expensive as PASSPORT but PACE enrollees have less need
- 80 percent of enrollees are also eligible for Medicare
- Evaluate cost-effectiveness of current PACE, seek cost-sharing with Medicare, and only then consider expanding
- \$200,000 in FY 2012

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
- 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
- Budget neutral

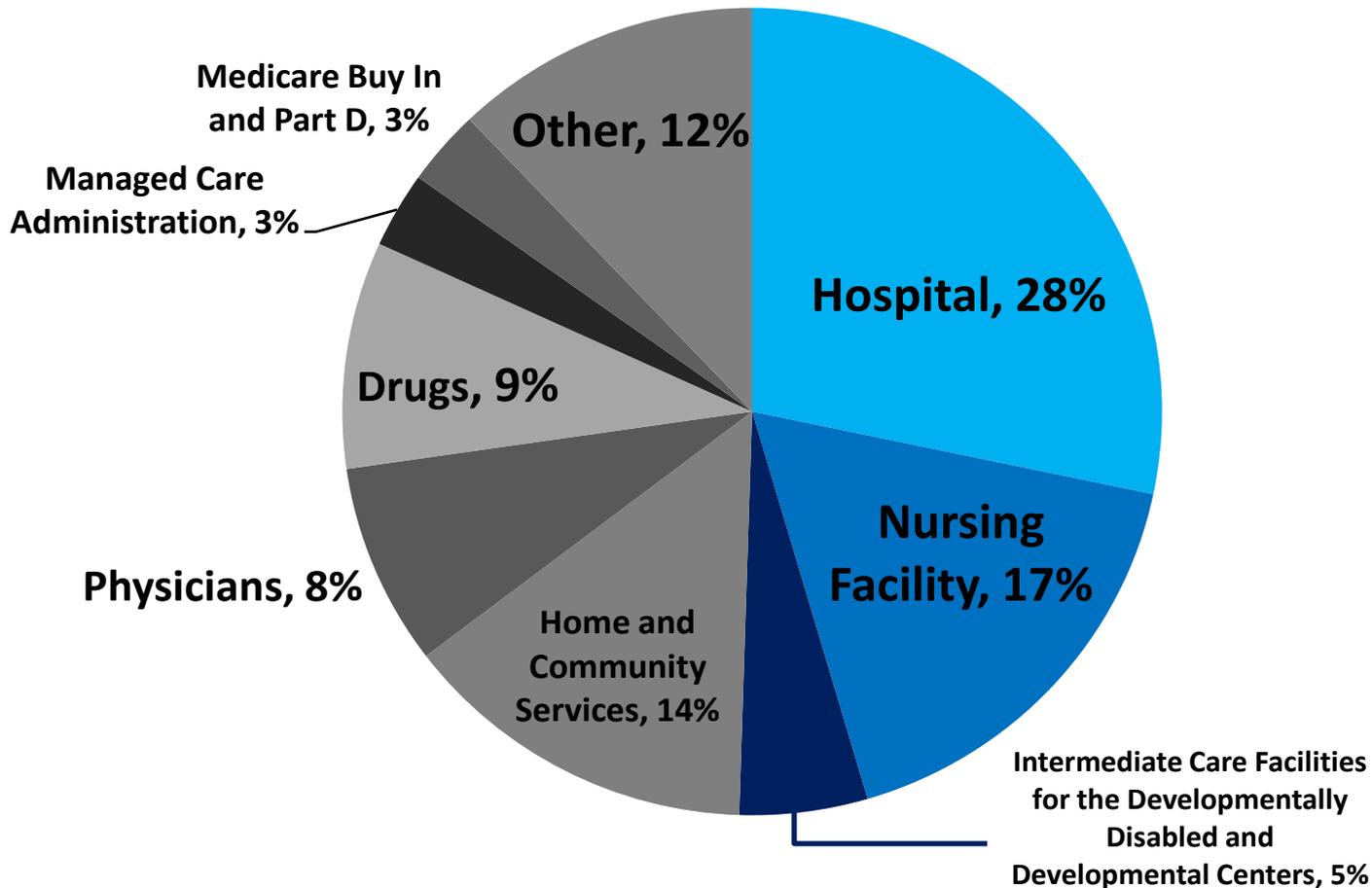
Modernize Reimbursement

Reset Medicaid payment rules to reward value instead of volume

RECOMMENDATIONS:

- Hospital payments
- Managed care plan payments
- Nursing facility payments
- Other benefits and payments

Total Ohio Medicaid Expenditures, SFY 2010



Source: Ohio Department of Job and Family Services and the Governor's 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.



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

RECOMMENDATION (continued):

Modernize Hospital Payments

- The current budget is supported by a hospital franchise fee that generates matching funds to be used for Medicaid spending
- The OHA proposed to continue and recalibrate the existing fee and apply the proceeds to extend the 5-percent rate increase

	SFY 2012	SFY 2013	Biennium
Hospital Franchise Fee Paid	\$436,000,000	\$436,000,000	\$872,000,000
State Gain -	<u>\$217,200,000</u>	<u>\$217,200,000</u>	<u>\$434,400,000</u>
Remainder	\$218,800,000	\$218,800,000	\$437,600,000
Federal Match +	<u>\$389,653,800</u>	<u>\$391,520,800</u>	<u>\$781,174,600</u>
Total Payments to Hospitals	\$608,453,800	\$610,320,800	\$1,218,774,600
Hospital Franchise Fee Paid -	<u>\$436,000,000</u>	<u>\$436,000,000</u>	<u>\$872,000,000</u>
Net Gain to Hospitals	\$172,453,800	\$174,320,800	\$346,774,600

RECOMMENDATION:

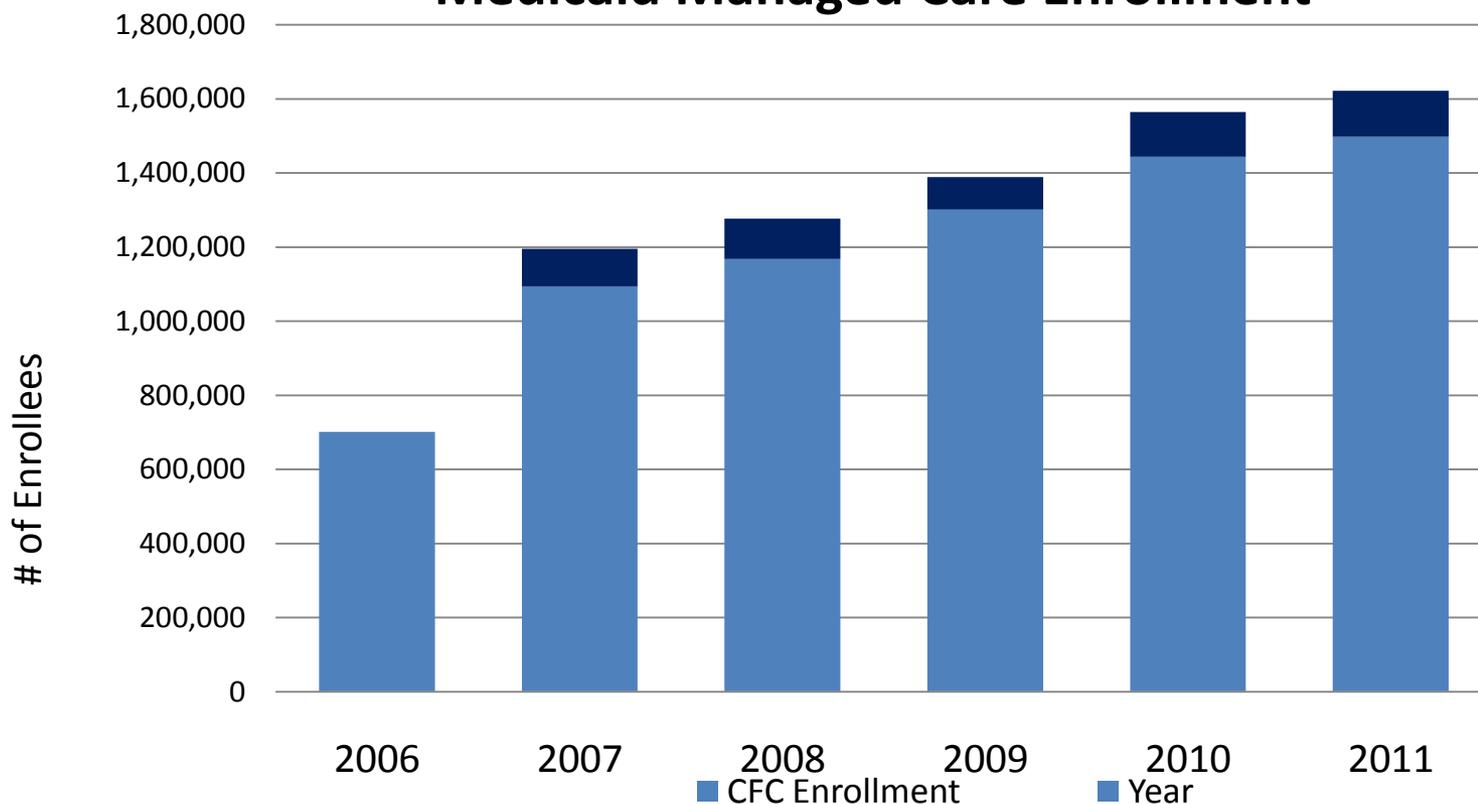
Reform Managed Care Plan Payments

- Create a pay-for-performance program
- Move to nationally recognized performance measures (HEDIS)
- Focus measurements on outcomes for high cost populations and prevalent chronic conditions (e.g., low birth weight, diabetes)
- Maintain accountability for preventive services (e.g., well-child visits and prenatal care)
- Withhold 1 percent of the capitation payment for plans to earn back as an incentive payment tied to performance

Managed Care Administration

Administration payment is a percentage of capitation rates

Medicaid Managed Care Enrollment



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Note: 2006-2010 = July enrollment, 2011 = March enrollment

RECOMMENDATION (continued):

Reform Managed Care Plan Payments

- Reduce the administrative burden on plans (e.g., move to national performance measures, accept NCQA accreditation)
- Reduce the administrative component of the capitation rate to reflect greater administrative efficiency resulting from increasing enrollment and market maturity
- Include pharmacy in the managed care benefit and develop a more standardized set of prior authorization criteria
- 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:

Reform Nursing Facility Payments

- Nursing facilities are an essential service in the continuum of long-term care
- Many are diversified and also offer community-based services, but some are stuck in the past and need to adapt to the 21st Century demand for more personalized services
- Ohioans pay more per capita for nursing facility services than residents in all but 5 states
- Approximately 15 percent of nursing home capacity is unused
- Medicaid reforms in FY 2007 began the process of addressing these issues by transitioning to a price-based payment system

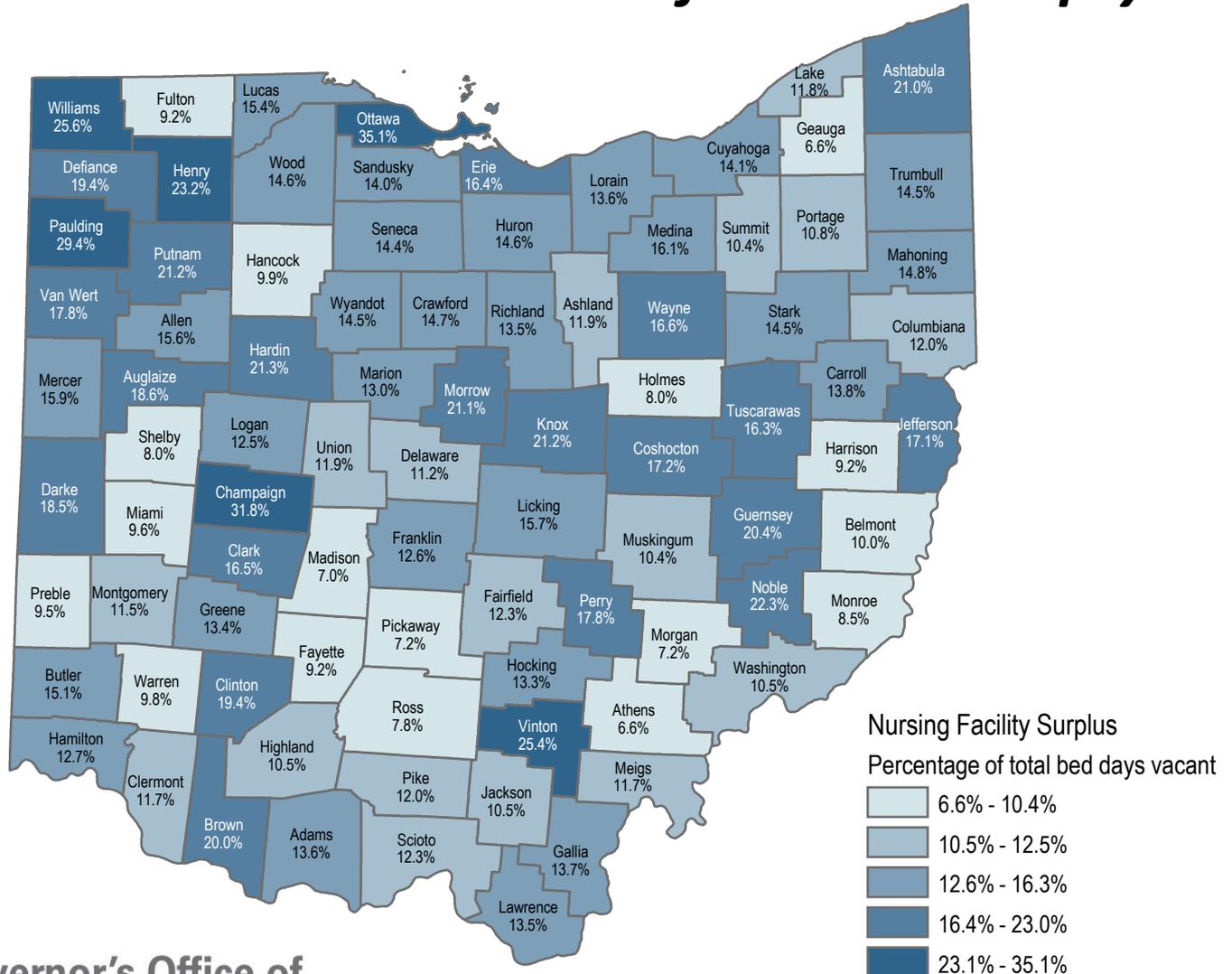
Medical Hot Spot: Per Capita Health Spending: Ohio vs. US

Measurement	US	Ohio	Percentage Difference	Affordability Rank (Out of 50 States)
Total Health Spending	\$5,283	\$5,725	+ 8%	37
Hospital Care	\$1,931	\$2,166	+ 12%	38
Physician and Clinical Services	\$1,341	\$1,337	- 0.3%	27
Nursing Home Care	\$392	\$596	+ 52%	45
Home Health Care	\$145	\$133	- 8.3%	35



Unused Nursing Home Capacity

In 70 counties more than 10% of beds are empty



RECOMMENDATION (continued):

Reform Nursing Facility Payments

- Keep price at the 25th percentile of peer group cost experience for direct care and ancillary/support services, but eliminate the statutory add-on and set capital at the 25th percentile
- Increase the quality incentive payment from 1.7 to 8.75 percent of the rate and link to patient-oriented quality measures
- Increase the portion of the rate that is related to direct care and quality from 50 to almost 60 percent
- 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
- Saves \$427 million over the biennium
- Reduces the nursing home franchise fee from \$11.95 per bed to \$11.38 in FY 2012 and \$11.60 in FY 2013

RECOMMENDATION:

Reform Other Benefits and Payments

- Reduce payment for the first 15 minutes of service from \$54.95 to 48.93 for nursing and \$23.98 to \$22.50 for home health aide
- Reduce PASSPORT, assisted living, and PACE provider rates 3 percent, PASSPORT emergency services rates 30 percent, and state support for federal Area Agencies on Aging 15 percent
- Limit physician payments to no more than Medicare would pay
- Set a maximum payment rate and prior authorize enteral nutrition products
- Implement a selective contracting program for diabetic test strips and incontinence garments, with authority to expand

Shared Services

In addition to being the direct recipient of federal funding for Medicaid, ODJFS provides:

- Human resources
- Facilities
- Contracts and acquisitions
- Legal services
- Performance management services
- Legislative and communication services
- Information services
- MITS

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)

What this budget does NOT do

- Does not cut eligibility
- Does not cut optional services, including dental
- Does not make arbitrary across-the-board cuts
- Does not resort to smoke and mirrors
- Does not count hypothetical savings



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