

# Transforming Ohio Medicaid

*Improving  
Health  
Quality  
and Value*

Recommendations from the Ohio Commission to Reform Medicaid  
January 2005



# Transforming Ohio Medicaid:

*Improving Health, Quality, and Value*



## VISION

*Ohio Medicaid will focus on consumers' health and related service needs, emphasizing wellness, prevention and personal responsibility through the purchase of quality, cost-effective services within a competitive marketplace. Service access will be seamless, supported by readily available information provided through a leading edge information technology structure. Providers, to be chosen in a competitive marketplace, will be those who achieve the highest quality health care according to accepted standards of practice at competitive prices. Ohio Medicaid will emphasize transparency of prices, outcomes reporting, and private sector-government partnerships, while maximizing its purchasing power.*

January 2005

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# The Commission's Charge and Process



On December 15, 2003, Governor Bob Taft provided opening remarks to the Ohio Commission to Reform Medicaid, where he expressed concerns that the Medicaid program is not well understood by the public at large, yet it has the potential to bankrupt the budget of the state of Ohio and every other state in the country. His remarks outlined the Commission's charge:

The Ohio Commission to Reform Medicaid derives its charge and legislative authority from Section 59.29 of the Ohio Revised Code which states that *"the Commission shall conduct a complete review of the state Medicaid program and shall make recommendations for comprehensive reform and cost containment. The Commission shall submit a report of its findings and recommendations to the Governor, Speaker, and Senate President not later than January 1, 2005."*

The Commission was chaired by Dr. Bernadine Healy and vice chair David Brennan and consisted of seven other private sector citizens who came from a variety of professional backgrounds and experiences. The commission conducted its work through three subcommittees: 1. Aged, Blind, and Disabled, 2. Eligibility and Covered Families and Children, and 3. Medicaid Implementation and Reimbursement.

Each subcommittee developed its scope of work that included: an assessment of existing problems; a set of principles for resolving these problems; goals or outcomes measures for its recommendations; and requests for research or analysis from state agencies or outside groups. The findings led to the recommendations.



# The Case for Transformation

Ohio's Medicaid program is swamping the state budget. Expenditures are increasing at twice the rate of growth of state revenues, and, despite past aggressive cost containment and budget strategies, this \$10.5 billion entitlement program now comprises over 40% of the state's general revenue fund spending.<sup>1</sup>

Medicaid, an entitlement program that covers health care services for certain low-income parents and children, disabled and elderly individuals, was enacted by the federal government as part of the Social Security Act of 1965. Each state operates its own distinct program in accordance with federal laws and regulations. Ohio's Medicaid program began in 1968 and is primarily administered by the Ohio Department of Job and Family Services (ODJFS).

A patchwork of unsynchronized activities has evolved over four decades since the creation of the Ohio Medicaid program. The program is fraught with structural, policy, and programmatic complexities and inefficiencies that make it inadequate to meet the needs of the 1.7 million low-income and disabled Ohioans it serves. And, it continues to grow unchecked.

## **PROBLEM: Ohio Medicaid is Complex**

- **10 state entities**
- **14 waivers**
- **28 + mandatory and optional services**
- **50 + eligibility categories**
- **88 county offices**
- **90 + contractors**
- **136 local boards**
- **42,869 providers**
- **1.7 million consumers**

**The Ohio Medicaid system is broken and must be transformed.**

1 The projected \$10.5 billion spending for Ohio Medicaid for State Fiscal Year (SFY) 2005 is spending by the Ohio Department of Job and Family Service (ODJFS), which includes \$4.3 billion in state funds and \$6.2 billion in federal funds. Ohio's total Medicaid commitment (state, federal, and local funds) for state fiscal year SFY 2005 is projected to be close to \$13 billion; for SFY 2007, it is expected to rise to \$15 billion.

## Ohio's Fiscal Realities and Program Challenges

After a year of research, more than 40 public meetings and testimony from hundreds of health care experts, consumers, and interested parties, the Ohio Commission to Reform Medicaid has determined that all the major challenges in the Medicaid program — be they financial, structural, policy, or programmatic — are overshadowed by one overriding reality: **the rate of growth in Medicaid spending is unsustainable.**

Over the last six years, there has been a 78% increase in Medicaid expenditures. Growth has been so dramatic that the Ohio Medicaid budget is now larger than Ohio's entire budget in State Fiscal Year (SFY) 1987. If Medicaid continues to grow at its current rate (an average of 8.7% per year since 1999), while the state general revenue fund continues to grow at an average annual rate of 4.5%, the program will consume more than half of all state spending by 2009.

Consequently, Medicaid spending creates enormous pressure on the entire state

budget, crowding out funding for other essential services, including education, economic development, transportation, and public safety.

### Medicaid Is a National Problem

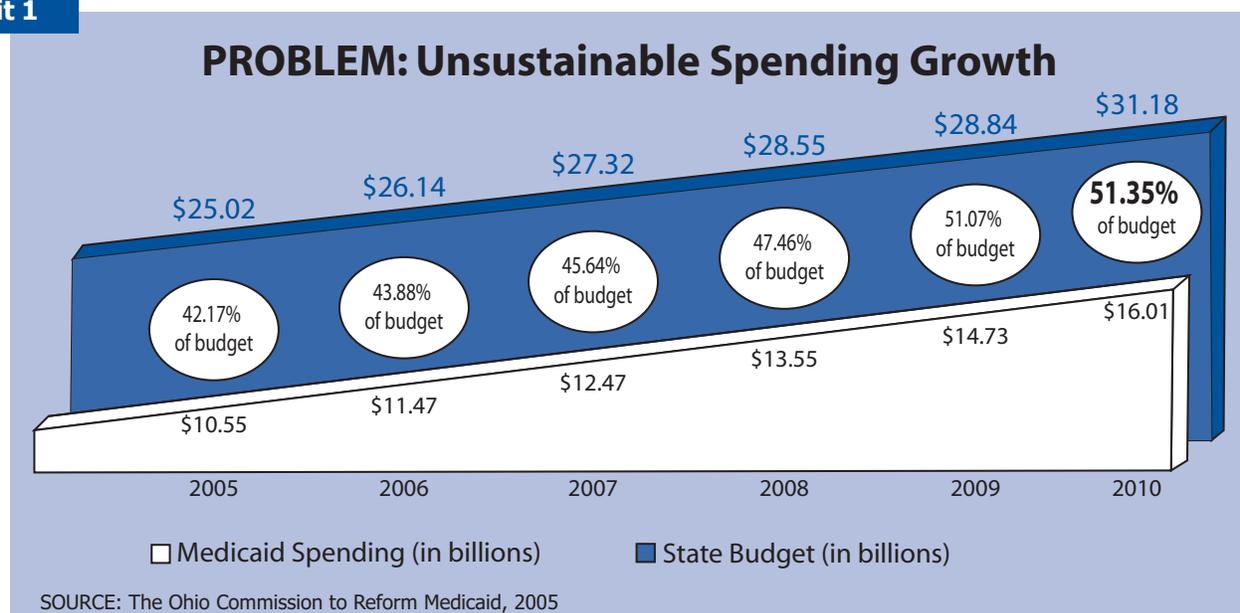
The Medicaid spending hemorrhage is not unique to Ohio: every state is experiencing skyrocketing Medicaid costs coupled with declining state revenues. Nationally, Medicaid spending rose from \$206 billion in 2002 to \$276 billion in 2003, a \$70 billion or 10.2% annual increase.<sup>2</sup> Over the next 10 years, American taxpayers will spend nearly \$5 trillion on Medicaid.

Because the federal government provides each state with matching funds based on state Medicaid expenditures, it also is feeling pressure to rein in Medicaid spending. In 2004, it spent more on Medicaid than Medicare, the federal government's health insurance program for the elderly.

By 2013, health care costs are projected to be 18.4% of the GDP.<sup>3</sup> From 1980 through 2002, United States per capita spending for

*The Ohio Medicaid budget is now larger than Ohio's entire state budget in 1987. By 2009, Medicaid spending will consume more than 50% of the state budget.*

### Exhibit 1



<sup>2</sup> Urban Institute's Health Policy Center researchers in the January-February 2005, Health Affairs.

<sup>3</sup> Behn R, Keating E, "Facing the Fiscal Crisis in State Government: National Problem; National Responsibility," Taubman Center for State and Local Government, John F. Kennedy School of Government, Harvard University, August 21, 2004. Behn R, Keating E, "Facing the Fiscal Crisis in State Government: National Problem; National Responsibility," Taubman Center for State and Local Government, John F. Kennedy School of Government, Harvard University, August 21, 2004. School of Government, Harvard University, August 21, 2004.

health care grew faster than inflation; in 15 of these 23 years, it grew at twice the rate of inflation. Health care spending also is consuming a much greater share of total spending. These rising costs threaten the affordability of health care for all Americans – families, employers, and governments.

Health care costs are only half of the problem. Consumer health care expectations are the other, particularly for state health programs that rely on taxes to pay their bills. A recent Harvard study concludes that Medicaid deficits reflect a fundamental mismatch between expectations for health care services and rising health care costs that cannot be solved with quick-fix solutions to balance the books.<sup>4</sup> As health care expenditures increase faster than state revenues, particularly in periods of economic downturn, there is an ever growing gap between the services that are expected and the taxes citizens are willing to pay.

But Ohio, despite its Medicaid program being the sixth largest health care program of any kind (public or private) in the nation, thus far has not taken the difficult steps to stem the fiscal bleeding. Decades of “reform” have failed, and attempts to reform will continue to fail until we finally get the right kind of competition and structural change. The Medicaid system can achieve significant gains in quality and efficiency.

Because states must operate within a straitjacket of federal regulations and mandates, it is difficult for states to run their programs in a cost-efficient manner. Thus, while seeking to transform its Medicaid program, Ohio must also participate in health care reform at the national level and in the private sector.

The Commission received testimony on a number of models for consumer-directed care in Medicaid. The Administration should monitor and consider developing pilot projects to these contemporary market-based approaches at the federal level and in states such as Florida.

### **Principles of Ohio Medicaid Transformation**

Notwithstanding the fiscal challenges, the Commission affirms that Ohio Medicaid should remain an essential part of the social contract entitlement between Ohio and its citizens. Advocates, providers, and experts stated convincingly and repeatedly during the Commission’s public hearings that to eliminate services or eligibility groups would deny basic health care to Ohio’s neediest citizens: a fundamental part of the social contract. It also will shift costs to private employers and overburden state health care institutions.

Moreover, the Commission examined optional Medicaid services, which might be candidates for elimination. With the exception of pharmacy (where significant reforms are proposed), the Commission found that optional services do not involve significant Medicaid spending. Any savings that might be obtained through eliminating other optional programs would be marginal.

The Commission also received testimony underscoring the continuing budgetary cost savings attributed to the successful 1996 federal welfare reform legislation, which reduced the time an individual could receive welfare cash assistance. Medicaid has been an integral component to the continuing success of welfare reform for families. This is another reason for retaining Medicaid services and eligibility for covered families and children as they transition from public assistance to the workforce.

*Decades of “reform” have failed, and attempts to reform will continue to fail until we finally get the right kind of competition and structural reform.*

*The Medicaid system can achieve significant gains in quality and efficiency.*

*The Commission affirms that Medicaid should remain an essential part of the social contract entitlement between Ohio and its citizens.*

<sup>4</sup> Behn R, *Ibid.*

The Commission believes that rooting out inefficiencies and employing the right kind of market place competition will produce significant savings. Without these savings and disciplines long-term transformation of the program will not occur and the state will be forced to retreat on the social contract by cutting services and eligibility: a short-term relief to a disease that demands a long-term cure.

### Create Sustainable Growth for Medicaid

The Medicaid program must operate with a new fiscal discipline consistent with the taxpayers' ability and willingness to pay. It should adhere to the following principles:

1. Consume no more of the state budget, percentage-wise, than it currently consumes, and potentially less. This means that growth in its programs should not exceed the growth rate of state revenues: historically, an average 4.5%.
2. On a per-recipient basis, average expenditure growth should not exceed the medical inflation rate.

Under these principles, the growth rate in each State Fiscal Year (SFY) 1995-2004 would have been held to 4%: almost half of the average growth rate for Medicaid spending for SFY 2005 alone, and one-third of the projected 13% Medicaid "baseline" growth rate for SFY 2006. That projected increase is attributed to both soaring medical care costs and to the number of low-income persons who will be eligible for Medicaid benefits.

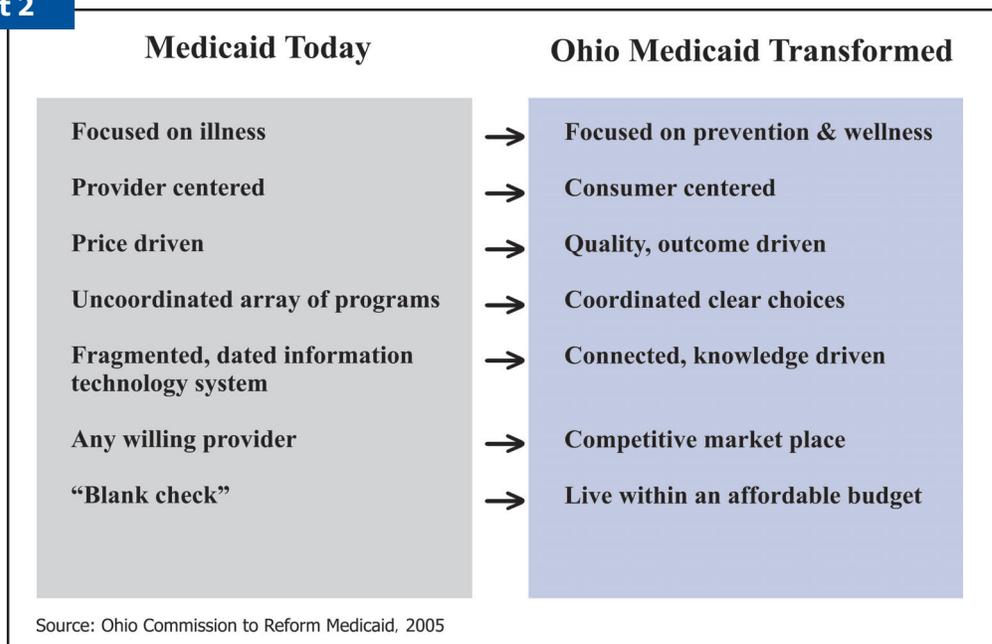
In addition, there must be a periodic, independent review of the program. The state must never stop looking for ways to make Medicaid efficient and to slow the growth of the largest single part of the state budget.

### A Bold New Vision and Structure for Medicaid

The Commission recommends a dramatic transformation of Ohio Medicaid, which requires a bold new vision and structure that puts the consumer at the center through choice, competition, and individual responsibility. The vision significantly increases the state of Ohio's massive health care buying power and expands its use of competitive selective contracting. It

*The Commission believes rooting out inefficiencies and employing the right kind of market place competition will produce significant savings and will lead to long-term care transformation.*

## Exhibit 2



compels a system wide commitment to care management initiatives designed to improve health, and it requires Ohio to begin paying for quality and outcomes, not just fee-for-service (FFS). The Commission vision of transformation accomplishes all of this while controlling Medicaid's major cost drivers – long-term care, hospitals, and pharmaceuticals. A competitive Medicaid program operated with 21st century technology and knowledge management systems is the clear path to better services for consumers at a price taxpayers can afford.

### **Get Started Now: An Imperative for the SFY 2006 - 2007 Biennial Budget**

Because the new vision will take time to implement, the Commission recommends a two-stage strategy:

1. Restrain state spending through cost-containment measures that can get Medicaid's unsustainable growth under control and within the short-term budget target, while long-term strategies are developed and implemented; and
2. Act now to remove the vulnerabilities and barriers that threaten Medicaid's viability and lay the foundation for long-term reform.

The Governor should immediately appoint an independent Medicaid Transition Council to initiate, guide, and oversee the implementation of the Commission's recommendations. This Council could be comprised of senior executives from each of the state's six Medicaid service agencies,<sup>5</sup> the Office of Information Technology, and Office of Budget and Management. Merely delegating implementation of the Commission's recommendations to the Ohio Department of Job and Family Services (ODJFS) will not work. The

department does not have the staff or the perspective to bring about change of this magnitude within an urgent time frame.

The SFY 2006-2007 biennial budget bill should serve as a transition budget that begins the process of stabilizing Medicaid and puts in place the building blocks for successful, sustained, reform of Ohio Medicaid.

**Stage One:** The Governor and the Ohio General Assembly should implement the following nine steps during the first six months of 2005.

- Step 1:** Establish and adhere to a firm Medicaid budget target and specific mechanisms to enforce this target.
- Step 2:** Use selective contracting and other care management initiatives to better leverage the state's massive buying power to control and improve service quality.
- Step 3:** Eliminate the Medicaid rates from statute, specifically the nursing facility reimbursement formula, in order to facilitate negotiation with Medicaid providers for competitive rates and improved quality.
- Step 4:** Implement short-term, provider rate reductions or freezes, as appropriate.
- Step 5:** Expand Ohio's estate recovery laws to align with federal Medicaid estate recovery laws.
- Step 6:** Strengthen Medicaid audit processes to reduce Medicaid fraud, waste, and abuse.
- Step 7:** Move Medicaid consumers into care management programs.
- Step 8:** Control pharmaceutical costs by formulary control step therapy, increase use of generic drugs, eliminate legislative and administrative barriers to competitive pricing, and maximize state purchasing power.
- Step 9:** Apply for 90% federal financial match to implement a comprehensive technology system across all state Medicaid agencies.

*Short-term funding relief is critical to the transformation of the program, but it is the transformation itself that is the key to sustaining the program over time.*

5 Departments of Job and Family Services, Aging, Drug and Alcohol Addiction Services, Health, Mental Health, and Mental Retardation and Developmental Disabilities.

Enacting these nine steps now will stabilize Medicaid cost growth and begin the transformation needed to sustain the Medicaid program over the long term. Short-term funding relief is critical to the transformation of the program, but it is the transformation itself that is the key to sustaining the program over time. Moving forward immediately with pragmatic business solutions, which re-balance both social and personal responsibility, is the path with the most promise. It is in this direction that the Commission has traveled to arrive at its recommendations.

Throughout this report the Commission has provided estimated cost savings. Although these savings will result in lower Medicaid growth rates in the short- and long-term, the Commission recommends that a portion of the cost savings be invested in needed operational support and upgrades, especially in information technology, which are essential to successful system change. These investments will generate significant financial return and increased quality of care.

The Commission's recommendations constitute a broad framework that will require considerable effort to put into action. They represent a process, not the final product. The involvement and commitment of legislative leaders, as well as federal partners, are critical to achieving success as the need for statutory changes, waivers, and plan amendments are determined. Transformation will not be quick or easy, but it must be accomplished if Ohio is to preserve its capability to protect the health of its vulnerable citizens.

Each recommendation and action step contains an **Impact** statement that gives the Commission's best assessment of the financial impact of the recommendation or action step. In some instances, this includes an actual dollar figure based on an analysis by ODJFS or an external consultant. In

some instances, the **Impact** assumes Ohio would achieve similar savings as other states. For some recommendations, such as those involving the governance of Medicaid, there are no actual cost figures, only a fervent belief that a better aligned organizational structure and management will make this enormously complex program more efficient and accountable.

The **Impact** assessments include savings or lower projected growth rates in both the short and long term. Several of the cost assessments are interdependent, and some are alternative. While each recommendation would have impact independently, it is their collective operation that will transform Ohio Medicaid to maximum benefit. (See Appendix A, Combined Estimated Savings.)

### **Recommendations**

The following integrated set of recommendations is designed first to balance the Medicaid budget, and then to transform the program. Recommendations are grouped into six areas: Long-Term Care, Care Management, Pharmacy, Eligibility, Finance, and Structure and Management.

*Transformation will not be quick or easy, but it must be accomplished if Ohio is to preserve its capability to protect the health of its vulnerable citizens.*

# Long-Term Care



**T**he amount of money spent on Aged, Blind, and Disabled (ABD) consumers is the fastest growing segment of the explosive Ohio Medicaid budget. The ABD category of Medicaid beneficiaries includes the elderly, younger persons with disabilities, persons with mental retardation and developmental disabilities, and individuals with chronic mental illnesses. These consumers comprise 24% of the entire population served by Ohio's Medicaid program, yet they consume 74% of the Medicaid spending.

The Ohio Commission to Reform Medicaid makes four recommendations to reform Ohio's long-term care system and to promote the independence, safety, and well-being of seniors and people with disabilities:

1. Ensure access to a full range of service and financing options, from home and community-based to institutional settings.
2. Ensure that elderly and disabled Ohioans and their families/caregivers have easy and immediate access to information about long-term care services, especially in crisis situations.
3. Promote personal choice and responsibility for long-term care through a consumer-centered system.
4. Create a cost-effective long-term care system with consolidated planning, budgeting, and data collection.

Medicaid spending for nursing facilities has risen by 90% over the past eight years, even though the number of people in nursing facilities has declined by more than 4,600. This decline can be attributed to the growth in home- and community-based service waivers. There are 45,000 Ohioans who have a nursing facility level of care but who are able to stay in their own homes. Yet, the current nursing facility occupancy rate is only 75% because Ohio has not taken beds out of the system in proportion to the numbers of people no longer served in the nursing facilities.<sup>6</sup>

Ohio has the ninth highest number of nursing facility beds per 1,000 persons aged 65 and older and the 43rd lowest occupancy rate in the nation. Perhaps the most telling and significant point is that Ohio Medicaid pays for 25% more nursing facility days per 1,000 persons aged 65 and older than the rest of the country.

Ohio's current long-term care system is difficult to access, navigate, comprehend, and manage for all Ohioans whether receiving government assistance or not. It

<sup>6</sup> AARP report – December 2004.

is confusing, biased toward institutional care versus home- and community-based care, is inconsistent in different geographic areas of the state, provides minimal options, and is not prepared to address the growing needs of an aging population. Thus, the system lacks coordination, allows for duplicate services, is inefficient and expensive, and often fails to provide optimum or appropriate care.

The Commission recommends a new long-term care system that is responsive, accessible, coordinated, and consumer-centered giving consumers and their families timely information about options and costs. Reforms should provide numerous choices for home and community-based long-term care options, assisted living, and nursing facilities. Empowering consumers with vouchers will allow money to follow the individual to any appropriate service setting. It is important to note that the components of the recommendations to reform the long-term care system are interdependent.

**Recommendation 1: Ensure access to a wide array of long-term care service and financing options in home and community-based settings or in institutions.**

Long-term care transformation requires eliminating the statutory reimbursement and competitive shelters for nursing facilities, so that they are required to compete in the market place on the basis of quality, access, and price. Competitive markets are the most efficient means for achieving optimal allocation of resources. Further, removing the statutes will enable the Administration to use the enormous bargaining power of the state to contain the high cost of nursing facility care, and manage the costs of a full range of alternatives.

*Ohio pays for 25% more Medicaid-funded nursing facility days per 1,000 persons aged 65 and older than the national average.*

*Ohio has the ninth highest number of nursing facility beds per 1,000 persons aged 65 and older and the 43rd lowest occupancy rate in the nation.*

## Transformed Long-Term Care System

### Inform and Guide Consumers and their Families

- Provide pre-admission screening
- Provide timely information through AAAs and Long-Term Care Resource Centers
- Designate one state agency to manage both institutional and home and community based programs for adults



### Establish A Competitive Market Place

- Utilize “cash and counseling” and “money follows the person”
- Provide a “banking” option which allows consumer and state to benefit from unused resources

Least Restrictive



Home or Apartment

### Provide Continuum of Options with a “Home and Community First” Approach

In-home Assistance

Adult Care Home

Adult Foster Care Home

Assisted Living/Residential Facility

Nursing Facility/Residential Care

Most Restrictive



Specialty Unit within a Nursing Facility

Source Ohio Commission to Reform Medicaid 2005

*Ohio spends more per capita on long-term care than most states, and spends a high proportion of those resources on nursing facility care.*

Institutional bias is caused by one federal regulation and two Ohio statutes (nursing facility reimbursement formula and CON) that favor nursing facilities over home and community-based services (HCBS) and assisted living.

The net effect is that Ohio spends more per capita on long-term care than most states, and spends a high proportion of those resources on nursing facility care.<sup>7</sup> A nursing facility is treated much like a utility – it is highly regulated, protected by government, and, in Ohio, Medicaid is the largest purchaser. As a result, the Commission believes that removing the statutory protections for provider rates and the supply of beds are both necessary steps to making it possible to rebalance the long-term care system.

<sup>7</sup> Burwell B, “Presentation to the Ohio Medicaid Reform Commission,” August 10, 2004, <http://ohiomedicaidreform.com>.

<sup>8</sup> Ohio CON law governs the conditions that must be met to build or move nursing facilities and ICF/MR facilities. See Action Step 2.

**Action Step 1: Remove the nursing facility reimbursement formula from Ohio statute, and give the executive branch authority to negotiate fair and reasonable rates that require nursing facilities to achieve performance-based outcomes and objectives. This should happen in connection with the phase out of Certificate of Need (CON).<sup>8</sup>**

Note: Modification of the capital components of the nursing facility formula is necessary when considering the termination of CON laws.

**Rationale:** A nursing facility reimbursement rate sheltered in state statute creates several problems:

1. It guarantees steady revenues for the nursing facility industry, with no incentive for them to improve effectiveness or pursue new efficiencies.
2. Nursing facilities do not have to compete in the health care marketplace on the basis of quality, access, and price.
3. State administrators cannot readily modify nursing facility payments or access to reflect changes in available revenue, consumer preference, or population changes.
4. It guarantees the majority of Medicaid's limited funds go to nursing facilities despite consumer preference for home and community-based services (HCBS) and non-institutional alternatives.

Ohio and North Dakota are the only states with a formula protected in state statute. Modifying a formula codified in statute requires multi-party discussions with industry interests and elected officials to make change. The special protection, when coupled with a CON law that secures the market position of facilities in locations regardless of the demographic and economic changes in a county, gives nursing facilities an unfair advantage when it comes to being the first at the table for the distribution of long-term care resources. Nursing facility industry representatives have taken advantage of this special relationship to block or control the development of other alternatives.

The Commission's work was simultaneous with the work of the Nursing Home Reimbursement Study Council. Chaired by Representative Shawn Webster, the Council, comprised of government officials and representatives of the nursing facility

industry and a consumer representative, has the statutory charge to examine and make recommendations for reforming the nursing facility reimbursement formula to the Governor and General Assembly. While the Council has not completed its work as of this writing, it considered but has not reached consensus on removing the formula from statute. Other than this point, the Commission generally supports the Council's recommendations presented at the June Commission meeting.<sup>9</sup>

Nursing facilities are a critical part of the long-term care system as medical needs make care in other locations more expensive and unnecessarily unsafe. However, nursing facilities should be utilized when all other methods have been considered and found inadequate, not as the default or first option. There must be a level playing field in the philosophy of providing long-term support and service. If there should be any bias at all, it should be toward taxpayers.

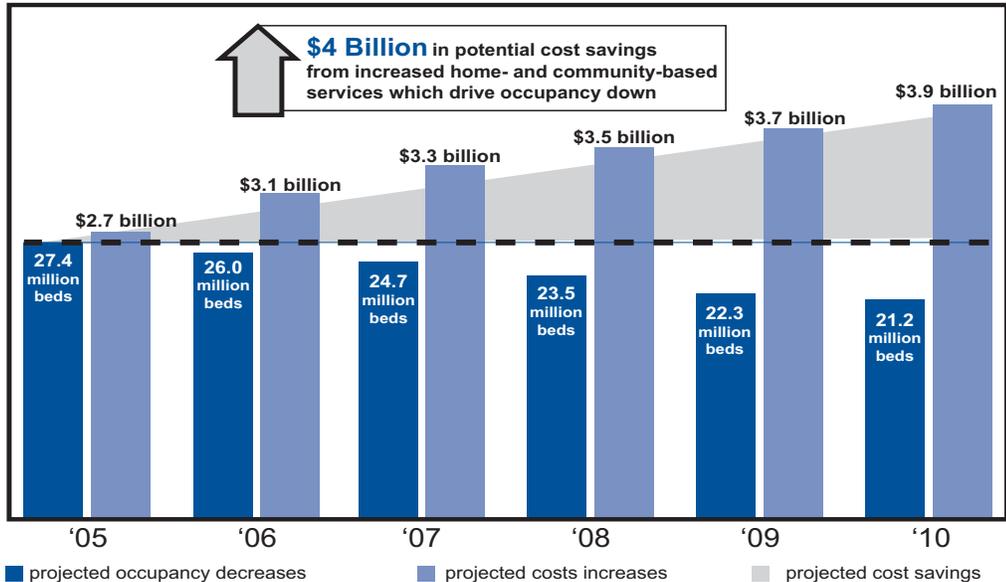
**Impact:** Removing the formula from statute will free Medicaid dollars to meet the growing demand for alternative, less costly, long-term care service options. The Commission believes that nursing facility total reimbursement can be held at zero growth over the five-year period (SFY 2006-2010) as Ohio captures the savings of the projected 25% reduction in nursing facility use. This calculation is based upon a 5% per year reduction in nursing facility bed use and a 5% medical inflation increase, which result in flat total cost growth. Reduced nursing home use will require a variety of coordinated tactics which are recommended in this and the Care Management Section. A chart comparing a zero growth rate to the projected growth rate is at Exhibit 4.

*Nursing facilities should be utilized when all other methods have been considered and found inadequate, not as the default or first option.*

<sup>9</sup> The Ohio Commission to Reform Medicaid, retrieved August 2004, <http://ohiomedicaidreform.com>.

**Exhibit 4**

**Nursing Facility No Cost Growth Savings**



Source: ODJFS Nursing Facility annual cost report; '03 beds occupied assumed for '05 occupancy. ODJFS budget projections SFY '05 through '07 based on current reimbursement policy and reimbursement formula, 5% growth assumed thereafter. The shaded area represents potential cost savings from increased home and community services which drive occupancy down over time. A portion of these savings can be used to fund these home and community services.

**Action Step 2: Phase out the current CON for Ohio’s nursing facilities.**

**Rationale:** A CON issued by the Ohio Department of Health (ODH) permits a nursing facility owner to construct a nursing facility and operate a defined number of nursing facility beds within a particular county in Ohio. CONs limit the number of nursing facility beds in each county, essentially creating a monopoly that both artificially inflates the value of nursing facility beds and limits competition from any provider who lacks a CON. The existence of CON in Ohio removes market incentives for nursing facility owners to compete and adjust their supply of nursing facility beds and services to meet the changes in market demand.

The Commission recognizes improvements can be accomplished only over a period of years. Consequently, it recommends that during the phase-out period, the following tools be extended to the ODH:

1. Eliminate the “one-day nursing facility openings” loophole that removes some facilities from ODH oversight;
2. Curtail “bed banking” to remove unused beds from the system;
3. Permit regionalization of nursing facility bed redistribution throughout the state;
4. Eliminate unnecessary movement of beds by ensuring that transfers occur only to providers with high utilization and high quality of care;
5. Prohibit providers from selling their CON or ensure that the reimbursement formula prohibits providers from claiming Medicaid funding for amounts spent to acquire operating rights; and
6. Revoke licenses of nursing facilities that have demonstrated poor quality or committed violations that jeopardize health and safety of residents.

**Impact:** Phasing out CON in conjunction with removing the nursing facility formula from statute will reduce the state's expenditure on nursing facility care because Ohio's nursing facility supply is greater than its demand and the CON artificially inflates the value of the beds. A chart comparing a zero growth rate to the projected growth rate is at Exhibit 4.

**Recommendation 2:** Ensure that elderly and disabled Ohioans, their families and/or caregivers have easy, immediate access to a full range of cost-effective options and needed information about long-term care service options, especially in a crisis situation.

**Action Step 1:** Create a comprehensive pre-admission screening process for any Ohioan in need of Medicaid-funded long-term care, especially nursing facility care.

The process should:

1. Require an in-person pre-admission assessment for all consumers prior to nursing facility placement for those who will require Medicaid nursing facility payment within six months of admission.
2. Modify the existing contract with the Area Agencies on Aging (AAA), which helped 600 nursing facility residents in SFY 2004 relocate to the community.
3. Expedite the waiver enrollment process to allow immediate access to home and community-based services (HCBS).
4. Make it easier for residents of nursing facilities to relocate to community settings.

**Rationale:** Timing is critical when consumers or caregivers are faced with finding suitable long-term care. Ohio's current pre-admission screening process was designed more than a decade ago, and since then, long-term care in Ohio has changed significantly. The current process, set in statute, was created to simplify the movement of consumers from hospitals to nursing facilities rather than to adequately informing consumers about long-term options.

Excess nursing facility capacity combined with inadequate pre-admission screening rules often results in inappropriate placement of consumers in nursing facilities, especially those with mental illness rather than medical needs. In addition, there are bureaucratic and procedural barriers that can delay access to HCBS creating an additional incentive to use nursing facilities first. Numerous states like Pennsylvania have modified their access systems to expedite consumer applications. This process has resulted in virtually equal access to HCBS and nursing facilities.

A number of states currently allow case managers to presume eligibility and authorize HCBS when, based on a review of information provided by the applicant and/or their family, it is likely that the Medicaid application will be approved. Federal law does not allow states to receive federal financial participation for services provided to applicants who upon completion of the process are determined to be ineligible. Ohio should seek assistance from best practice states, such as Washington, where they have had an effective program of state-funded presumptive eligibility for long-term care for several years. According to the state officials, the modest cost of less than \$100,000 per year that the state has incurred

*Excess nursing facility capacity combined with inadequate pre-admission screening rules often results in inappropriate placement of consumers in nursing facilities.*

*Ohio should implement presumptive eligibility and remove bureaucratic and procedural barriers to provide equal access to home and community-based services and nursing facilities.*

for providing services to consumers who are not ultimately found to be eligible for Medicaid has been far exceeded by the savings generated from diverting clients from institutional care into lower-cost community care.<sup>10</sup> Nebraska established a similar process through their “Waiver While Waiting” program.

Ohio should have additional options to simplify eligibility for individuals in long-term care and to improve the balance between the provision of institutional and HCBS.

Revising the current pre-admission screening process will supply needed information at the decision point and encourage other “gatekeepers,” such as hospital discharge planners, to think through long-term care alternatives for their patients. The result will be reduced institutional and “medical” bias inherent in current gatekeeper mechanisms that establish nursing facility placement as the rule and HCBS and any other placement as the exception. Consumers’ level of need should be assessed for alternative services after they enter a nursing facility for short-term rehabilitation.

According to a 2001 report from Scripps Gerontology Center, 27,000 consumers admitted to Ohio nursing facilities were discharged within 15 days of admission. The revised pre-admission screening process should target consumers who are at greater risk of longer stays than this short-term rehabilitation population.

Ohio has a federal grant designed to relocate residents who have been in nursing facilities for at least 18 months to community settings, known as Ohio Access Success. State funds are used to allow for small “transition services” payments (e.g., rent deposits, utility deposits, housekeeping supplies, etc.). This minimum length of stay

threshold should be eliminated because by then consumers have spent down their assets and no longer have the financial means to live in the community. Not only must the timing restriction change, its relationship to the new pre-admission process needs to be rationalized.

**Impact:** Revising the pre-admission screening process will help consumers choose less expensive long-term care alternatives, help lower nursing facility utilization to achieve the savings in Exhibit 4.

**Action Step 2: Establish Long-Term Care Resources Centers in each Area Agency on Aging service area.**

1. Establish at least one Long-Term Care Resource Center in each AAA region in the state within six months.<sup>11</sup>
2. Require co-location of county eligibility determination workers to ensure speedy access to eligibility decisions and information.
3. Develop comprehensive information on state and locally funded long-term care options in each service area.
4. Provide care planning and family caregiver support to all who request such assistance.
5. Provide comprehensive educational information and develop a coordinated state and local information campaign to educate health care professionals and other “gatekeepers” about new state policy and program initiatives and service options under development.

**Rationale:** Consumers and their families need timely access to information and objective advice to make the best choices in long-term care. Community professionals

<sup>10</sup> “Money Follows the Person and Balancing Long-Term Care Systems: State Examples,” Centers for Medicare & Medicaid Services, retrieved December 13, 2004, p. 11.

<sup>11</sup> If policy were to evolve to the point that services for younger persons with disabilities would be managed through the same state system as those for older persons, these centers could be called “Aging and Disabilities Resource Centers.”

need education as well. The system and its options are confusing and poorly understood by most health care practitioners. And those who do understand Ohio Medicaid long-term care frequently have a vested financial interest. States that have implemented similar processes have demonstrated that the costs incurred are more than compensated by the increased number of people choosing options that they find preferable, making such process cost effective to the state.

ODJFS should develop an informative, consumer-friendly manual on private long-term care insurance in conjunction with the Ohio Department of Insurance. The manual should include information on the effect of long-term care insurance on Medicaid eligibility, the availability of tax deductions, and general information on types of coverage and cost. Identify an individual within each LTC Resource Center to answer any Medicaid-related question pertaining to long-term care insurance.

**Impact:** Consumers, their families, and community professionals will be educated about a broader array of service options best matched to their needs and preferences. The added cost of managing the resource centers will be offset by reducing the number of placements in more expensive institutional settings.

**Action Step 3: Offer assisted living as a Medicaid option.**

**Rationale:** According to the National Academy for State Health Policy, 41 states have implemented a Medicaid-funded assisted living program. Assisted living<sup>12</sup> is a service option that addresses the needs of many persons whose care needs go beyond the capacity of home care programs such as PASSPORT.<sup>13</sup> Assisted living is often viewed as the best setting for consumers whose care needs cannot be scheduled in

advance but need 24-hour supervision. Without an assisted living option, many of these individuals are placed in nursing facilities.

Assisted living services in Medicaid should begin slowly, first under a Medicaid waiver where the supply of available “slots” can be controlled.

Ohio should review the success of group and family home options developed by New Jersey, Florida, Oregon, Vermont, and Maine.

**Impact:** Assisted living would save about \$28 million for State Fiscal Year (SFY) 2006 (about \$11 million state share). This assumes an average assisted living monthly caseload of about 760 people in FY 2006, based on an average annual assisted living service cost of \$41,600 and an average nursing home cost of \$58,400.

Assisted living will provide consumers and families with a long-awaited alternative that fills in the gap between PASSPORT and nursing facility care.

**Action Step 4: Increase the clinical capacity and flexibility of home care options for consumers.**

**Rationale:** Current Ohio Medicaid State Plan amendments for waiver programs such as PASSPORT are too restrictive in the scope of service, and cannot keep up with consumers whose care needs escalate. An unintended result is sometimes that the consumer must be admitted to a nursing facility even though the needed clinical services are available in the community.

**Impact:** Some consumers can remain in their homes and receive needed clinical services. It is initially budget neutral and in the long run will save money.

41 states have implemented a Medicaid-funded assisted living program. Ohio has not.

<sup>12</sup> The definition of an assisted living facility and its requirements are found in amended substitute HB 152 of the 120th Ohio General Assembly.  
<sup>13</sup> PASSPORT is a Medicaid 1915C waiver program that begins with an assessment and a care plan which supplies supportive services to enable someone to remain in their community.

**Recommendation 3: Encourage personal choice and responsibility for long-term care by modifying estate and asset recovery, as well as state funding policy.**

**Action Step 1: Modify Ohio’s estate recovery process to the maximum extent allowed under federal Medicaid estate recovery law. In addition, use waivers to create an estate recovery model that provides incentives for consumers to select the lowest cost care options.**

Components include:

1. Expand the list of assets recoverable outside of state probate law, to include other real and personal property and other assets for which the individual had any legal title or interest at the time of death.
2. Restructure the estate recovery process to receive federal match for the legal administrative costs involved.
3. Establish through a waiver “tiered asset recovery policies,” which give consumers and their heirs the opportunity to share in the benefits of cost containment when they choose alternatives that save the state money.

**Rationale:** For most of the program, Medicaid covers low-income individuals. There is one notable exception, and it exists only for nursing facility care. Individuals with much higher incomes (up to the monthly cost of a nursing home) may qualify for Medicaid-covered nursing facility care, if they limit their assets. The asset rules, however, leave loopholes that allow middle and upper-income individuals to qualify for Medicaid-covered nursing facility services. A married individual may keep an expensive home, for example, and

individuals may transfer assets to others if they do so prior to three years before they apply for Medicaid. Later transfers will delay, but not deny, an individual’s eligibility for Medicaid. Individuals, with the help of elder attorneys, find ways to transfer substantial assets within the confines of these state and federal asset rules. Medicaid is required by federal law to recover these assets after the individual’s death, but Ohio state law currently restricts that recovery to assets in probate, allowing further assets to be off-limits to Medicaid.

The complex asset eligibility and recovery system raises three problems: first, it diverts substantial state resources away from truly low-income individuals; second, it perpetuates the institutional bias in Medicaid-covered long-term care services; and third, the availability of Medicaid for individuals with higher incomes discourages them from purchasing long-term care insurance or setting aside other private funds for long-term care. The Commission has three specific strategies where Ohio can implement better available methods for asset recovery.

**Strategy 1.** Ohio law should not limit assets recoverable by Medicaid to the assets in probate. As permitted under federal law, Ohio should include other real and personal property and other assets in which the individual had any legal title or interest at the time of death, with exceptions for hardship.<sup>14</sup> Federal law permits states to collect on assets outside of probate to include assets conveyed to a survivor, heir, or assign of the deceased through joint tenancy, tenancy in common, survivorship, life estate, living trust, life insurance or other arrangement.

Medstat provided an analysis of Medicaid probate collection by state, federal fiscal year 2003. Thirty-three other states have

*Ohio law should not limit assets recoverable by Medicaid to the assets in probate.*

*As permitted under federal law, Ohio should include other real and personal property and other assets.*

<sup>14</sup> Byrne B, “Transfer on death deeds with respect to Medicaid Estate Recovery,” July 13, 2004.

more aggressive collections as percentage of nursing facility expenditures. Arizona, for example, collections are 9.6%. An earlier study conducted by the National Council of State Legislatures (NCSL) indicates that a more aggressive estate recovery system will increase probate estate recovery revenue between 1% to 2% of total Medicaid spending on nursing facilities.

Ohio Medicaid must not become an inheritance protection plan. We must close the loopholes and focus Medicaid's resources on helping those who really need it.

The Preble County Department of Job and Family Services conducted a four month review of the eligibility process and found two areas of concern affecting the current estate recovery process. The first is that individuals are seeking legal advice to lawfully hide assets to make them eligible for Medicaid, and the second is that there are significant amounts of assets that should be subject to asset recovery, since Medicaid is the payer of last resort.

Specifically in the four month period of review, there were five individuals who sought the advice of elder attorneys and transferred \$393,000 in assets to other family members. They thereby exempted enough money to seek access into a nursing facility and became eligible for Medicaid. There were two other cases where individuals had \$442,000 in a trust or life estates. The transfer of funds and non recoverable assets are completely lawful under Ohio law.

**Strategy 2.** Establish through a waiver “tiered asset recovery policies,” which give consumers and their heirs the opportunity to share in the benefits of cost containment when they choose alternatives that save the state money.

Ohio should investigate the feasibility of a federal waiver to vary a Medicaid consumer's estate recovery liability based on his/her choice and cost of long-term care services. Under this model, Ohio would relax the estate recovery requirements for those individuals who select non-institutional alternatives for their long-term care. This tiered approach will provide for a smaller percentage of recovery for lower cost long-term care services.

A specific example would be to seek a federal waiver to implement an option that was provided under Ohio law in 1997 regarding life insurance proceeds of a Medicaid-covered individual. An individual may opt to have the value of a life insurance policy excluded from a determination of Medicaid eligibility if the policy-holder designates Medicaid as a beneficiary of the policy up to the amount of the Medicaid claim. This is an intriguing model that allows an individual some benefit from having paid premiums over many years while allowing the state to recover amounts it has paid for Medicaid services. (See Action Step 3.)

**Strategy 3.** Restructure the estate recovery process to receive federal match for the legal administrative costs involved.

Federal reimbursement is available for the administrative cost of estate recovery efforts if those costs have been competitively bid or if the public entity providing collection efforts retains only the administrative cost after Medicaid is made whole. Ohio's present practice is to pay a local lawyer 20% of asset recoveries out of an estate, plus 9% to the Attorney General for standard collection fees.

Because the arrangement with the local attorney is not bid competitively, the federal government will not share in the

*Ohio Medicaid must not become an inheritance protection plan.*

*We must close the loopholes and focus Medicaid's resources on helping those who really need it.*

administrative costs. Thus, the state bears the full cost of estate recovery, despite refunding the federal portion of Medicaid services provided to the individuals while they were alive. Expenses all now come out of the state's 40% share, thus netting Medicaid only 11% of expended state general revenue funds.

Ohio could look to Massachusetts where the University of Massachusetts Medical School has acted as a collection agent for the Massachusetts Medicaid program's estate recovery program. By contractual arrangement, it has negotiated a fee of 5% to 7% for its collection activity.

If Ohio established a 5% collection fee for recoveries, the state will receive 37.5% of any asset recovery (40% of the recovery minus 50% of the state cost).

**Impact:** Consistent with Medstat and NCSL, Ohio should expect to collect between 2-9% through probate. Based on SFY 2004 collection of nearly \$16 million or .5% of the benefits paid. Assuming that the state should have collected 2% of paid benefits, the state could experience an additional \$38.2 million in savings.

Collecting assets outside of probate could not be determined.

The potential collection of federal financial participation for administration costs is \$2.93 million (state funds) based on the 9% AGO SFY 2004 collections.

The foregoing strategies are substantial in their effect with respect to asset transfer and recovery to tailor Medicaid long-term care services to the medical and financial need of the individual. Attention must be paid, for example, to keeping the playing field level between nursing facility and HCBS services in terms of how many assets (see

Action Step 3) and how much income (see Recommendation 2 in the section on Eligibility) an individual may have to qualify for Medicaid. Focus should also be made on how to encourage and facilitate private savings for long-term care, including long-term care insurance, beginning at younger ages so that asset transfers and "spend down" become less and less attractive.

**Action Step 2: Establish a long-term care "voucher program" to accommodate "cash and counseling" and "money follows the person" approaches to improve care and reduce costs.**

**Rationale:** The key to quality and cost effectiveness in long-term care is enabling consumers to exercise control over the setting and nature of their care within an established budget that is less costly than hospital and nursing facility care. Medicaid financial resources should be structured so they can "follow" the person as they make a transition from, for example, a hospital to a nursing facility and then back to their own home with services and supports.

Care managers will assist consumers with decision-making and care planning and consumers will then determine how the money was spent. The "voucher" benefit could follow the person if he/she changed services or location with adjustments appropriate to the new circumstances.

Cash and counseling is a consumer-directed model of care that provides a flexible allowance, or budget, to purchase and manage their own care services within needs identified during an assessment process.

Arkansas's cash and counseling program is a good example of a successful program. Its recent evaluation showed that consumers

*The key to quality and cost effectiveness in long-term care is enabling consumers to exercise control over the setting and nature of their care within an established budget that is less costly than unnecessary reliance on hospital and nursing facility care*

employing their own caregivers received virtually 100% of the services authorized because there were few caregiver “no shows” or “call offs”. These consumers also had an 18% lower rate of use of institutional services (hospitals and nursing facilities). This finding was coupled with extraordinarily high levels of consumer satisfaction with virtually no reports of abuse or consumer neglect.

Several states use money follows the person to overcome barriers in their home and community based services waiver program operations.<sup>15</sup> The programs give HCBS waiver program slots to individuals being discharged from nursing facilities and allow some of the Medicaid funding stream to follow the client to community living. Further, money follows the person prioritizes state HCBS program slots that are usually closed to new admissions. This program will allow Ohio to give priority for community services to nursing facility residents.

Other state findings regarding money following the person are consistent with the Scripps Gerontology Center’s evaluation of the Ohio Department of Aging’s “Choices” demonstration Medicaid waiver in central Ohio. Scripps found that participants in the Choices waiver had greater disabilities than participants in PASSPORT. Consumers should be afforded control over decisions regarding their plan of care, selection of caregivers, and their location. The only way to give consumers control is to relax existing Medicaid regulations to allow money to follow the person as the consumers’ needs change.

Ohio’s “voucher” program should include these elements:

1. Consumer control over a limited budget within which the consumer can purchase and direct her/his own care. The dollar value varies depending on the person’s medical and functional needs and the range of services included in the program.
2. An array of service providers and setting options from which the consumer can choose, including certified agencies as well as independent providers.
3. A “safety net” to cover emergency or unexpected needs that are in excess of the voucher’s face value or that occur if an informal arrangement breaks down.
4. A “banking” option, which allows the consumer and the state to benefit from any unused resources.
5. A fiscal intermediary option to manage thorny issues such as payroll taxes that consumers become responsible for as “employers of record” for their caregivers.

*Consumers should be afforded control over decisions regarding their plan of care, selection of caregivers, and their location.*

**Impact:** Ohio can expect as much as 18% lower rate of use of institutional services by consumers using a voucher program, as did Arkansas. Ohio can expect a decrease in the overall cost and consumption of other services as consumers tend to use resources more prudently and in the least restrictive setting when they consider them “their own.”

**Action Step 3: Increase assets that may be retained by income-eligible Medicaid waiver applicants to avoid premature admission to an institutional setting, and explore tiered asset recovery policies.**

15 “Texas-Appropriations Rider: Promoting Independence ‘Money Follows the Person;’ Shifting Funds from Nursing Facility to Community-Based Services Budgets When People Leave Nursing Facilities,” Center for Medicare & Medicaid Services, retrieved January 2005, <http://www.cms.hhs.gov/promisingpractices/moving.asp>.

*Current eligibility policy requires consumers to sell their home (and all other assets) after they have been in the nursing home for six months...*

*This policy can be replaced with "TEFRA" liens, which permit the person to fully exhaust the possibility of returning to their home without artificially cutting it off with an arbitrary deadline.*

**Rationale:** All ABD consumers may not have assets greater than \$1,500. Any assets in excess of \$1,500 must be “spent down” in order to become Medicaid eligible. This is true whether the person is applying to enter a nursing facility or a HCBS waiver program. This requirement prematurely forces some Medicaid applicants into a nursing facility when, if allowed to achieve Medicaid eligibility while retaining a larger amount of their assets, they might be able to remain in their own homes with waiver services such as those provided by the PASSPORT program. These assets could be used for home modifications, such as hand rails or ramps, or for adaptive equipment to allow a consumer to remain in their own home. If the person eventually enters a nursing facility or Medicaid-funded assisted living arrangement, the assets could be used as “spend down” to pay for their care or could become part of the assets subject to estate recovery.

The state could negotiate with interested families to enter into contractual obligations to re-insure the stated value of unliquidated assets in return for the state agreeing to reimburse the costs of services until after the consumer no longer needs care. Current eligibility policy requires consumers to sell their home (and all other assets) after they have been in the nursing home for six months (provided that there is not a spouse or other protected individual residing in the home), thereby virtually eliminating the possibility of returning to their home and further fueling the institutional bias. There are consumers who have the ability to leave the nursing facility after six months, but do not have the option to return to their home and receive services in a less costly setting. This policy can be replaced with “TEFRA” liens, which permit the person to fully exhaust the possibility of returning to their home without artificially cutting it off with an arbitrary deadline.

In addition, the Commission believes that Ohio should apply for a federal waiver to develop asset recovery policies that offer genuine incentives to pursue options to nursing home care. One option would be to recover the costs of lower cost services at lower rates, thus sharing the benefit of the consumer’s choice to the state with the consumer and/or their family on a three-tiered schedule: 50% for home-based care, 75% for assisted living, and 100% for nursing facility care. Tiered recovery policies will require waivers of federal policy, and will have to be developed in a fashion that have safeguards to ensure that consumers will not be forced by potential heirs to avoid gaining access to the care that they truly need. The employment of economic incentives is a backbone of the economy, the tax system in this country, and at the core of other major public policies. It simply is common sense to try to utilize similar mechanisms in the effort to put consumers in charge of their destinies as much as possible in a true partnership with the taxpayer who is bearing the growing cost of insuring the costs of their care.

**Impact:** This step will increase the number of consumers eligible for HCBS waivers and delay and reduce nursing facility admissions. Because assets will either be used upon nursing facility admission or recovered through appropriate estate recovery activity, there should not be costs once the work of implementing new policies is done. Depending on the results of the exploration of waivers, these steps could substantially shift the economic incentives involved in Medicaid long-term care toward pursuing services in less costly settings than nursing facilities. This recommendation also supports consumer preference to stay in a home setting.

**Recommendation 4: Create a cost-efficient long-term care system with consolidated budgets, data collection and planning.**

**Action Step 1: Create a unified long-term care budget managed across all state and all local governmental agencies and service settings, and establish a single accountable head to provide leadership and direction for meeting the long-term care needs of Ohioans.**

**Rationale:** A unified long-term care budget is necessary to provide a balanced long-term care system that improves the quality and reduces the duplication of services and cost. Such a comprehensive budget will assist Ohio to meet the needs of persons requiring long-term care.

Experience in other states has demonstrated that unified budgets are a core component of successfully rebalancing a long-term care system, coordinating effectively with non-Medicaid services, and ensuring the redirection of existing long-term care resources within that same system. Oregon, Washington, and Vermont have each had great success in controlling the costs of long-term care by creating unified budgets and expanding HCBS.

Begin first with the “aging” segment of the long-term care system. Designate the Department of Aging as the single point of operational and policy-making responsibility for managing both institutional and home- and community-based services.

Housing the budget in this agency allows local case managers in leverage non-medical dollars (Older Americans Act state block grant funds, local dollars) to build a complete care plan for the client.

**Impact:** Potential administrative savings would result from increased efficiencies and

quality of care improvement, cost reduction from better coordination of state long-term care policies and programs. A long-term care budget is necessary to achieve the growth rates set forth in these recommendations and maintain them over time.

**Action Step 2: Establish a long-term care policy coordinating entity with authority that spans all state long-term care plans and programs.**

**Rationale:** Establish a policy coordinating body comprised of state officials, providers, consumers, and advocates to review and discuss the ongoing efforts to re-balance the long-term care system. The entity will advise the appointed officials responsible for long-term care, the Governor, and the General Assembly on progress or recommend solutions to obstacles. The mission of this entity must be clear, and it should be chaired by the state official charged with overall implementation of the re-balancing effort. Initial work will focus on implementing the changes recommended in this report. Subsequent responsibility will include reviewing the results and evaluations of program and management initiatives; recommending subsequent initiatives; and recommending adaptations of policy in response to the continuing evolution of technology, federal policy, and consumer needs.

**Impact:** Potential administrative savings would result from increased efficiencies and quality of care improvement, resulting in cost reduction from better coordination of state long-term care policies and programs.

*The Ohio Department of Aging should be given responsibility for managing both the institutional and home and community based programs for older adults.*

*The State should build on the Current PASSPORT/AAA system, creating a strong “front door” that aggressively works to direct medicaid eligible individuals to the least restrictive appropriate setting possible.*

*The state must adopt a “home and community first” approach making it clear that the goal is to place eligible consumers in the least restrictive, most cost efficient appropriate setting possible.*

# Care Management



*Only about 30% of Ohio Medicaid consumers are covered by managed care compared to a national average of 60%.*

Ohio Medicaid provides health care services through two programs, fee-for-service (FFS) and care management. Only about 30% of Ohio Medicaid consumers are covered by managed care compared to a national average of 60%.<sup>16</sup> The Ohio Department of Job and Family Services (ODJFS) recently initiated several care management programs that have limited enrollment. The Ohio Commission to Reform Medicaid believes that a statewide commitment to the full range of care management strategies for all Ohio Medicaid consumers will improve health care quality and contain costs.

Under FFS, the state bears full financial risk for health care costs and has limited ability to control costs or impact health outcomes. FFS relies on consumers, physicians, and other providers to determine the frequency and types of medical services, by paying claims submitted by providers determined either by fee schedules or, in the cases of hospitals and nursing facilities, by cost reports. Currently, Ohio Medicaid has flexibility in determining payment rates except for nursing facilities and children's hospitals, whose rates are established by statute.<sup>17</sup> Another detriment to FFS is that it has no quality or performance incentives.

<sup>16</sup> Kaiser Family Foundation, [statehealthfacts.org](http://statehealthfacts.org), Medicaid and SCHIP data, 2003.

<sup>17</sup> See Long-Term Care Recommendation 1, *supra*.

Further, under FFS, Ohio does not possess the infrastructure to effectively manage Medicaid consumer access to health care. There is no centralized coordination to plan and monitor services for individuals and their families. As a result, consumers must go to multiple providers, which creates problems in quality of care and control of costs.

In contrast to FFS, care management encompasses a wide variety of payment and performance arrangements ranging from full-risk managed care to new approaches for shared-risk care management, like Ohio Medicaid’s Enhanced Care Management (ECM) program. The premise of care management is that quality can be improved

and costs controlled more effectively if health care services are provided in a coordinated fashion across a continuum of services. Care management may include specific services (e.g., management by primary care physicians, prevention, outreach, transportation), financial incentives for health care providers to provide a comprehensive set of services to consumers, and quality assurance and utilization review to ensure accountability of providers for consistency with accepted standards of clinical practice.<sup>18</sup>

The advantages and disadvantages of FFS vs. full- and shared-risk care management arrangements are shown in Exhibit 5.

**Exhibit 5**

<b>Advantages and Disadvantages of Care Management and Fee-for-Service</b>		
<b>Delivery System</b>	<b>Advantages</b>	<b>Disadvantages</b>
<b>Fee-for-Service</b>	<ul style="list-style-type: none"> <li>● Providers prefer</li> <li>● In place; no change needed</li> <li>● Direct relationship between state and providers</li> </ul>	<ul style="list-style-type: none"> <li>● 6-8% higher cost</li> <li>● Less control of quality and cost</li> <li>● State bears full financial risk</li> <li>● Does not contract selectively with providers</li> <li>● No financial incentive for providers to improve quality</li> </ul>
<b>Care Management: Full Risk</b>	<ul style="list-style-type: none"> <li>● At least 6-8% lower cost</li> <li>● Budget predictability</li> <li>● Opportunity to improve quality</li> <li>● Shift financial risk to care plans</li> <li>● Contracts selectively with providers</li> <li>● Use financial incentives to improve outcomes</li> <li>● Improved access</li> <li>● Focus on prevention and wellness</li> <li>● Care plans manage provider networks</li> <li>● Focus is on consumers</li> </ul>	<ul style="list-style-type: none"> <li>● Change from retrospective to prospective payments.</li> <li>● Provider resistance to participation</li> <li>● May offer lower payments to providers</li> <li>● History of managed care plan insolvency</li> <li>● By nonparticipation, a provider group (e.g., hospitals) can block coverage into some counties</li> </ul>
<b>Care Management Shared Risk</b>	<ul style="list-style-type: none"> <li>● Opportunity to improve quality</li> <li>● Cost efficiency</li> <li>● State shares financial risk with care plans</li> <li>● Contract selectively with provider</li> <li>● Use financial incentives to improve outcomes</li> <li>● Streamlined access</li> <li>● Focus on prevention and wellness</li> <li>● State controls provider payments</li> </ul>	<ul style="list-style-type: none"> <li>● State must invest dollars initially</li> <li>● Lack of known savings</li> <li>● Lack of budget predictability</li> <li>● By nonparticipation, a provider group (e.g., hospitals) can block coverage into some counties</li> <li>● No current state system to administer</li> </ul>

SOURCE: Ohio Commission to Reform Medicaid. 2004

<sup>18</sup> Rich R, Erb C, "Two Faces of Managed Care Regulation and Policy-Making," University of Illinois, Urbana-Champaign.

Weighing these advantages versus disadvantages, the Commission makes the following recommendation to achieve full enrollment of all Medicaid consumers in some form of care management.

**Recommendation 1: Establish a statewide care management program for all Medicaid recipients.**

**Action Step 1: Expand the current full-risk managed care program to all Medicaid-covered families and children (CFC) throughout Ohio.**

**Rationale:** Under Ohio's current Medicaid managed care waiver program, consumers on the Healthy Start and Healthy Families programs, consisting of children and low-income and working parents, may enroll in managed care plans. With 550,000 consumers enrolled so far, ODJFS reports high consumer satisfaction and clinical performance that is higher than national benchmarks in all nine clinical measures tracked by ODJFS. ODJFS also reports \$68 million in savings for State Fiscal Years (SFY) 2004 and 2005 (3% to 4%).

Because the CFC consumers are younger and healthier than the Aged, Blind, and Disabled (ABD) consumers, their health care needs are easier to manage. Managed care provides the most value to CFC consumers by helping them access services in the most appropriate setting, obtain wellness and prevention services, and arrange for transportation to medical providers. It is the right time to undertake a significant expansion of managed care for CFC consumers.

**Impact:** Full risk managed care reduces unnecessary costs and improves quality of care by emphasizing preventive health care. According to cost savings calculated by Milliman Consultants and Actuaries and Mercer Government Human Services Consulting, enrolling an additional 637,000

CFC consumers in full-risk managed care will save Ohio Medicaid up to \$93.2 million (\$37.5 million state share) in SFY 2006.

Moving payments from a retrospective basis in FFS to a prospective basis in managed care creates a claims lag payment and occurs because providers will continue to bill Medicaid directly for services provided prior to the consumer enrolling into a managed care plan. This would be a cost to implementing this recommendation. However, an 8% reduction in FFS spending is projected after first year start-up costs.

Therefore, the Commission estimates \$80 million in savings (\$32.2 million in state share) in SFY 2006 and \$71.2 million in savings (\$28.6 million state share) in SFY 2007 after accounting for a fee-for-service claims lag during the year of consumer enrollment as provided by ODJFS.

**Action Step 2: Apply care management to the ABD population through the most effective approach, recognizing established medical relationships within special needs populations, such as those in intermediate care facilities for the mentally retarded (ICF/MR).**

**Rationale:** Other states have reined in out-of-control Medicaid costs for the ABD population through better care management of their health care needs. The Commission supports a consumer-centered, integrated long-term care coordination model, in which consumers and their families are fully involved in care planning, goal setting and provider selection.

And, as growing numbers of long-term care consumers increase the pressures on Medicaid budgets, the budget predictability that comes with full-risk and shared-risk care management makes this approach appealing.

*Managed care provides the most value to CFC consumers by helping them access services in the most appropriate setting, obtain wellness and prevention services, and arrange for transportation to medical providers.*

*It is the right time to undertake a significant expansion of managed care for CFC consumers.*

*The Commission supports a consumer-centered, integrated long-term care coordination model, in which consumers and their families are fully involved.*



## Care Management Options Needed for ABD Consumers

The ABD population has complicated and diverse medical needs with 42% dually eligible for Medicare and Medicaid, which creates specific challenges. Care management options are needed to serve their range of needs.

Certain ABD consumers such as special needs children and those with mental retardation in intermediate care facilities often have established medical relationships and support networks. Others with severe and persistent mental illness also have medical conditions that include different functional abilities and/or substantial behavioral health needs.

Integrating acute care and behavioral health care services for these consumers is necessary to promote consistent well being and address historically unmet behavioral health issues, such as depression, which can affect acute care costs. Yet, acute care services and behavioral health services, such as community mental retardation, mental health, and alcohol and drug addiction services have been separate for years. A collaborative approach to care management is required to provide a variety of services across settings (e.g., home, doctor's office, hospital, day care center, nursing facility).

*Integrating acute care and behavioral health care services is necessary to promote consistent well being and address historically unmet behavioral health issues.*

The Commission proposes that ODJFS implement a hybrid care management program for ABD consumers, based on the following strategies:

1. Involve advocates, local payers, plans, and providers in the design and ongoing monitoring of care management strategies.
2. Create an exemption process for consumers with unique health care needs that require a specific provider or treatment plan.
3. Expand and build on existing infrastructure.
4. Continue current treatment plans and pharmacy regimens for at least 60 days upon initial participation in a care management program.

### ***Option 1: Support and Build on the Enhanced Care Management (ECM) Program.***

In October 2004, ODJFS began its ECM program for ABD consumers with disabilities who are not dually eligible, do not reside in institutions or are not enrolled in existing waiver programs. Consumers can choose ECM for congestive heart failure, diabetes, asthma, coronary artery disease, and non-mild hypertension. ECM identifies a single primary care provider who directs the development of the treatment plan and coordinates care. Enrollment is about 1,000 now with 30,000 projected for the future.

Medstat performed an analysis of the existing ECM program and determined that the most expensive conditions, schizophrenic disorders and psychoses are not being care managed. Further, Medstat found that many persons with a mental health condition also suffer from a chronic condition subject to

the ECM program. The ECM program must take steps to build capacity to provide care management to persons with mental illness.<sup>19</sup>

ODJFS should expand upon its ECM program in two areas: (1) Consumers with significant medical and behavioral health needs, and (2) “High-cost utilizers” (i.e., consumers who have uncommon conditions with particularly high-cost medical needs).

**Option 2: Pursue enrollment in full-risk managed care.** Reports from the Milliman and Mercer actuary firms indicate potential savings associated with extending a full-risk managed care plan analysis (such as that proposed for the CFC population) to a subgroup of the ABD population. The subgroup excludes: (1) dually eligible consumers, (2) consumers under 20 years of age, (3) consumers in nursing facilities or ICF/MR facilities, (4) consumers in waiver programs, and (5) “spend-down” consumers (discussed in the Eligibility section).

**Option 3: Develop additional care management programs.** Applying care management to long-term care consumers

will improve health outcomes and reduce costs compared to FFS.

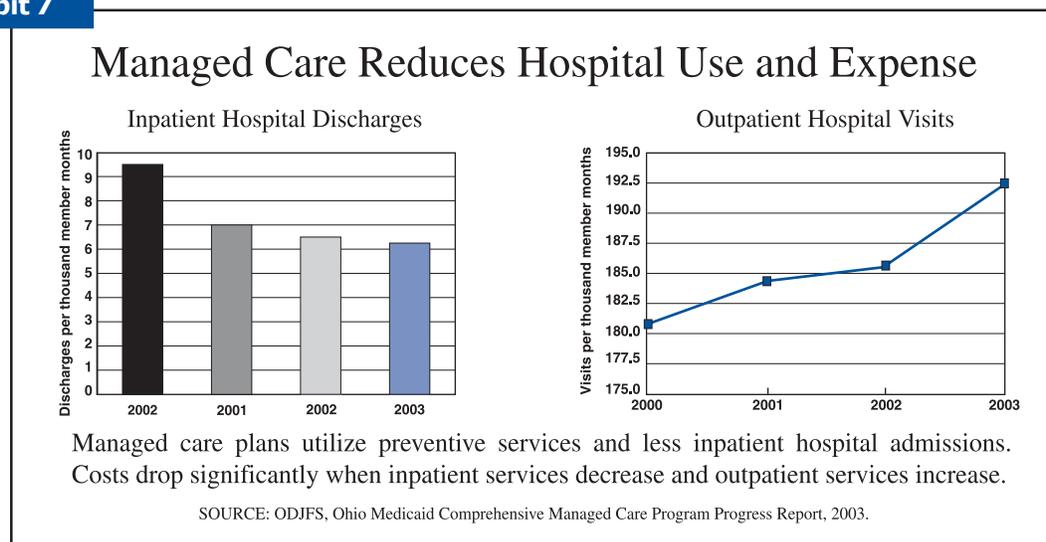
Ohio already operates a long-term care managed care program (PASSPORT) that serves more than 24,000 Medicaid consumers with a nursing facility level-of-care need. Per person health care costs for consumers in PASSPORT are only 25% of nursing facility costs.

**Option 4: Apply Care Management for Acute and Long-Term Care.** The Commission supports a consumer-centered, integrated, long-term care coordination model, such as Program for All Inclusive Care for the Elderly (PACE), where Medicare and Medicaid pay providers a per capita rate that can be no higher than 45% of nursing facility rates for both acute and long-term care services. Participation is voluntary. Consumers enrolled in the PACE must meet the functional criteria for Medicaid nursing facility placement.<sup>20</sup>

The Commission supports a consumer-centered, integrated, long-term care coordination model, where Medicare and Medicaid pay providers a per capita rate.

Programs such as PACE have experienced a range of savings from 20% to 25%, which is higher savings than other programs because they divert consumers from the nursing facilities.<sup>21</sup> An evaluation prepared

**Exhibit 7**



19 Medstat, “Analysis of Ohio’s Enhanced Care Management Population,” August 10, 2004

20 Two integrated programs (under the PACE model) already exist in Ohio: Tri Health Senior Link in Hamilton County and Concordia Care in Cuyahoga County.

21 An evaluation of PACE by Abt Associates found decreased inpatient hospital admissions and days, and decreased nursing facility days. Chatterji, Pinka, Burstein N, Kidder D, and White A, “The Impact of PACE on Participant Outcomes,” Cambridge, Mass: Abt Associates, 1998.

for the Centers for Medicare and Medicaid (CMS) found that Minnesota Senior Health Options reduced emergency room admissions, hospital length of stay, and short-stay nursing facility admissions.<sup>22</sup> Ohio Medicaid should expand PACE and similar programs for integrated care.

Ohio will not be the first state to adopt a combination of integrated care programs for the dually eligible, as well as for Medicaid-only populations, from which consumers may choose. For example, Wisconsin consumers can choose PACE, the Wisconsin Partnership (similar to PACE, but home based), or Wisconsin Family Care (which integrates Medicaid-only acute and long-term care services).

**Impact:** The financial impact of this recommendation will vary depending upon the care management approach employed. ODFJS projects that the ECM program will generate cost savings of about 4% or about \$9 million for SFY 2007.

Milliman Consultant and Actuaries and Mercer Government Human Services Consulting estimates that extending full-risk managed care to a subgroup of 112,000 consumers in the ABD population would save \$121.9 million (\$49.2 million state share). Moving payments from a retrospective basis in FFS to a prospective basis in managed care creates a claims lag payment and occurs because providers will continue to bill Medicaid directly for services provided prior to the consumer enrolling into a managed care plan. An 8% reduction in FFS spending is projected after first year start-up costs.

The Commission estimates \$105.1 million in savings (\$42.3 million state share) for SFY 2006 and \$93.9 million in savings (\$37.5

million state share) in SFY 2007 after accounting for a fee-for-service claims lag during the year of consumer enrollment as provided by ODJFS. This subgroup excludes children, the dually-eligible, those in institutions, those enrolled in waiver programs, and those in the “spend-down population.”<sup>23</sup>

Other states have experienced 6% to 8% savings in dual-eligible ABD care management programs. If applied to all other ABD consumers, Ohio could save from \$360 million-\$480 million.

Further, dual-eligible ABD state programs have reported cost savings of 20% to 25% per consumer for integrated care offered through PACE.

**Action Step 3: Expand financial incentives in various Medicaid managed care capitation rates using managed care plans that develop and implement protocols to improve outcomes through patient education and compliance, community health education and outreach, and coordination with social service organizations.**

During the SFY 2006-2007 biennium, protocols should address the following:

1. Prenatal care beginning during the first trimester
2. Diabetes
3. Asthma
4. Chronic obstructive pulmonary disease
5. Chronic heart failure
6. Delaying or preventing nursing facility admissions.

<sup>22</sup> Kane R, Homayak P, “Minnesota Senior Health Options Evaluation Focusing on Utilization, Cost and Quality of Care,” Minneapolis: Division of Health Services Research and Policy, University of Minnesota School of Public Health, Final Version (Revised August 2003).

<sup>23</sup> A recent analysis conducted for the Texas Health and Human Services Commission by the Lewin Group has projected substantial savings from their “Star+Plus” managed care program if the program is expanded to 51 counties in metro areas of the state. Higher savings (8.6%) are projected for SSI consumers under 65 years of age than for older people (5%). See, The Lewin Group, “Actuarial Assessment of Medicaid Managed Care Expansion Options,” Prepared for the Texas Health and Human Services Commission, January 21, 2004 (amended version).

**Rationale:** An effective model for outcome-based protocols is the Community Health Access Project (CHAP) currently being implemented in three Ohio counties. Developed by Dr. Mark Redding, CHAP employs a “Pathways Outcome Production Model” that shifts the focus from paying for specific services to paying for achievement of positive health and social outcomes. The model relies on a “community hub” system that educates consumers and administrators and engages in community outreach, focusing on disease prevention and helping patients manage their health before they end up in the emergency room.

Data from CHAP proves that financial incentives for performance improves outcomes and reduces health care costs, far offsetting the costs of the program. The prenatal protocols in CHAP, for example, resulted in a reduction from 22% low birth weight babies to 4%. This represents an 82% decrease in low-birth rate babies in one county.

During the 2006-2007 biennium, Ohio should incorporate pay-for-performance strategies such as CHAP into the expansion of all care management strategies.

**Impact:** Significant health care quality improvement will be achieved in the preceding six health conditions. If Ohio adopted CHAP statewide and achieved just a 25% reduction in low birth weight babies in prenatal care alone, it could save \$18.9 million in health care costs for those babies’ first year of life. A 50% reduction will result in a net savings of nearly \$40 million.

**Action Step 4: Improve the management, quality review, and financial strength of Medicaid care management with the following steps:**

1. Increase the coordination between the Ohio Department of Insurance (ODI), ODJFS, and the state-contracted actuary in July 2005 to determine the actuarially sound capitation rates to be paid to the Medicaid managed care plans.
2. Eliminate duplicative review requirements between the Ohio Department of Health (ODH) and ODJFS to ensure better management of the health plan licensing process.
3. Adopt nationally recognized performance standards for Medicaid managed care.
4. Require full-risk managed care plans to purchase surety bonds as a component of their risk-based capital and financial solvency requirements under Ohio law.
5. Inform care management plans doing or seeking to do business in Ohio about Ohio Medicaid’s expenditure growth target, and invite initiatives that will enable them to support state government in meeting spending targets.

*Ohio regulators should continue their efforts to ensure managed care plans are able to meet newly implemented financial standards and national quality measures.*

**Rationale:** As Ohio implements best practice care management strategies, further efforts and assurances may be necessary. In moving forward with expanding full-risk managed care, Ohio regulators should continue their efforts to ensure managed care plans are able to meet newly implemented financial standards and national quality measures.

As a result of past financial insolvencies among Ohio health plans, the Ohio General Assembly passed legislation to implement more stringent, nationally recognized financial solvency standards on health plans. ODI accredits the managed care plans for financial solvency using National Association of Insurance Commissioners' solvency standards, including a Risk-Based Capital (RBC) standard of 200%. RBC is a formula that calculates the amount of capital appropriate for a managed care plan to support its overall business operations based on its size and risk profile. Quarterly reports are filed on RBC to ODI and quarterly conference calls are held with all health plan chief executives on their financial reports. If a plan were to fall below 200%, ODI requires the managed care plan to implement procedures to meet the statutory standard. This step is commonly addressed by an infusion of capital and strict oversight by ODI.

The higher the financial risk, the more the health plan must have in reserve to cover liabilities. Additionally, Ohio law provides for recovery of debts incurred by a health plan doing business in Ohio from the health plan parent corporation.

A new requirement forcing managed care plans to secure surety bonds as part of the RBC will ensure providers that the managed care plans are solvent. According to ODI, the current plans participating in the Medicaid managed care program exceed the RBC standard, which should ease the transition to a surety bond requirement.

To ensure that managed care plans operate below the historic cost trend for FFS reimbursement, ODJFS should inform managed care plans of Ohio's spending growth targets and require the plans to help Ohio Medicaid meet those targets. (See Finance Section for further discussion.)

**Impact:** As the capacity, performance, and financial position of managed care plans are strengthened, health care providers will be more likely to participate. The pay-for-performance incentives in Action Step 3 also will contain costs by providing financial incentives to providers and rewarding them for improving quality and reducing waste.

**Action Step 5: Establish a Care Management Working Group (CMWG), including representatives from Medicaid care management plans, major health care and behavioral health professional and trade associations, consumer advocates, county agencies, and state departments of Job and Family Services (ODJFS), Health (ODH), Insurance (ODI), Aging (ODA), Mental Health (ODMH), Alcohol and Drug Addiction Services (ODADAS), Mental Retardation/Developmental Disabilities (ODMR/DD), and the Rehabilitation Services Commission (RSC).**

**Rationale:** Currently, three government agencies are involved in regulating managed care plans for Ohio Medicaid: ODJFS, ODI, and ODH. Expansion of care management will require better coordination among these agencies and improved standards to ensure both solvency and quality.

The Care Management Working Group will be charged with resolving issues and barriers that arise as managed care expands to statewide coverage.

**Impact:** Implementation of a CMWG will increase consistency and facilitate care management expansion, including coordination of regulatory relationships and improved resolution of contract issues among the major parties in the managed care systems.

**Recommendation 2: Withhold payment of the hospital Graduate Medical Education (GME) Medicaid subsidy from hospitals that fail to participate in expansion of managed care and other care management strategies. (recommendation not unanimous)**

*Rationale:* Historically, hospital system opposition has been a barrier to the expansion of Medicaid managed care in Ohio. Managed care does result in lower admission rates and reduced length of stay which impact a hospital's bottom line. The Administration will need to communicate with hospital systems regarding the imperative of cost containment for the Medicaid program and potential savings as a result of managed care. In addition, managed care expansion can incorporate goals for Medicaid funding of graduate medical education ("GME") that are consistent with the new vision for Ohio Medicaid.

Ohio Medicaid makes payments for direct medical education and indirect medical education expenses as part of its fee-for-service reimbursement to hospitals and payments to currently operating managed care plans. As managed care expands, so do opportunities to tailor those payments to the needs of the Medicaid population. Several states have linked Medicaid GME payments to Medicaid goals such as the training of physicians in primary care or rural settings.<sup>1</sup> Ohio similarly could link GME to hospital system participation in full-risk managed care and other care management programs.

State support for medical education and training is an important policy goal for Ohio which hosts many robust and top-tier medical programs. The state does not want to squander its current ability to attract top medical students and residents just as it has reaffirmed the value of higher education to the economy.<sup>2</sup> At the same time, hospital systems are a critical element of care management strategies, just as they are to the Medicaid program in general. The vast majority of hospitals in counties with Medicaid enrollees

in managed care do, in fact, hold contracts with one or more Medicaid managed care organizations. However in other counties, hospitals have declined to participate in such plans. Some hospitals claim that they cannot accept managed care plans if their reimbursement rates are set at a level that put the hospital in financial jeopardy. Their unwillingness or inability to accept the reimbursement of the managed care plans operating in their community would lead to an exclusion of Medicaid patients from their hospital. This would appropriately eliminate support to them for trainees who have in the past participated in the care of Medicaid patients. Were the hospital however to continue to accept Medicaid patients outside of managed care, loss of education dollars would be financially punitive for its existing trainees.

The Commission believes that the Administration should withdraw GME funding by Medicaid from hospitals not participating in managed care, regardless of whether the hospital accepts other Medicaid patients. The Commissioners, however, did not reach unanimous agreement on this: The majority of the Commissioners believed that GME funding should be immediately contingent upon managed care participation, while others believed that education dollars should not be withdrawn as a punitive action to achieve an otherwise important policy goal without further analysis of its full impact.

**Impact:** Review of GME funding with the intention of linking it to care management will engage the hospital systems in helping the state contain costs while improving access to, and quality of, health care services for the Medicaid population.

This is the only recommendation not unanimous. At the same time several commissioners proposed that the Administration similarly withhold monies from the Hospital Care Assurance Program (HCAP) from institutions that do not participate in managed care. But this received no support as a motion for formal adoption.

<sup>1</sup> Medicaid's Role in Financing Graduate Medical Education, Tim M. Henderson, Health Affairs, January/February 2000.

<sup>2</sup> Report of the Governor's Commission on Higher Education and the Economy, 2004.

# Pharmacy



Ohio Medicaid drug spending is spiraling upward, doubling in the past five years and projected to double again in the next five. According to the ODJFS baseline projections, pharmacy costs in Ohio are projected to grow to 20.5% of overall Medicaid expenditures by SFY 2007, an increase of 35% from the 15.2% that pharmacy represented in SFY 2001. Medicaid spends approximately \$2 billion, with 42% covering low-income Medicare patients who are referred to as “dual eligibles.” Efforts by many states to rein in pharmaceutical costs, including purchasing drugs from Canada, demonstrate the need to achieve both short- and long-term solutions to manage Medicaid pharmacy costs.

Like other areas of Medicaid, federal and state statutory and regulatory requirements affect the prices Ohio pays for drugs. Although the Ohio Medicaid staff have worked diligently within legal confines to cost-effectively manage the program, they face significant roadblocks to controlling costs.

Drug costs are set through complex and confidential negotiations between drug manufacturers and federal and state authorities over mandated supplemental rebates. Cloaked in statutorily protected secrecy, the final cost to the Medicaid program for any individual drug is neither publicly disclosed nor available for competitive analysis by any other than a few confidentiality-bound Medicaid staff.

Due to confidentiality restrictions, the Ohio Commission to Reform Medicaid was not provided access to individual prices for patented products, the group of drugs that comprise 75% of Medicaid drug expenditures. Therefore, analysis of the escalating costs and pharmaceutical price comparisons were not possible. This seriously hampered the work of the Commission on the second highest cost-driver in the program.

The Commission recommends that Ohio work toward systemic change that will enable drug pricing for Medicaid and other state programs to be publicly transparent and market driven. This ambitious goal will require statutory and regulatory changes at both the federal and state levels. How can the state construct a cost-effective formulary without the General Assembly, Governor and other state government officials knowing how we are spending our taxpayer dollars?

Ohio should take the lead and work with other states to open up the system to price transparency and competition. Structural change at the national level will make other

recommendations in this report more effective.

However, there is much that can be done in the short term to alleviate escalating drug costs, including establishing a more restrictive drug formulary, increasing the use of less expensive but equally effective generic drug, and expanding Ohio's buying power through participation in statewide and multi-state buying pools. Ohio can slow escalating drug costs by establishing a more restrictive drug formulary, increasing the use of generic products, and expanding Ohio's buying power by pooling drug purchases in Ohio and with other states.

The Commission reviewed the impact on Ohio of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Medicare Part D), which goes into effect in January 2006 for Medicare consumers. Although the dual-eligible population (for both Medicaid and Medicare) who represent 42% of Ohio Medicaid's \$2 billion annual drug expenditure will begin receiving drug coverage through the new Medicare Part D benefit, Ohio Medicaid will continue to share the cost.

Because the Medicare bill specifically restricts government negotiation for drug prices under Medicare, the cost of Medicare Part D to state Medicaid programs is unclear at this point. Medicaid staff have advised the Commission that Medicaid pharmacy expenditures could increase if Ohio kept the responsibility to manage the pharmacy benefit, even with the implementation of the Part D benefit. This is a major issue for Ohio and must be monitored carefully as the program is rolled out.

The following five recommendations will help Ohio realize the twin goals of reducing overall cost and growth rate of the drug program while maintaining important health

*Ohio can slow escalating drug costs by establishing a more restrictive drug formulary, increasing the use of generic products, and expanding Ohio's buying power by pooling drug purchases in Ohio and with other states.*

care services for the needy through improved medication management. The Commission received assistance from The Ohio State University College of Pharmacy and School of Public Health and Health Management and Associates in analyzing and quantifying recommendations. At the time of this writing, another study is yet to be completed regarding medication therapy management issues, specifically inappropriate use of medications.

**Recommendation 1: Secure the best prices for pharmaceuticals (brand, generics and over-the counter medications) through expansion of buying power and creation of a more competitive market for price negotiation.**

**Action Step 1: Consolidate all pharmaceutical purchasing by the state and other public entities with Ohio Medicaid to create an efficient pharmacy program through negotiating better rebates and overall prices for individual drugs. Participate in a multi-state drug purchasing pool.**

**Rationale:** In the current rebate-driven pharmacy market place, volume creates better pricing. Consolidating procurement into one program better leverages Ohio's purchasing power to obtain maximum value<sup>24</sup>

For example, if Ohio combined drug purchases of the Bureau of Workers' Compensation and the departments of Rehabilitation and Correction and Youth Services, it will save more than \$45 million per year. Other states that have combined state-funded pharmacy purchasing to reduce costs include West Virginia and Georgia.

Specifically, Georgia's intra-state purchasing system utilized its Drug Utilization Review Board to establish a single preferred drug list (PDL), with state-set rates, and its pharmacy benefit manager

(PBM) manages the drug purchasing program for Medicaid, State Children's Health Insurance Program (SCHIP), and public employees. Georgia reduced by 10% its cost growth trend line in State Fiscal Year(SFY) 2001 and 2002.<sup>25</sup>

Multi-state consortia for drug purchasing are taking hold across the nation. Michigan, Vermont, New Hampshire, Alaska, Nevada, Hawaii and Minnesota have pooled their Medicaid purchasing power. So far, Ohio has not participated, in part because its own \$2 billion expenditures have provided the state with substantial bargaining power. With the advent of Medicare Part D, however, that purchasing power will be cut in half. The Commission recommends that Ohio participate in a multi-state purchasing consortium.

Other collaborations to achieve efficiencies and economies of scale include Minnesota Multi-State Contracting Alliance for Pharmacy and Oregon's Drug Effectiveness Review Project. Last, but not least, in 2004, the Ohio public employees joined a multi-state coalition.<sup>26</sup>

**Impact:** Consolidating all state drug purchasing will result in a minimum of \$45 million in savings. Although savings for Ohio in a multi-state purchasing pool cannot be projected at this time, other states have realized substantial savings, and Ohio can expect the same.

**Action Step 2: Lift restrictions in the supplemental rebate system that exclude certain Medicaid drug purchases from negotiated cost recovery. These include mental health and HIV/AIDS drugs. Seek rebates on physicians' office purchases and purchases in the Disability Assistance Medical program.**

*The Commission recommends maximizing our state purchasing power and increase administrative efficiencies by consolidating all drug purchasing.*

24 Such a recommendation was presented to the Rhode Island governor and legislature in a study commissioned by the Heinz Family Philanthropies, "Coordinated Contracting of Prescription Drugs: A Fiscal and Policy Strategy for the State of Rhode Island – The Rhode Island Blueprint," February 2004.

25 Silow-Carroll S, Alteras T, "Stretching State Health Care Dollars: Pooled and Evidence-Based Pharmaceutical Purchasing, One of a Series of Reports Identifying Innovative State Efforts to Enhance Access, Coverage, and Efficiency in Health Care Spending," October 2004, retrieved November 2004 <http://www.cmfw.org>.

26 While Ohio is not a member, 41 states participate in this purchasing group to date. Additional background on the Minnesota Multi-State Contracting Alliance for Pharmacy is available at <http://www.mmd.admin.state.mn.us/mmap/background.htm>.

**Rationale:** State law prevents Ohio Medicaid from negotiating supplemental rebate agreements with manufacturers of drugs for HIV/AIDS and mental illness.<sup>27</sup> While this prohibition reflects sensitivity to vulnerable populations, the result is the state pays higher prices for drugs that comprise a major part of its overall drug expenditure. Mental health drugs accounted for more than 24.4% of all Medicaid drug expenditures for all eligibles and 24% of all Medicaid drug expenditures for dual eligibles. Antipsychotics (\$274.6 million) and anticonvulsants (\$99 million) are two of the three classes of drugs in which Ohio Medicaid spends the most money.

Ohio should follow the actions taken by other states to collect rebates on Medicaid-purchased drugs administered in physicians' offices. In 2001, Ohio Medicaid reimbursed \$13.3 million in this category and would have been able to seek about \$2.3 million in rebates. Several states reported spending \$300,000 to \$600,000 for necessary computer systems development, then collected gross recoveries of \$2 million to \$3 million the first year.<sup>28</sup> In a similar vein, in the Disability Medical Assistance (DMA) program, approximately 18,000 persons receive nearly \$100 million in prescription drugs, offering the opportunity for \$15.5 million in yearly savings through rebates that are not being negotiated for DMA.<sup>29</sup> The state should also review back-billing for individuals on DMA as there is a high rate of consumer who later become Medicaid eligible.

**Impact:** Collecting rebates for Ohio mental health and HIV/AIDS drugs will save up to \$43.6 million. Medicaid will save another \$33 million by including physician office and DMA drug purchases in the Ohio rebate program. Because of the ongoing

implementation of the Medicare Part D benefit, these calculations are based on expenditures for both Medicaid-only and dually eligible consumers. The state should pursue retroactive reimbursement when possible. This analysis may be impacted by Medicare Part D.

**Action Step 3: Change state and federal law and regulations so that drug purchases are transparent.**

**Rationale:** Both federal and state laws force drug price and negotiation into confidential rebate system based on volume, which obscures the price of individual drugs. The law that needs to be modified is the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), which prohibits Centers for Medicare and Medicaid Services (CMS) and state agencies from publicly disclosing rebate information. Supplemental rebate agreements negotiated by individual states with pharmaceutical manufacturers contain similar confidentiality requirements. In Ohio, information related to supplemental drug rebates is made confidential by statute as well<sup>30</sup>

The Commission believes the lack of a fully transparent drug pricing system in Medicaid is anti-competitive and contributes to the double-digit growth rate in pharmaceutical expenditures. Ohio is not alone. Other states are frustrated with the rebate system as well. Ohio should lead a coalition of states to develop national Medicaid pharmacy reform that allows for direct and transparent drug price negotiation.

**Impact:** If Ohio achieved a cost reduction of 5% through transparent, competitive pricing, it could save up to \$115 million per year.

*The Commission believes the lack of a fully transparent drug pricing system in Medicaid is anti-competitive and contributes to the double-digit growth rate in pharmaceutical expenditures.*

27 Ohio Revised Code § 5111.082.

28 Office of Inspector General, Department of Health and Human Services, "Medicaid Rebates for Physician-Administered Drugs," April 2004.

29 There are a number of ways to reduce state expenditures for this state-funded program, including securing federal funds through a waiver, securing rebates, retro claiming when individuals become Medicaid eligible and care management.

30 Ohio Revised Code § 5101.31.

**Recommendation 2: Restrict drugs eligible for payment under the Medicaid program using a more limited formulary than the current one, with preferred status going to similar, if not identical, lower cost drugs.**

**Action Step 1: Limit the number of preferred drugs to equivalent, lower cost products, and require documentation and prior authorization (PA) for use of non-preferred drugs.**

**Rationale:** Ohio's PDL is less restrictive than other public and private PDLs. A recent analysis of the 2003 Medicaid drug expenditures compared the top 100 drugs by total expenditure on Ohio's PDL to two other PDLs. The Veterans Administration (VA) excludes 33 of the top 100 drugs on Ohio's PDL, and, in 2003, 98% of all VA prescriptions were for drugs listed on the formulary.<sup>31</sup> MEDCO, a PBM, also excludes 21 of Ohio's 100 costliest drugs.<sup>32</sup> Ohio should implement similar restrictions.

*Ohio's PDL is less restrictive than other public and private PDLs. The Veterans Administration (VA) excludes 33 of the top 100 drugs on Ohio's PDL...MEDCO, a PBM, also excludes 21 of Ohio's 100 costliest drugs.*

**Impact:** Without access to the price of individual formulary drugs, the Commission could not estimate savings. Actual savings will depend upon which particular drug classes and preferred products are in Ohio's formulary.

**Action Step 2: Regularly evaluate and sponsor evidence-based research on the use of prescription drug therapies and use prior authorization to align drug therapies with the most up-to-date research.**

**Rationale:** Ohio Medicaid's formulary should provide best practice guidelines to its physicians, a practice that has improved quality, increased the use of generic drugs, and reduced costs in other states. Kentucky, for example, requires step therapy

guidelines in the prior authorization requirement of its formulary, and Oregon uses evidence-based protocols.<sup>31</sup> Both states have experienced increased utilization of generic drugs and significant savings.

Step therapy is a monitoring mechanism that ensures that payment for selected expensive drugs occurs only after safe, effective, and less expensive drug treatments are tried first. Physicians and pharmacists must be involved in developing evidence-based guidelines for a pharmacy therapy management program through a formalized process. The state should work to identify the best therapeutic options for patients with chronic costly disease states, in deference to merely utilizing less expensive and less effective therapeutic alternatives. These professionals would have the capacity to interact on the issues surrounding the economics of sound clinical intervention and knowledge in areas specific to chronic disease states and or pharmacoeconomics. Exclusionary criterion should be if an individual works for a pharmaceutical manufacturer.

**Impact:** The creation of evidence-based guidelines for prescription drug therapy will increase utilization of generic and other lower-cost drugs leading to significant savings. Each 1% shift to generics will save Ohio up to \$20.4 million. (See Action Step 3.)

**Action Step 3: Set incremental goals for increasing the use of generics as opposed to patented drugs as a percentage of all drug expenditures.**

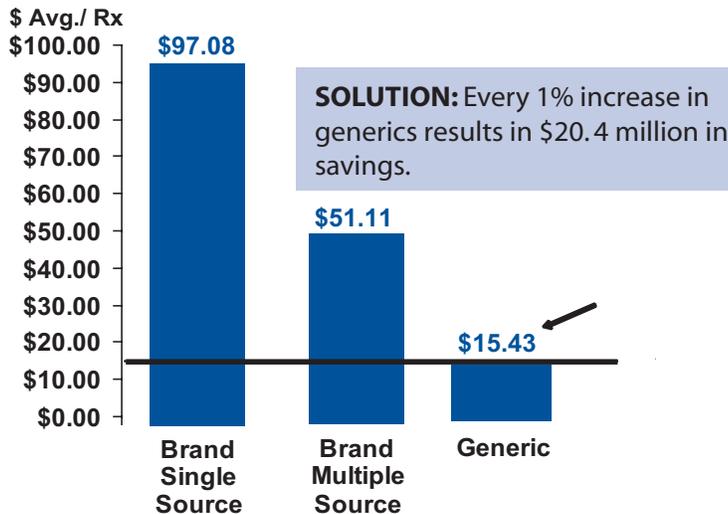
**Rationale:** Brand name drugs eventually lose their patent protection. Although Ohio Medicaid has added several new generic medications to its preferred drug list, other

<sup>31</sup> Canzolino J, VA Pharmacy Benefits Management Strategic Healthcare Group Update, 2004, retrieved December 2004, <http://www.vapbm.org/pmbpresentation/Kansas.pdf>.

<sup>32</sup> Seoane E, "Alternatives for Reform of the Ohio Medicaid Pharmaceutical Program," Table 1, Sept. 28, 2004, <http://www.ohiomedicaidreform.com>.

## Exhibit 8

**PROBLEM:** Ohio Medicaid spends 86% of its dollars on brand drugs, which cost 5 times as much as generics.



Source: The Ohio Commission to Reform Medicaid. ODJFS, Pharmacy Claim Data. SFY2003.

key brands will lose patent protection in 2005, including Nexium (gastrointestinal), Pravachol and Zocor (cholesterol), and Zoloft (antidepressant). After these high-use, high-cost drugs lose patent protection, the door will open to generic equivalents and generate significant savings without jeopardizing patient care.

Ohio regulation allows pharmacists to substitute generics using Food and Drug Administration (FDA) measures of therapeutic equivalence. Educating physicians and pharmacists on the benefits of generic substitution and requiring specific notification<sup>33</sup> on the prescription that a brand drug is essential for a patient will contribute to an increase in generic use without compromising patient care.

**Impact:** The average price per prescription that Ohio Medicaid pays for generic drugs is \$15.43 compared to \$97.08 for sole-source patented drugs. With nearly 30.5

million prescriptions for which Ohio Medicaid paid during fiscal year SFY 2003, even incremental shifts from brand-name equivalents and single-source drugs to generics will provide significant savings.<sup>34</sup>

Ohio's generic use rate is nearly 50%, which is well below other states such as Illinois at 62%, Kansas at 59%, and Kentucky at 57%.<sup>35</sup> Moving to a 60% generic use rate could save Ohio Medicaid between \$160 - \$210 million; or about \$20.4 million for every 1% increase.

**Recommendation 3: Reduce state expenditure at the point-of-sale of Medicaid drugs.**

**Action Step 1: Bring Medicaid pharmacy reimbursement into parity with commercial insurers.**

**Rationale:** Pharmacy reimbursement is based on two components: ingredient cost

<sup>33</sup> See note 3.

<sup>34</sup> Currently, Ohio law only requires a physician to check a box "DAW" (dispense as written) on a prescription. This is all too easy and requires little thought by a physician. If such a simple method were eliminated, and a specific notation and reason were required to do so on a prescription to dispense as written, greater generic substitution will occur.

<sup>35</sup> Seoane, Ibid.

reimbursement and a dispensing fee. While the dispensing fee is predominately constant for each prescription paid, the ingredient cost reimbursement varies for brand names and generics.

In determining the Medicaid acquisition cost of drugs themselves (ingredient cost), patented drug prices are set by manufacturers. As for generics, which often have multiple manufacturers, some drug purchasing vendors have suggested that the Ohio Medicaid program could save as much as \$2.70 per generic prescription through its purchasing clout.

In addition to obtaining better prices for ingredients, states are required to pay a “reasonable” dispensing fee. The national average is approximately \$4 per prescription. Ohio Medicaid pays a dispensing fee of \$3.70 per prescription. The Ohio state employee health plan pays a dispensing fee of \$2.50.<sup>36</sup> The largest private payers average \$2.25 per prescription,<sup>37</sup> and other insurers and state Medicaid programs pay even less.

**Impact:** The generic ingredient cost savings experienced by generic drug management vendors has been shown to produce \$30 to \$35 million annually in savings in other states. Ohio should evaluate the advantage of contracting with a specialized generic drug management vendor over its current internal system to see if additional savings could be realized.

If Ohio Medicaid reduced its current \$3.70 dispensing fee to the \$2.50 rate paid by the state employee plan, it will save \$1.20 per prescription. Based on 30.5 million annual prescriptions, estimated annual gross savings will be \$36.6 million.

Further, reducing the price paid by Medicaid

to wholesale acquisition cost (WAC) plus 5% of trade name pharmacy (currently Medicaid pays WAC +9%) will provide an estimated \$17.41 million savings the first year and \$29.85 million savings the second fiscal year of implementation.

**Action Step 2: Create a system of modest patient cost-sharing for drug purchases.**

**Rationale:** In January 2004, Ohio Medicaid imposed a \$3 co-payment requirement for non-formulary prescription medications. According to CMS,<sup>38</sup> other states did the same thing. The Medicaid program also should develop a plan to enforce prescription co-payment requirements; if necessary, seeking a federal waiver. Pharmacies report difficulty in collecting co-payments and often waive them.

**Impact:** Implementing a \$1 co-payment on patented drugs in compliance with federal regulations will produce a savings of \$11.7 million annually for Medicaid-only consumers, and \$4 million savings for dual-eligibles for six months. The co-payment will also promote the shift to generic drugs.

**Action Step 3: Implement a mail-order program for Chronic Care Maintenance Medications.**

**Rationale:** A common cost containment measure in the private sector is the practice of encouraging or requiring consumers to obtain maintenance medications for chronic conditions from mail-order pharmacies. Though not applicable to all consumers, the use of a mail-order program for the persons with disabilities and/or the chronically ill, who are consistently Medicaid eligible and who make up a significant share of the Medicaid pharmacy program, will generate savings.

*The Medicaid program also should develop a plan to enforce prescription co-payment requirements; seek a federal waiver.*

*A common cost containment measure in the private sector is the practice of encouraging or requiring consumers to obtain maintenance medications for chronic conditions from mail-order pharmacies.*

<sup>36</sup> Other state estimates are based on the “educated guess” of state Medicaid pharmacy officials, and not on quantitative analysis. Crowley J, Asher D, and Elam L, “Medicaid Outpatient Prescription Drug Benefits: Findings from a National Survey, 2003,” [http://www.kff.org/medicaid/upload/30030\\_1.pdf](http://www.kff.org/medicaid/upload/30030_1.pdf).

<sup>37</sup> Seoane E, Survey of Pharmaceutical Programs Managed by Ohio, November 16, 2004.

<sup>38</sup> House Energy and Commerce Subcommittee on Oversight and Investigations, Internal Committee Memorandum, December 6, 2004.

The program should begin with the waiver population, and should include provisions to minimize waste to prevent, for example, a situation wherein a consumer's 90-day drug supply was ordered and paid for, and then not needed.

Wisconsin saved \$900,000 per year with a mail-order program for Chronic Care Maintenance Medications<sup>39</sup> and Florida saved \$1.5 million per year.<sup>40</sup> In addition, Washington expects to save \$2.7 million within two years with a mail-order pharmacy plan.<sup>41</sup>

**Impact:** Like other states, Ohio can expect to save with a mail-order drug program. These savings will include a portion of the dispensing fee, bulk discounts due to filling larger prescriptions and savings on non-emergency transportation for homebound consumers who would otherwise need multiple trips to a pharmacy. The mail-order plan should begin with the waiver population.

**Recommendation 4:** Set up systems to monitor cost-effective management of drugs by Medicaid-reimbursed prescribing physicians and health plans.

**Action Step 1:** Initiate medication therapy management.

**Rationale:** The improper use of medication, especially when multiple medications are being used by a consumer, can lead to health complications and a waste of drugs. Waste includes: (1) use of high-cost medication when an equally effective, low-cost medication is available; (2) a medication fails to achieve intended results; (3) a consumer is non-compliant; and (4) a consumer requires additional medical treatment due to a side effect. Medication therapy management improves health

outcomes and reduces drug waste in other states. Therapy management can be administered by physicians working with pharmacists in their practice or by pharmacists at local pharmacies.

For example, Ohio Medicaid spent an estimated \$3.7 million (drug and dispensing fees) on 9.9 million doses of low-dose thiazide diuretics to treat hypertension in 2003. These doses could have been combined into one dose with ACEI or ARBs as an anti-hypertensive medication through a medication therapy program, resulting in a net savings of about \$2.5 million. Low-dose thiazide should be the second choice drug following an ACEI or ARB drug and, if required, should be added to the first-choice medication therapy as a combination product. Lisinopril/HCTZ 20 mg/25 mg. would have been a more appropriate drug and is an example of how two medications can be combined.

Drug utilization and expenditures are concentrated in a small percentage of patients, therapeutic classes, and providers. Medication therapy management efforts should especially target these small, high-cost groups to change inappropriate patterns for patients and providers.

For Medicaid consumers enrolled in a managed care plan or in the state's Enhanced Care Management (ECM) program (see Care Management Section), medication therapy management should continue to be carried out by the managed care organizations and ECM providers with performance measures established by the state.

A University of Iowa College of Public Health pharmacy case management project involving nearly 1000 Medicaid high-use pharmacy consumers found 2.6 medication-related problems per individual. During the project, 52% of the individuals started a new

*Drug utilization and expenditures are concentrated in a small percentage of patients, therapeutic classes, and providers.*

*Medication therapy management efforts should target these small, high-cost groups to change inappropriate patterns for patients and providers.*

39 State of Wisconsin Department of Health and Family Services, "Pharmacy Cost Containment," retrieved November 13, 2004, <http://www.dhfs.state.wi.us>.

40 The Seattle Press, "New Mail-Order Pharmacy Service to Keep Medicaid Costs Down," December 12, 2001, retrieved November 2004, <http://www.sptimes.com>.

41 The Seattle Press, "New Mail-Order Pharmacy Service to Keep Medicaid Costs Down," February 6, 2003, retrieved December 2004, <http://www.seattlepress.com>.

*A medication therapy management program has significant potential to ensure the appropriate use of pharmaceuticals... and reduce overall costs 6% to 8%.*

medication for untreated conditions, 36% changed to a more appropriate medication, and 33% discontinued a medication being taken.<sup>42</sup> The Iowa Medicaid Drug Utilization Review (DUR) Commission, which fosters physician-pharmacist pharmacy management partnerships, has saved \$3.76 for each dollar spent on the program.

**Impact:** A medication therapy management program has significant potential to ensure the appropriate use of pharmaceuticals especially for high-utilization consumers. This is also a key component of the care management approach, which is estimated to reduce overall costs 6% to 8%.

**Action Step 2: Provide incentives for physicians and hospitals to use electronic prescribing.**

**Rationale:** Electronic (E-) prescribing uses computers to write and communicate drug prescriptions.<sup>43</sup> An electronic prescribing system includes multiple tools to facilitate the work of prescribers, pharmacists, and other health care providers, as well as health care insurers, all at a push of a button.

E-prescribing replaces the paper prescription. Advanced systems include clinical decision support, formulary information, integration with electronic medical records, and communication with other health care systems. E-prescribing reduces medical errors and facilitates the cost-effective use of drug therapies.

Today, physicians and other health care providers make their drug-prescribing decisions using medical, medication, and eligibility information that is known or available to them. Then they give a handwritten prescription to the patient or fax it to the patient's pharmacy of choice. At

the pharmacy, tasks are somewhat more automated. Through electronic claims, eligibility, and benefits submission, the dispensing pharmacist may learn about drug interactions, disease management concerns, the need for prior authorization, or lower cost alternatives. The pharmacist may then contact the prescriber by phone for approval of changes, refills, or renewals. This process can be very repetitive and time consuming for both the pharmacist's and the prescriber's office staff. According to CMS, almost 30 percent of prescriptions require pharmacy call backs, resulting in 900 million prescription-related telephone calls that are placed annually.

Contacting the prescriber by phone to clarify what is ordered and to make changes often results in delays for the patient and is time consuming for the prescriber and the pharmacist. There are disconnects between the prescriber and patient in the medication process on whether a prescription was filled or refilled. These disconnects can lead to preventable adverse drug events (ADEs) that are common and can be serious. According to the Center for Information Technology Leadership, more than 8.8 million ADEs occur each year in ambulatory care, of which over three million are preventable.<sup>44</sup> Medication errors account for one out of 131 ambulatory deaths. In addition, the current system results in numerous and pervasive administrative and workflow inefficiencies, which affect costs and quality of care. CMS has estimated that the use of e-prescription technology could eliminate up to 2 million harmful drug events each year.

In a Florida Medicaid pilot program, the state provided physicians with hand-held devices that displayed the Florida Medicaid preferred drug list, provided clinical

42 Iowa Medicaid Pharmaceutical Case Management Program: Final Report – Executive Summary, December 2002.  
43 "Electronic Prescribing: Toward Maximum Value and Rapid Adoption Prescribing Initiative," eHealth Initiative, Washington, D.C., April 14, 2004, retrieved December 2004, [http://www.providersedge.com.ehdocs/ehr\\_articles/Electronic\\_Prescribing\\_Toward\\_Maximum\\_Value\\_and\\_Rapid\\_Adoption.pdf](http://www.providersedge.com.ehdocs/ehr_articles/Electronic_Prescribing_Toward_Maximum_Value_and_Rapid_Adoption.pdf).  
44 "The Value of Computerized Order Entry in Ambulatory Care," Center for Information Technology (CITL, a research organization chartered in 2002), Wellesley, MA (781-416-9200) 2003 report, retrieved December 2004, <http://www.citl.org>.

information about prescription drugs, and included patient medical histories. As a result, Florida found less inappropriate or duplicative prescribing, a reduction in severe drug interactions, and fraud reduction.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 also promotes E-prescribing by requiring CMS to implement a pilot program beginning in 2006, adopt mandatory standards by April 2008, and provide \$50 million in information technology grants for physicians.

Although electronic prescribing is used by only 10% of physicians nationwide now, Ohio should lead the trend to use low-cost web technology and palm-sized devices by focusing first on high volume Medicaid prescribers. Target the top 10 providers who write 2.1 million prescriptions per year amounting to \$115.5 million.

Florida Medicaid has expanded the use of PDAs with E-prescribing to 3,000 or 80% of its Medicaid providers. The overall impact on Florida Medicaid costs is estimated at \$700 per physician per month. At 3,000 doctors, this translates to \$25.2 million in annual savings, in addition to significant improvements to the quality of care and provider accountability. According to the Florida Medicaid department, 72% of physicians reported identifying a clinically relevant drug interaction that was previously unknown to them.

**Impact:** Ohio's cost savings and health care improvements should be similar to states such as Florida. By conducting at least a pilot program of 3,000 physicians, Ohio potentially assume greater savings than \$25.2 million. If Ohio receives the 90% federal match for technology improvements

(see Structure and Management Section), additional savings can be expected.

**Recommendation 5:** Monitor the shift to the Medicare Part D formulary for the dually eligible population, operating on the premise that Ohio will not provide additional subsidies for products covered in the Ohio formulary and not in the federal schedule, but will consult with other states and with Medicare if clinically important differences become apparent.

**Rationale:** Certain commonly covered drugs under Medicaid (including over-the-counter drugs and benzodiazepines, barbiturates, proton pump inhibitors, cough and cold medications, and vitamins) do not have to be covered under Medicare Part D. In 2003, Ohio Medicaid reimbursed more than \$735 million for 15 million prescriptions for persons dually eligible for Medicare and Medicaid. Of that amount, \$16 million (1.9 million prescriptions) would have been excluded under Medicare Part D guidelines.

Ohio could choose to continue to cover and receive federal matching funds for drugs not covered under Medicare Part D. With this action, Ohio's estimated share of the cost will be almost \$7 million per year. Such action would not be fiscally prudent, particularly in light of the inability of the state Medicaid program to influence the overall cost or content of the Medicare formulary.

**Impact:** Currently, Ohio's estimated cost to cover drugs in the Ohio formulary and not in the federal schedule is \$7 million. If Ohio does not cover drugs outside of Medicare Part D, it will save \$7 million.

*Ohio should lead the trend to use low-cost web technology and palm-sized devices by focusing first on high volume Medicaid prescribers.*

# Eligibility

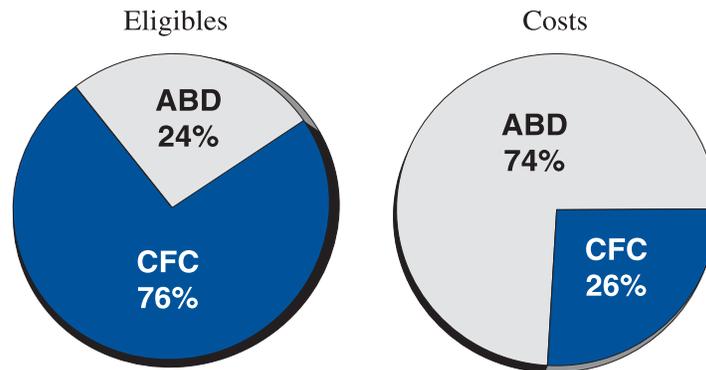


**T**he Ohio Commission to Reform Medicaid believes that Ohio's current Medicaid eligibility standards for low-income families and children should be maintained by the Governor and General Assembly. Beyond Medicaid's central role in ensuring health care to this population, beyond the program's importance as a support to low-wage workers and their employers, and beyond its importance in sustaining the success of welfare reform, the Commission believes as a basic principle that cost containment strategies must concentrate on areas where expenditures are greatest.

Medicaid covered the health care costs for one in six Ohioans in 2004. These 1.7 million people qualify through two general eligibility categories that are broadly defined in federal law: Covered Families and Children (CFC) and Aged Blind and Disabled (ABD). Ohio Medicaid currently serves 1.3 million people under CFC and 420,000 persons who are ABD. CFC consumers represent 76% of all persons eligible for Ohio Medicaid but only 26% of total Medicaid spending. Conversely, ABD consumers represent 24% of all persons eligible but 74% of costs. Accordingly, the Commission has focused considerably greater attention on costs associated with the ABD population.

**Exhibit 9**

# ABD Dominates Medicaid



Aged, Blind, or Disabled (ABD): 420,000  
 Covered Families and Children (CFC): 1,300,000

SOURCE: Ohio Department of Job and Family Services, 2004.

CFC recipients represent 76% of all persons eligible for Ohio Medicaid and only 26% of total Medicaid spending. Conversely, ABD recipients represent 24% of eligibles but 74% of costs. Accordingly, the Commission has focused considerably greater attention on reducing costs associated with the ABD population.

## Eligibility for Covered Families and Children

Generally, the CFC group includes adults with children in families with incomes below 100% of the federal poverty guidelines; children below 200% of the poverty guidelines; pregnant women below 150% of the poverty guidelines; and recipients of Ohio Works First (OWF) cash benefits. (See Exhibit 10.)

Prior to the implementation of welfare reform in 1996 (or Temporary Assistance to Needy Families) and the State Child Health Insurance Program (SCHIP) in 1997, Medicaid eligibility for the CFC group was tied to an individual’s eligibility for welfare benefits. Enactment of these laws opened the door to Medicaid eligibility based primarily on family income, reducing reliance on “categorical eligibility.”

In passing welfare reform, Congress de-

linked Medicaid from welfare, recognizing that the potential loss of health benefits was a barrier to leaving welfare for low-wage jobs that usually do not provide employer-sponsored health benefits. As Ohio implemented welfare reform, it extended Medicaid to cover low income families up to the federal poverty guidelines.

In 1997, the SCHIP program extended federal funding to states for covering health benefits for children in families with incomes below 200% of the federal poverty guidelines. Providing enhanced federal

**Exhibit 10**

2004 Federal Poverty Guidelines	
Family Size	Federal Poverty Guideline
1	\$ 9,310
2	\$12,490
3	\$15,670
4	\$18,850

SOURCE: Centers for Medicare and Medicaid Services, 2004.

matching funds to the states for this purpose, SCHIP fills a significant need for low income workers who do not receive employer-sponsored health benefits for family members. In an effort to efficiently manage the program, Ohio opted to operate its SCHIP program through its policies and procedures for Medicaid, providing the same benefits under both programs.

The positive impact of welfare reform, SCHIP, and related changes in federal and state Medicaid policy has been significant. Ohio's welfare caseloads in 2004 are two-thirds less than their pre-welfare reform levels (86,000, down from their high of 263,000 in 1992). Expenditures for Ohio cash assistance have declined from \$673.1 million in 1997, to \$325.5 million in 2004. Further, between 1998 and 2004, a period that included a major recession, the number and percentage of Ohio children without health insurance significantly declined from 9.8% to 5.4%, while the number of uninsured adults below age 65 remained relatively constant.

## Eligibility for Aged, Blind, and Disabled

Ohioans who are over 65 (41% of the ABD category) may be eligible for Medicaid if their income and resources fall below certain levels, if they spend down their income or resources on medical expenses to below those levels, or if they live in nursing facilities or other medical institutions under higher income and resource criteria. Reforms relating to eligibility for the elderly, particularly those who require an institutional level of care, are discussed in the Long Term Care Section. Medicaid also covers these dually eligible individuals for the cost of their Medicare premiums, deductibles, and co-insurance if their income is below 100% of federal poverty guidelines.

Ohioans under age 65 (59% of the ABD category) also may be eligible for Medicaid if they have a disability and meet or spend down to the income and resource standards. For the entire ABD category, the 2004 income

### Exhibit 11

Medicaid Eligibility Categories and Income/Resource Limits		
Category	Monthly Income Limits	Resource Limit
1. Persons Over Age 65 2. Blind Persons 3. Disabled Persons	\$490 for an individual, or those who "spend down" to this level on healthcare costs  \$846 for a couple (applies if both persons in the couple are eligible as Aged, Blind, Disabled)	\$1500 for individual  \$2250 for a couple
4. Persons receiving Ohio Works First benefits	Same monthly income limit as Ohio Works First	No limit
5. Former recipients of Ohio Works First benefits for up to 12 months after benefits end (transitional)	No limit first six months  185% of federal poverty guidelines (FPG) for second six months	No limit
6. Pregnant Women	150% of FPL	No limit
7. Families with a child under age 19 in the assistance group	100% of FPL	No limit
8. Children under age 19	200% of FPL	No limit

SOURCE: Ohio Department of Job and Family Services, 2004.

standard was \$490/\$864 for individuals/couples and the resource standard was \$1,500/\$2,250 for individuals/couples.

In arriving at these standards, Ohio did not follow most other states (now 39) that apply the same standards as for Supplemental Security Income (SSI), which provides federal cash benefits to the low-income disabled. When the federal government enacted SSI in 1972, it gave states the option of using SSI's eligibility process to determine Medicaid eligibility under a "section 1634" contract with the Social Security Administration. Alternatively, a state could apply its existing standards for cash benefits under section 209(b). Ohio opted to become a "209(b) state."

While 209(b) states are considered to have "more restrictive" eligibility standards than 1634 states, data collected by the Commission suggests the reverse, at least for Ohio. There has been a significant acceleration of growth in the number of ABD Medicaid eligibles since 1990, nearly doubling from 216,000 to 420,000 in 2004. Some growth in this group might be expected in light of an aging population, but most new ABD Medicaid eligibles are people with disabilities under age 65. Moreover, as shown below, the rise in ABD Medicaid eligibles does not mirror a similar rise in individuals in Ohio qualifying for SSI.

With a relatively constant statewide population, and SSI eligibility remaining relatively constant since 1995, demographic

**Exhibit 12**

**Ohio SSI and ABD Medicaid Caseloads**

Year	OHIO SSI	OHIO MEDICAID ABD
1990	156,000	216,000
1991	169,000	233,000
1992	176,000	256,000
1993	214,000	280,000
1994	236,000	313,000
1995	248,000	245,000
1996	254,000	367,000
1997	247,000	370,000
1998	249,000	365,000
1999	243,000	373,000
2000	240,000	372,000
2001	242,000	376,000
2002	242,000	383,000
2003	244,000	401,000
2004	245,000 (est)	420,000
Total Change from 1990 to 2004	+ 89,000 (+57%)	+ 204,000 (+94%)

SOURCE: Ohio Department of Job and Family Services, 2004.

explanation for this phenomenon is not clearly discernable. Indeed, the apparent upward spikes in ABD eligibility during periods of economic recession in the early 1990s and again in the early 2000s are unexpected trends that suggests Ohio may be extending benefits to people not intended, as a matter of policy, to be covered.

Given that caseload growth escalates Medicaid costs, particularly for a group with increasingly higher utilization rates, it is time to modify the process for determining eligibility (Recommendation 1) and review the merits of the 209(b) eligibility option overall (Recommendation 2).

**Recommendation 1: Effective July 1, 2005, terminate the duplicative disability determination process administered by the ODJFS Office of County Medical Services, require ABD Medicaid applicants to first apply for federal Old Age, Survivors and Disability Insurance (OASDI) and Supplemental Security Income (SSI), and base disability determinations upon disability reviews conducted for the Social Security Administration (SSA) by the Bureau of Disability Determination at the Rehabilitation Services Commission (RSC).**

*Rationale:* Applicants for Medicaid based on disability<sup>45</sup> must go through two disability determination processes: one by the ODJFS Office of County Medical Services, and one by the Bureau of Disability Determination Services at the Rehabilitation Services Commission (RSC) on behalf of the federal Social Security Administration. The former determines eligibility for Medicaid while the latter determines eligibility for SSI and Old Age, Survivors and Disability Insurance (OASDI). ODJFS requires both because one

requirement for Medicaid eligibility is that the applicant must have applied for SSI; indeed, all applicants for Medicaid must show proof that they have at least submitted an application to the RSC.

The ODJFS review layer is duplicative on the question of whether the individual has a qualifying disability. It is also understaffed to the point of jeopardizing accuracy. The Office of County Medical Services within ODJFS that performs this review has five, full-time staff, with limited support from about 10 external consultants. They receive about 20,000 new applications annually, a processing these along with an average of 15,000 pending applications on which action has been deferred. The ratio of staff to new applicants is about 1:4,000 and the staff to all cases ratio is about 1:7,500. Of the 14,800 disability determinations actually rendered during 2003, about 9,800, or two-thirds, were approved and the balance denied.

The RSC's Bureau of Disability Determination Services applies the same definition of disability as the Office of County Medical Services. The RSC employs 330 full-time staff, with extensive support from an additional 95 external consultants (including physicians) conducting disability reviews for all Ohioans applying for federal disability benefits (not just those applying for Medicaid). RSC receives between 100,000 to 110,000 initial applications for disability determination annually from the Social Security Administration (SSA), and the staff to applicant caseload is between 1:300 to 1:330, a fraction of the ratio in the ODJFS CMS process. Of the 110,000 disability determinations made during 2003, about 31,000, somewhat less than one-third, were approved, and 77,000 were denied.

As it stands now, the two state agencies apply the same criteria to the same

<sup>45</sup> It should be noted that individuals who are 65 and also have a disability first become eligible for Medicaid due to age, not disability.

applicants. This duplication is wasteful for the program and complicated for applicants. Ultimately, a disability determination made by the RSC is binding on Ohio Medicaid anyway (discrepancies seem to arise as the application is being processed).

A further reason to concentrate resources on the RSC process is that eligibility for SSI recipients (through OASDI) are eligible for Medicare coverage after a period of time. Facilitating Medicare coverage for persons with disabilities will sharply reduce Medicaid costs as Medicare, not Medicaid, becomes the primary payer for these consumers' complex acute care needs.

While ODJFS will save administrative costs that had been allocated to its Office of County Medical Services, it will need to provide the RSC with Medicaid administrative funds for any additional steps to its existing review. In enacting this change for the SFY 2006-2007 biennium, the General Assembly should require an analysis of the amount of financial support that ODJFS should provide to RSC initially and in the future.

**Impact:** The Commission estimated state and federal combined savings will be up to \$46.9 million the first year and \$51.3 million the second year.

It is probable that the state will experience savings for three reasons. First, in light of the historically lower disability approval rate experienced through the RSC process, it is likely that the rate of increase in ABD Medicaid caseloads will decline. Second, by ensuring that individuals complete the SSI process, it is likely that Medicare will take over the acute care costs of these individuals after the required waiting period. Third, although not a large cost-driver, the shift will save administrative costs.

**Recommendation 2: Develop further data and policy alternatives for amending Ohio's Medicaid State Plan to shift from being a "209(b) state" and adopt the eligibility criteria for SSI.**

**Rationale:** Thirty-nine states base Medicaid eligibility for the low-income disabled on SSI using a section "1634" contract with the federal government. As previously noted, Ohio adopted an apparently more restrictive ABD eligibility as a "209 (b) state." Such a change has the potential of: (1) more closely aligning ABD eligibility with financial needs; (2) modifying the service offerings for "spend-down" consumers to provide greater consumer choice and reduce reliance on institutional long-term care services; and (3) reducing the rate of growth in Medicaid costs for ABD consumers.

Ohio and SSI income standards are only marginally different: \$490 individual/\$846 couples (Ohio) and \$564 individual/\$846 couple (SSI); importantly, Ohio does not count SSI payments in counting monthly income for Medicaid eligibility, rendering moot the income difference between the two programs. The comparative resource standards are \$1,500 individual/\$2,250 couple (Ohio) and \$2,000 individual/\$3,000 couple (SSI). The comparable data from Ohio and SSI in Exhibit 12, however, demonstrates that these "more restrictive" standards are actually resulting in far more Medicaid-eligible than SSI-eligible applicants.

One reason for the escalating Medicaid numbers may be found in Ohio Medicaid's "spend-down" eligibility, a requirement for 209(b) states. Specifically, an individual whose income exceeds the financial need standard may spend down his income to below that standard on qualifying medical expenses. There is no upper limit on a

person's gross monthly income before subtracting medical expenses, and, for 209(b) states, there can be no limitation on the types of services available to this group.

States using the "1634" contract with the federal government, on the other hand, are not required to allow spend down, although most states have added a "medically needy" option (in effect, a spend-down) to their programs. The separate "medically needy" option allows states to tailor their spend-down eligibility to the particular needs and policies of their Medicaid programs. Several 1634 states, for example, have restricted their benefits packages to the medically needy, and some have changed income and resource methodologies for this group.

Amending the Ohio Medicaid State Plan to become a 1634 state has the potential of more closely aligning the spend-down requirement to the specific needs of the program. Spend-down consumers are very costly by definition: they have to continually incur substantial medical expenses in order to become eligible. Changing the services available to them could accommodate other policy goals, particularly the rebalancing of the long-term care system.

The existing unconstrained spend-down eligibility may offer a real clue to the fact that the so-called more restrictive 209(b) state has approved far more Medicaid applications than its SSI counterpart. At the same time, Ohio's eligibility standards preclude approximately 35,000 low-income SSDI SSI recipients from receiving coverage. It is in this manner that Ohio Medicaid spends a significant portion of annual Medicaid appropriations for Ohioans with incomes many times greater than the SSI payment levels, while failing to provide coverage for many recipients of SSI.

The Commission did not come to a final conclusion on the 209(b) issue but believes that further analysis and development of policy options should be vigorously pursued by ODJFS and the General Assembly. The Lewin Group provided an analysis on the issue just prior to the completion of this report. The shift to the RSC to determine Medicaid eligibility (Recommendation 1) will generate further data on whether caseload has escalated due to weaknesses in the process. Further data should be developed to assess whether the spend-down group is driving the escalating caseload and how spend-down policy could be modified to reduce the rate of growth in caseload or cost.

**Impact:** Depending on policy decisions and federal approvals regarding grandfathering current recipients, the scope of a medically needy option, and the service mix for this spend-down group, net annual costs could decline by as much as \$307 million or increase by as much as \$65 million if Ohio became a 1634 state. (See Appendix for detailed analysis prepared for the Commission by The Lewin Group.)

**Recommendation 3: Expand health care coverage through a better-defined relationship between Medicaid and employer-based health plans.**

**Action Step 1: Collect premiums from persons receiving transitional Medicaid benefits.**

**Rationale:** Recognizing that for most workers the cost of health care is shared between employers and employees, Ohio could make more extensive use of consumer cost-sharing alternatives allowed under federal policy. While such cost sharing will not save significant dollars – and indeed could increase costs if it caused deferral of

low-cost services by cash-strapped patients who later require more expensive care – there clearly is value in promoting patient responsibility.

Sensitizing consumers to the cost of health care engages them in more cost-effective health care purchasing decisions and may result in behavior modification regarding their personal health. Currently, the only cost-sharing in place for CFC Medicaid participants is a limited \$3 co-pay for prescription drugs not included in the “preferred” portion of Ohio Medicaid’s prescription formulary. The Commission recommends adoption of an income-based premium schedule for employed CFC participants during months seven through twelve of the transitional benefits period. The purpose of this recommendation is to provide a gradual transition from publicly financed health care benefits to employer-based or self-paid benefits.

**Impact:** Net savings of up to \$5 million could be generated through premiums for transitional Medicaid adults only. This savings is based on a 3% of income premium contribution, the estimated number of Medicaid transitional months for months six through twelve, and a 15% administrative cost through a private vendor.

**Action Step 2: Require certain Medicaid recipients to enroll in private employer insurance.**

**Rationale:** At least 13 states currently make available alternatives to full Medicaid health benefits for consumers who have access to an employment-based group health plan. Pennsylvania, for instance, has about 20,000 enrolled in their program. States’ interest in what is known as “premium assistance” programs for Medicaid consumers who have access to private insurance coverage is also

growing. The National Academy for State Health Policy has a national working group of states pursuing or interested in this approach to support private insurance coverage. Under a “premium assistance” approach, states provide a subsidy through Medicaid to cover costs associated with premium payments, as well as other patient costs such as deductibles and co-insurance. Some consumer premium contribution, and cost sharing also could be required.

Current Ohio laws (R.C. Sections 5111.13 and 5111.023) direct ODJFS to implement a program to require Medicaid consumers to enroll in employer-based group health plans under specific circumstances. Ohio should pursue such a program that is based on a cost-effectiveness analysis for each eligible consumer who has an employer offer of health insurance. Ohio should consider contracting with a private vendor to collect other premiums.

Medicaid consumers who access employer-based group health plans also may be able to access health savings accounts (HSAs). ODJFS should work with employers to accommodate this new model of health care coverage for Medicaid consumers, which is emerging as a significant alternative to traditional benefit design. While offering strong incentives to contain costs and promoting personal responsibility, HSAs remain a relatively untested, disaggregate risk, and likely will be challenging for families with limited disposable income. Allowing premium and cost-sharing assistance for consumers enrolling in HSAs is one way to pilot this model for Medicaid.

An independent evaluation of HSAs should be undertaken as part of such a pilot to determine the strengths and weaknesses of this model for lower-income families, as well as the potential of HSAs in expanding

*Sensitizing consumers to the cost of health care engages them in more cost-effective health care purchasing decisions and may result in behavior modification regarding their personal health.*

coverage to a larger group of low-income individuals.

**Impact:** If Ohio enrolled 20,000 consumers in a premium assistance program and saved a conservative estimate of 10% on average, the state could save up to \$4 million per year after administrative costs, for each consumer enrolled in employer coverage.

**Action Step 3: Establish a Medicaid Buy-In Program for People with Disabilities after implementing Commission recommendations to control the rapid growth in Medicaid spending.**

**Rationale:** The Medicaid Buy-In (MBI) program is a sound policy that continues the outstanding progress in restoring the capabilities of people with disabilities. The MBI allows people with disabilities who have income up to 250% of the federal poverty level and resources of up to \$10,000 for individuals or \$15,000 for couples to “buy in” to the Medicaid program under an income-based premium schedule. The MBI

program will remove health insurance as a barrier to employment, allowing these people to earn an income and make an economic contribution to the state.

Because of the additional costs associated with this recommendation, implementation of MBI program should not begin until at least the short-term cost containment measures in this report are in place.

**Impact:** An MBI program will result in an additional annual state cost of \$20 million, based upon an analysis prepared by the Ohio Developmental Disabilities Planning Council. This estimate assumes that an additional 7,000 working disabled Ohioans would receive Medicaid. They would include those with incomes up to 250% of poverty and assets of up to \$10,000 for individuals or \$15,000 for couples. This policy will remove the health insurance barrier to employment for up to 7,000 disabled Ohioans and could result in economic gains due to an increase in the number of working disabled.

# Finance



**T**he finance recommendations balance the Ohio Commission to Reform Medicaid's goals of: (1) maintaining the current eligibility groups and services in Medicaid; and (2) aligning expenditures with the ability and willingness of taxpayers to pay. The main finance reform is the injection of fiscal discipline in the form of biennial spending targets. Adherence to spending targets will necessitate spending cuts and freezes in the short term but can be achieved by systemic reform over the long term.

Other fiscal improvements to Medicaid involve payment management, coordination of benefits, and transitioning to prospective payment for specialty hospitals.

## **Establish and Adhere to an Overall Biennial Spending Target**

The biennial budget for State Fiscal Year (SFY) 2006-2007 should be a transitional budget that begins stabilizing Medicaid spending, and establishing building blocks for long-term systemic reform. To that end, the Administration should propose and the General Assembly should adopt an overall biennial spending target, and the executive branch should be empowered to take the necessary steps to stay within the specified spending target.

To live within the spending target, provider rates must be adjusted in the short-term. Ongoing reforms of eligibility, health care delivery, and program management discussed in other sections of the report will supplant this kind of adjustment over the long term. These recommendations present strategies to more effectively manage utilization and administration, and improve the quality of care, which will help Medicaid lower its rate of cost growth and stay within its spending targets.

## **Many Factors Put Pressure on Medicaid Costs**

Medicaid costs fluctuate according to the number and types of participants (eligibility), what services are covered and the rates at which they are prescribed (utilization), and the amounts paid for these services (price). Some variations in these factors are beyond the control of policy makers and can cause both upward and downward cost pressures.

For example:

1. In terms of eligibility, an improving economy could lead to more employed people, who then receive privately financed health insurance. A steadily aging population, on the other hand, increases the number of elderly and disabled consumers each year.
2. In terms of utilization, new diagnostic tests could increase the rate at which disease is detected and treated, which may increase utilization, while another new technology might replace inpatient procedures with less expensive outpatient alternatives.
3. The price paid for a particular drug might decline when patent protection expires and generic alternatives become available; or, prices for diagnostic imaging may increase because of massive investment in new equipment and facilities.

## **Growth in Medicaid Spending Exceeds the Rate on Spending for Other Vital Services**

The collective impact of external pressures, combined with decisions of Ohio policy makers over time, have increased Medicaid spending at a rate that exceeds growth in spending for other important state services; and, more importantly, exceeds general revenues produced through taxation.

Ohio Department of Job and Family Services (ODJFS) usually has been successful in managing Medicaid spending within appropriations approved by the Ohio General Assembly. However, the method of determining appropriation levels in the first place – from the executive budget through the deliberations of the General Assembly to enactment – has lacked the discipline of a consistent methodology for establishing an overall spending target.

Accepting that trends and forces – i.e., eligibility, utilization, and price – are the sole reasons for increasing program cost is flawed for two major reasons. First, it has led to Medicaid’s consumption of a steadily increasing portion of the state budget. Second, allowing trends beyond the policy makers’ control to set the starting point for appropriations makes it virtually impossible to establish reasonable limits on program growth.

**Recommendation 1: Establish firm annual spending targets for Medicaid. Beginning with the SFY 2006-07 biennium, appropriations to the Ohio Department of Job and Family Services’ line-item 525 account should be based upon actual spending for the most recent fiscal year for which data are available, adjusted for changes in the number of participants, health care costs, and state revenues.**

**Rationale:** The Office of Budget and Management (OBM) in consultation with ODJFS and the Medicaid Transition Council (see Structure and Management Section), should calculate a spending target. For example, the ODJFS appropriation line-item could be adjusted as follows:

1. Medicaid per member/per month (PMPM) costs for each category of consumers (CFC and ABD) multiplied by the projected number of consumers in each category of eligibility and the average annual rate of change in the Medical Care Component of the Consumer Price Index – All Urban Consumers (Medical CPI-U) for the past three years;
2. The average annual rate of change in the Medical CPI-U over the most recent three-year period; and
3. The projected rate of change for the biennium in total state general revenues from the previous state fiscal year.

Projections must take into consideration the impact of changes in federal and state policy adopted during the previous biennium (e.g., enactment of Medicare Part D) or projected for the subsequent biennium (e.g., changes in the rate of federal financial participation).

Any prospective policy change initiated by state policy makers should be individually evaluated for its impact on spending targets produced through this methodology. This formula should be allowed to function for a period of three biennia, after which it should be evaluated for its efficacy and a decision made to continue or modify it.

**Exhibit 13**

**Missed Opportunity: Savings That Could Have Occurred if Target Budget Had Been in Place**

Year	Actual	Target Projection	Target minus Actual	Projection vs. Actual
1997	\$5,002,069,413			
1998	\$5,164,719,152	\$5,239,772,185	\$ 75,053,033	1.5%
1999	\$5,367,486,067	\$5,410,422,882	\$ 42,936,815	0.8%
2000	\$5,696,537,528	\$5,675,305,186	\$ (21,232,342)	- 0.4%
2001	\$6,674,987,846	\$5,932,546,785	\$ (742,441,061)	-11.1%
2002	\$7,126,610,366	\$6,215,812,881	\$ (910,797,485)	-12.8%
2003	\$8,008,531,528	\$6,645,677,916	\$ (1,362,853,612)	-17.0%
2004	\$8,912,897,216	\$7,119,871,057	\$ (1,793,026,159)	-20.1%

SOURCE: Ohio Commission to Reform Medicaid, 2004.

If a spending target had been adopted and enforced in 1997, Ohio Medicaid spending in 2004 could have been reduced by as much as \$1.8 billion, or 20.1 percent in that year alone.

*A firm spending target will allow the Medicaid program to be sustained over time and allow the state to achieve financial control of the Medicaid budget.*

**Rationale:** A firm spending target will allow the Medicaid program to be sustained over time and allow the state to achieve financial control of the Medicaid budget. The objectives are to: (1) limit overall spending growth; (2) increase predictability; (3) provide a context for consideration of the multitude of alternatives available to policy makers for managing costs within a budget; and (4) improve effectiveness and efficiency in the health care delivery system to achieve quality health outcomes.

Basing the spending target on a blended medical inflation index is intended to provide sufficient flexibility to adjust for periodic increases and declines in the number of eligible Ohioans, thus affirming Ohio’s commitment to the health care needs of its low-income and vulnerable citizens. It also recognizes the impact of medical inflation and the underlying costs that providers incur in the delivery of the service.

The flexible medical inflation index must then be balanced by the state’s ability to pay (usually counter-cyclical to changes in eligibility). Merely passing through the annual calculated increase in health care costs will further fuel

inflation. This final adjustment allows the state to better align appropriations with the state’s ability to pay. As Ohio Medicaid succeeds at meeting its annual spending target, funding levels for other vital state services also can be stabilized.

While federal statutes, regulations and case law limit the extent to which sub-caps may be imposed, ODJFS, upon the General Assembly’s approval, can establish “sub-caps” for some major cost categories to the extent allowed by federal law. In addition, the state may choose to withhold discretionary or supplemental payments paid to providers as a matter of state policy (e.g., hospital disproportionate share payments through the Hospital Care Assurance Program [HCAP] and efficiency incentives and return on net equity payments [profits] to nursing facilities) to the extent that costs for each respective sector per unit or per sector overall fail to remain at or below changes in the rate of medical inflation. The Center for Medicare and Medicaid Services (CMS) has established, and periodically adjusts, provider sector-specific rates of medical inflation that could be used for this purpose.

For now, this recommendation should be applied only to the ODJFS line-item 525 appropriation, which is funded by state general revenues. Increasingly over recent years, local funds generated through county and special purpose subdivision tax revenues have been used to leverage federal matching funds for some services to people with mental illness, alcohol or drug addiction, and developmental disabilities. While the Commission does not believe that the spending target should be applied to these arrangements at this time, the need for a comprehensive analysis of these arrangements and their impact on the Medicaid budget is discussed in the “Further Consideration” Section of this report.

**Impact:** Exhibit 13 shows that if a spending target had been adopted and enforced in 1997, Ohio Medicaid spending in 2004 could have been reduced by as much as \$1.8 billion, or 20.1%, in that year alone.

**Action Step 1: Beginning with the SFY 2006-2007 biennial budget, give ODJFS the power within state law and regulation, in consultation with interested parties, and subject to legislative oversight, to manage utilization rates and prices paid for health care services within appropriation levels. Toward this end, statutes establishing payment methodologies for specific services should be repealed. (See the Long-Term Care Section for a separate discussion of nursing facility reimbursement policies.)**

**Rationale:** Any new Medicaid law must be individually evaluated for its impact on the spending target. Health care needs of Ohioans are substantial, and it is natural for legislators to want to meet them. To sustain the program, Medicaid must operate with new fiscal discipline.

Codified reimbursement formulas, such as the nursing facility formula, severely

hamper the ability of executive agencies to adjust payments and realign the role of nursing facilities as one of many options in an evolving continuum of long-term care services. ODJFS could better fulfill the critical role of managing costs and numerous program details by having the same authority and flexibility to determine and adjust nursing facility rates, as it has for other provider rates.

The Commission recommends the repeal of Sections 5111.23 to 5111.291 of the Ohio Revised Code. Ohio should adopt conforming amendments to other sections of Ohio Revised Code (ORC) 5111.21, et seq., effective July 1, 2005.

**Impact:** Repeal of nursing facility rates will permit the state to achieve the savings identified in Exhibit 4 in the Long-Term Care Section and will put nursing facilities on a level playing field as other providers when it comes to reimbursement. Also, an impact statement requirement for new Medicaid laws will reinforce the importance of the spending target and bolster the goal of fiscal discipline.

**Recommendation 2: During the State Fiscal Year (SFY) 2006-2007 biennium, freeze at SFY 2005 levels fee-for-service payment rates for hospital inpatient services, and reduce by up to 3% payment for nursing facilities and intermediate care facility/mental retardation (ICF/MR services), recognizing potential differences between the two in the final reduction determination.**

**Rationale:** Many of the Commission recommendations are specifically designed to reduce the rate of growth in Medicaid spending and will require several years to achieve their full impact. Forceful action must be taken now to reduce the rate of spending growth during State Fiscal Biennium 2006-2007.

*Repeal of nursing facility rates will...put nursing facilities on a level playing field as other providers when it comes to reimbursement.*

Reductions or freezes in payment rates should be imposed on institutional providers – a group which represents more than 55% of total program costs. They also are collectively best situated to absorb the impact on state revenues of the slowly recovering economy. All other provider rates should remain at SFY 2005 levels.

**Impact:** Holding hospital inpatient rates flat in SFY 2005 would save \$122.3 million. Reducing nursing facility and ICF/MR rates by up to 3% in SFY 2005 would save \$95.2 million. Holding rates flat the following year would result in significant savings.

**Recommendation 3: Optimize payment and cash flow schedule with a “just-in-time” program that pays all bills no sooner than the end of the month after receipt of a valid invoice.**

**Rationale:** Currently, Ohio Medicaid pays bills promptly, often within seven to 10 days, to avoid interest penalties set in Ohio law for bills paid more than 30 days after receipt. By establishing a better-timed bill payment schedule, bills can be paid later, and interest can be earned, without violating Ohio’s prompt pay law. These dollars need to be invested in SFY 2006 technology system changes.

**Impact:** Ohio Medicaid will have a one-time cost savings of up to \$100 million.

**Recommendation 4: Review and improve the coordination of benefit procedures to ensure that Medicare is the first payer for all dually eligible individuals. Extend these procedures to other public programs as permitted by law.**

**Action Step 1: Modify the current benefit coordination practices to ensure that Medicare is the first payer for all dually eligible individuals.**

**Rationale:** Ohio likely pays for some services for which Medicare should be paying particularly in long-term care (for post-acute care services) and community-based services. According to a June 2004 audit by the U. S. Department of Health and Human Services, for example, “Ohio’s processing system for Medicaid claims does not have the controls to prevent payment of fee-for-service (FFS) claims for services covered by Medicare managed care organizations.”<sup>46</sup>

Another example is that Medicaid covers home health care services when they are provided in the consumer’s home and often consist of nursing, nursing aides and various therapies (physical, speech, etc.) on a short-term, intermittent basis. Medicare also covers home health care services to its consumers, although Medicare requires that the patient be “homebound.” It is important to determine if the patient receiving home health care services meets the clinical requirement so that Medicare, not Medicaid, will pay for those services. The coordination of benefits policies and procedures also should extend to public health programs offered by the Veterans Administration, payments for services relating to Black Lung or Agent Orange, and all other programs that may be the primary payers.

**Impact:** Coordination of benefits for home health care services provided to dual-eligibles will save between \$27.2-\$40.8 million (16% to 24% of total expenditures.)

The Lewin Group identified \$116 million in cost avoidance and recoveries attributable to Washington State’s coordination of benefits program for 2002, a 25% increase from the previous year.<sup>47</sup> Furthermore, the University of Massachusetts recently

*“Ohio’s processing system for Medicaid claims does not have the controls to prevent payment of fee-for-service (FFS) claims for services covered by Medicare managed care organizations.”*

<sup>46</sup> Vengrin J, Review of Medicaid Fee-for-Service Payments for beneficiaries enrolled in Medicare Managed Care (A-05-02-00085) U.S. Department of Health & Human Services, June 3, 2004.

conducted a five-year, multi-state federally sponsored demonstration project that led to retrospective claims and interim payments of \$168 million to New York and \$32 million to Massachusetts. And, New York is projecting gross interim payments close to \$260 million for 2001-2003.

***Action Step 2: Improve the benefit coordination procedures so that non-Medicaid insurance plans are billed first.***

***Rationale:*** Ohio likely pays for some services when consumers have private payment sources that should pay first before Medicaid is billed. Payment sources include private health insurance, malpractice awards, and automobile insurance policies.

***Impact:*** Coordination of benefits for private health plans and other sources and improving the state third-party liability system will yield a positive return on investment.

**Recommendation 5: Shift Medicaid reimbursement for long-term acute care hospitals and rehabilitation hospitals from a cost-plus basis to a prospective diagnostic and risk-adjusted capitated rate, similar to that used by Medicare.**

***Rationale:*** Responding to spending pressures, Medicare and many states have moved from a cost-based reimbursement system to a prospective payment system to long-term care and rehabilitation hospitals. The prospective system, like the Diagnosis-Related Group (DRG) system used for other hospitals, will provide greater cost control and budget predictability and better align Medicaid reimbursement with hospital efficiency.

As medical technologies develop, and as the continuum of long-term care improves, the Commission hopes that clinically complex patients will have alternatives for medical care, including remaining in their homes. Shifting to a prospective payment system helps level the playing field so that clinical need and patient choice, rather than reimbursement, determines the setting for care.

***Impact:*** Ohio should expect savings between \$2.65-\$4.41 million and these expected savings are based on Ohio's 23 long-term acute care hospitals, with 1,635 discharges in SFY 2003 and total expenditures of \$44.1 million. Other states have generated 6% to 10% in direct service and administrative savings for reimbursement to these specialty hospitals.<sup>48</sup>

47 The Lewin Group, "Cost Containment in Washington State, Report 2," December 2002.  
48 Health Management and Associates, 2005.

# Structure and Management

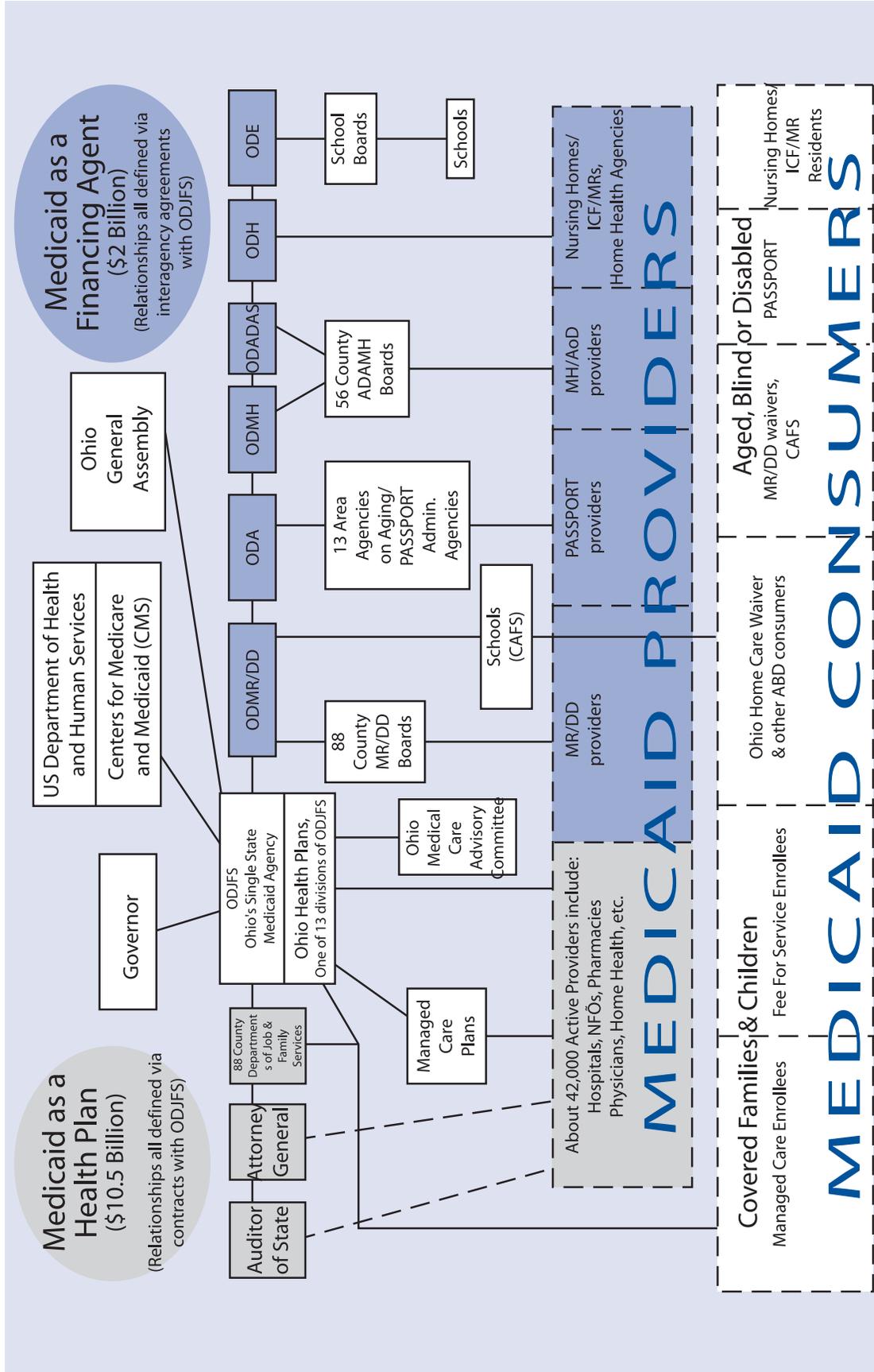


In 2003, 22 states restructured their Medicaid agencies. Although each state approached restructuring differently, all moved toward consolidation and centralization of Medicaid services and away from multiple agencies with narrow Medicaid-related responsibilities. Each state sought to improve the quality of health care service and reduce cost. Many established restructuring workgroups to advise and implement reforms.<sup>49</sup> Similarly, it is time for Ohio to make a dramatic change in the structure of its Medicaid health care delivery system.

Ohio Medicaid's organizational structure has become an increasingly complex maze during the past 40 years.

<sup>49</sup> "Reorganizing State Health Agencies To Meet Changing Needs: State Restructuring Efforts in 2003," National Governor's Association, Centers for Best Practices, 2004, retrieved November 2004, [www.nga.org/center/divisions/1,1188,C\\_ISSUE\\_BRIEF^D\\_7501,00.html](http://www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF^D_7501,00.html).

# Organizational Maze of Ohio Medicaid



SOURCE: Ohio Commission to Reform Medicaid.

The Commission recommends streamlining Ohio Medicaid into a single, cabinet-level department by July 1, 2008. The Ohio Medicaid organizational structure now has become increasingly complex, consisting of one federal agency, three Ohio statewide elected officials, six state agencies, 13 Area Agencies on Aging, 56 county ADAMH boards, 88 county MRDD boards, 88 county MRDD boards, 88 county departments of job and family services, more than 1.7 million Medicaid beneficiaries, who are served by more than 42,000 health care providers, who submit more than 50 million reimbursement claims each year.

Many challenges exist for the Ohio program, including lack of coordination among agencies, disjointed funding, lack of tracking of Medicaid expenditures, fragmented consumer access to services, payment restrictions and "red tape." These problems cause inefficiency and waste for the program and frustration for consumers and providers.

Separate data management and information technology systems process thousands of eligibility applications and more than one million reimbursement claims per year. No centralized audit program in Ohio detects patterns of mismanagement or breaches of program integrity (i.e., fraud, waste and abuse).

To make Medicaid as effective as possible, structural and management changes are necessary. Change should encompass transforming program integrity, modernize data management/information technology, maximize Ohio Medicaid buying power, increase use of selective contracting and pay-for-performance, and partner with Ohio's academic medical centers.

**Recommendation 1: Design and implement a comprehensive program of performance and fiscal compliance audits to improve effectiveness and operation of the Medicaid program.**

**Rationale:** Improper payments, as a result of error or intention, in Ohio Medicaid drain vital program dollars to the detriment of consumers and taxpayers. Improper payments include those made for services not covered, those not medically necessary, those billed but not provided, or those billed and paid for more than once.

The nature and magnitude of fraud, waste, and abuse in Ohio Medicaid is not sufficiently known although the Commission heard testimony about mechanisms to identify patterns of fraud, waste, and abuse, as well as process delays to pursuing cases, inconsistencies in pursuing quality assurance, and uncoordinated program integrity activities. The Ohio Inspector General recently released an Ohio Medicaid study confirming the need for a major overhaul.<sup>50</sup> The Inspector General's recommendations are in alignment with the Commission's and validates the Commission's report.

ODJFS, the main deliverer of Medicaid services, does not appear to have a comprehensive system to identify internal problem areas, test program compliance, and correct weaknesses. The Commission concluded that program integrity in Ohio Medicaid is disjointed, inefficient, and should be a focus of program restructuring, beginning with a performance audit to reveal gaps in program integrity policy and implementation. Performance audits also will uncover other inefficiencies such as duplication of effort and poor coordination of benefits (see Finance Section).

Performance and provider audits are interdependent with technology improvement and agency coordination (Recommendations 2 and 3, respectively). Improved technology is essential to an effective audit system as is greater coordination between the Auditor of State (AOS), the state Attorney General (AG), and other state and federal agencies.

**Impact:** Estimates of the prevalence of Medicaid fraud, waste and abuse vary. The U.S. General Accountability Office (GAO) and health care anti-fraud associations have estimated that, nationally, fraud or

*ODJFS does not appear to have a comprehensive system to identify internal problem areas, test program compliance and correct weaknesses.*

50 Retrieved December 2004, <http://www.cms.hhs.gov/researchers/demos/pgp.asp>.

erroneous payments account for 5% to 7% of total health care expenditures. Other reports cite fraud, waste and abuse as high as 10% to 15%.<sup>51</sup> If, for example, 10% holds true for Ohio, detecting fraud and erroneous payments could save \$1.2 billion for SFY 2005. The Commission believes a 1% to 5% range (\$105 million to \$525 million) in savings is achievable.

During subcommittee meetings, it was reported that ODJFS and the AOS identified \$21 million in overpayments for 1999, 2000, and 2001, combined. In a follow up memorandum, ODJFS reported that \$801 million was identified, avoided, or recovered.

The Commission does not necessarily believe that the higher percentages cited as national averages will necessarily hold true in Ohio. However, the wide disparity between national averages and the figures that ODJFS reported to the Commission make it clear that a comprehensive review of program integrity efforts is merited and should happen immediately.

The foregoing “Impact” analysis transcends each of the action steps that follow.

**Action Step 1: Provide the Auditor of State (AOS) with statutory authority to conduct program performance audits of the entire Medicaid system.**

The AOS should be authorized to conduct a performance audit of the Medicaid system to assess its overall efficiency and effectiveness. Currently, the authority to audit is diluted because a portion resides with the AOS and the other with ODJFS, which subcontracts with multiple sources. This fragmented auditing program should be redesigned as a consolidated and comprehensive audit system under the authority of the AOS.

Based on the findings of the comprehensive performance audit, the AOS, working with ODJFS, should design an all-inclusive program integrity system that meets state and federal standards and uses state-of-the-art technology.<sup>52</sup> The first performance audit will formalize and strengthen the program integrity system while subsequent audits will be central to that system by detecting patterns of fraud, waste, and abuse. Performance audits will also provide benchmark comparisons with other states’ Medicaid programs.

**Action Step 2: Create an Audit Integrity Fund within the Auditor of State’s (AOS) office.**

**Rationale:** Because ODFJS must pay for the audit procedures performed by AOS, the reviews are often predicated on the ability to pay as opposed to the need for review.

The cost/benefit analysis for ODFJS is further hampered by the federal Medicaid rule (§1903(d)(2)(A)) requirement that reduce the amount of federal reimbursement to a state in each quarter by the amount of the federal share of any identified overpayments. This typically is less time than it takes the state to recover the overpayment from the provider. Consequently, the state pays the federal government out of its own coffers before, and whether or not, it is able to recover the money identified in the finding.

States should not be required to remit overpayments to the federal government before the overpayment is recovered by the state.

The state should establish a dedicated audit integrity fund in the AOS budget to address this repayment issue. It should also join forces with other states to lobby for change to current federal requirements on the recovery of identified overpayments.

*...reports cite fraud, waste and abuse as high as 10% to 15%.<sup>50</sup> If, 10% holds true for Ohio, detecting fraud and erroneous payments could save \$1.2 billion for SFY 2005.*

*States should not be required to remit overpayments to the federal government before the overpayment is recovered by the state.*

51 Office of Program Policy Analysis and Government Accountability, “Medicaid Program Integrity Efforts Recover Minimal Dollars, Sanctions Rarely Imposed, Stronger Accountability Needed,” September 2001.

52 Ohio’s inadequate technology infrastructures create a basic inability to integrate databases efficiently in order to identify improper claims. The Commission is acutely aware of these challenges and begins to address them in Recommendation 2.

**Action Step 3: Provide the AOS with statutory authority to conduct provider audits within Medicaid.**

**Rationale:** Provider audits should be central to the Ohio Medicaid's program integrity system because errors and fraud are common in any program as complex as Medicaid.

Up until 1998, the AOS had the authority to audit Medicaid providers. However, a change in Ohio Revised Code § 117.10 makes ODJFS' approval necessary before the AOS can audit providers.

Since 1998, ODJFS has approved audits mainly of individual practitioners, which were just 6% of 2002 expenditures. And, although nursing facilities and in-patient hospitals comprised 67.3% of Medicaid costs in 2002, the AOS was not asked to conduct any independent reviews. Therefore, the AOS's independent authority to select providers for review should be restored.

**Action Step 4: Create a multi-agency Program Integrity Task Force to develop a strategic plan to combat fraud, waste, and abuse.**

**Rationale:** Program integrity in Ohio Medicaid has been an uncoordinated patchwork of independent activities among various agencies. The state should create a multi-agency task force for program integrity that includes ODJFS, AOS, the AG's Medicaid Fraud Control Unit and other state and federal partners.

The Program Integrity Task Force will identify program vulnerabilities at the outset and manage the transition to a comprehensive system. Information exchange will allow sharing of lessons learned and consideration of the best way to use new technologies.

Florida had unprecedented success in fighting fraud, waste, and abuse by getting Medicaid agencies, Medicaid fraud control units, Medicare claims processing contractors, and U.S. attorneys to work together to detect integrity problems in both Medicare and Medicaid. Ohio can learn from Florida in this instance.

**Action Step 5: Tighten enrollment controls to keep abusive providers out of the program.**

**Rationale:** In June 2004, the state Medicaid system listed more than 90,000 providers, of which approximately only 42,000 were active (had filed a claim within the last two years). In 2004, ODJFS attempted to purge inactive providers but was thwarted by of administrative cost issues.

Having inactive providers in Medicaid data files increases the risk of fraud because inactive provider numbers can be "stolen" and used to submit fraudulent claims. The GAO, the U.S. Department of Health and Human Services, Office of Inspector General, and CMS all recommend that state Medicaid programs purge inactive provider numbers and periodically "re-enroll" active providers to protect the accuracy of provider information.

ODJFS should purge Medicaid files of inactive providers and implement probationary and re-enrollment policies. California avoided more than \$200 million in Medicaid expenditures in state fiscal year 2003 by increasing scrutiny of new providers and placing them into a provisional status for the first 12 to 18 months of their enrollment.

**Action Step 6: Develop and implement techniques that calculate provider-specific and provider type-specific error rates.**

*Program integrity in Ohio Medicaid has been an uncoordinated patchwork of independent activities among various agencies.*

**Rationale:** Medicaid must have accurate information about provider-specific error rates, error rates by provider type and error rates by service type.

Several states have participated in two recent CMS pilot projects to strengthen program integrity efforts.<sup>53</sup> The results of the pilot will become a permanent, mandatory program, to be known as the Payment Error Rate Measurement (PERM) initiative to be implemented by all states in 2006. California participated in the pilot and, by linking Medicaid and Medicare claims, saved \$58 million in more than 80 cases after the first year of testing.

**Action Step 7: Reposition the Surveillance Utilization Review Section (SURS) as an independent entity within ODJFS.**

**Rationale:** The Medicaid program's financial integrity unit, SURS, is responsible for managing a statewide system of surveillance and utilization review of the program. SURS is mandated by the Code of Federal Regulations (CFR)-Title 42, and is required by the State Plan.

Its responsibilities include developing comprehensive statistical profiles and analyzing statistical data in order to reveal health care delivery patterns for various categories of service; identifying potential fraud, waste, over-utilization and abuse in the Medicaid program; conducting preliminary investigations of potential fraud and abuse in the Medicaid program based on complaints, program referrals, conflicting procedures edit (CPE) data, provider and patient profiling data; and referring appropriate cases to the Medicaid Fraud Control Unit in the Attorney General's office for criminal investigation and prosecution.

SURS' focus, however, has been limited to a portion of the Medicaid provider population that accounts for less than 20% of Medicaid expenditures. Program integrity functions for nursing facilities, hospitals, managed care, home health care, and expenditures by sister state agencies reside in separate units within ODJFS.

Also, SURS is organizationally placed five levels below the director of the ODJFS Office of Health Plans; it also resides within the unit that processes claims, calling into question its ability to be independent. As a result, SURS identified only \$1.8 million in overpayments in SFY 2004 despite performing more than 500 provider reviews.

SURS should be given broader and more independent audit functions in the comprehensive program integrity system. It should remain separate and distinct from the state Medicaid program and policy functions. In the interim, place SURS within the ODJFS Office of the Chief Inspector or the Office of Research Assessment and Accountability, which currently perform audits for the agency.

Further, the state should lobby for enhanced federal financial participation (FFP) for all staff engaged in SUR activities, not just clinical staff. Because all skills used in SUR activities result in reductions of fraud and abuse to the benefit of the federal government, enhanced FFP should be available.

**Action Step 8: Amend state laws, and seek change to federal laws that hamper the implementation of an effective program integrity system.**

**Rationale:** Certain state and federal laws hamper program integrity efforts. A change in Ohio law is needed, for example, to

*Medicaid must have accurate information about provider-specific error rates, error rates by provider type and error rates by service type.*

53 CMS is conducting a three-year Payment Accuracy Measurement (PAM) pilot to develop estimates for the level of accuracy in Medicaid claim payments, including administrative error and estimated loss due to abuse and fraud. The Improper Payments Information Act of 2002, Pub. L. No. 107-300, 116 Stat. 2350, requires each agency responsible for federal programs and activities with estimated improper payments exceeding \$10 million annually to report the estimates and planned corrective action to the Congress.

reverse the judicial holding of *The Ohio Academy of Nursing Home v. ODJFS* to allow more than one audit and recovery process regarding nursing facility expenses. State law should be reviewed for similar barriers. Ohio also should examine whether a state Qui Tam action (which allows a private citizen to report government fraud and share in any recoveries) will improve program integrity.

Federal laws and policies also can hamper program integrity efforts. Federal law prohibits a state from limiting or terminating health care benefits for consumers found guilty of Medicaid fraud. This policy should be re-examined: in protecting the “entitlement,” the program is omitting a key deterrent to fraud. As discussed in Action Steps 3 and 7, federal regulations on recovery of overpayments and enhanced federal financial (for clinical staff only) participation present a fiscal disincentive to ardent program integrity efforts.

Further, the state must gain access to the Medicare claims data and the Healthcare Integrity and Protection Database, which lists adverse actions against providers, suppliers, and practitioners. The later database is free to Medicare carriers and fiscal intermediaries. The federal government should eliminate the fee to access the per name search and encourage states to use the database in investigations and in the enrollment process.

**Recommendation 2: Update Ohio’s Medicaid information systems with current technology for the financial, health care delivery, eligibility, and data management functions.**

**Rationale:** Most of the changes in the action steps to follow, such as the improved Medicaid Management Information System, and Enterprise Data Warehouse, can be

achieved with state dollars that are subject to an enhanced federal matching rate of 90%. Ohio’s Medicaid information technology (IT) “system,” does not have the capacity and flexibility to collect, store, efficiently transmit and analyze Medicaid data across systems. (See Exhibit 14) The lack of comparable data across service delivery systems prevents the state from understanding the depth and breadth of Ohio Medicaid’s problems and making informed decisions for reform.

The Commission received testimony from national experts and experts from using technologies that are generating significant savings for their Medicaid programs. The proposal to transform the 20th century American health care system into a 21st century system must focus on the collection of information to make sound decisions. In particular, the state should:

1. Gain a comprehensive view of the enormous volume of Medicaid data stored in disparate databases across ODJFS and other Medicaid-service delivery departments.
2. Effectively connect Ohio’s health care IT “system” across six Medicaid-service delivery departments, providers and consumers.
3. Develop and require use of common coding standards across Medicaid-service delivery departments.

Modernizing the information system will result in three positive outcomes: (1) it will permit all Ohio decision-makers to manage in a coherent fashion the programs, policies, costs, and expenditures driving the Medicaid program; (2) it will make it possible for state agencies with Medicaid responsibilities to access, share, and secure information across secure networks; and (3)

it will allow agency analysts, those who know the programs best, to make rapid and sound recommendations based on the most timely and comprehensive information available. The result will be possession of the necessary knowledge to manage real structural reform in Medicaid.

***Action Step 1: Develop a business case analysis for a comprehensive Medicaid Management Information System (MMIS), consistent with the Medicaid Information Technology Architecture (MITA) initiative by the Centers for Medicare and Medicaid Services (CMS).***

***Rationale:*** Ohio must create a single Medicaid Management Information System (MMIS) with the capacity and flexibility to collect, store, efficiently transmit, and analyze data in a manner that allows policy-makers to understand the depth and breadth of consumer health care needs and make data-based recommendations for program change. A comprehensive, broad-based data system also will facilitate the coordination of services across a variety of state and county systems and minimize the potential for duplicative services. The system will adopt standards for identifying providers, services and consumers to allow effective data analyses to be performed system-wide.

To create an effective and efficient Medicaid delivery system, a multi-agency business case analysis must be conducted immediately. It should take a system-wide view in determining what minimum required information is needed to meet the IT business needs and how that information can be accessed and used across Medicaid-serving agencies to run their businesses and support a system-wide program and policy development.

An analysis based on just the view of any single agency (the current approach that

ODJFS is taking to procure a new MMIS) is apt to be efficient for that agency, but not necessarily for the state Medicaid system as a whole. Any such multi-agency project should be coordinated through the Governor's office or another agency not delivering Medicaid service and should be an immediate focus for the Medicaid Transition Council (as proposed in Recommendation 3 of this section).

***Impact:*** The federal government will pay 90%, with the state assuming the other 10%, of the cost to design, develop, and test a new MMIS. Once operational, the federal government will pay 75% of the continuing operating costs, with the state paying the remaining 25%. (The federal government will not pay for the development or acquisition of proprietary fraud and abuse detection products but will pay for continuing operating costs.)

***Action Step 2: Immediately design and implement an Enterprise Data Warehouse.***

***Rationale:*** An enterprise data warehouse will provide a method for measuring the impact of Medicaid policy changes and tracking cost savings across multiple state agencies. It also will reduce administrative costs by consolidating or eliminating redundant reporting systems and exposing operational inefficiencies. (See Exhibit 15.)

In order for its benefits to be fully realized; the enterprise data warehouse must be available to all Medicaid-serving departments and have common standards for automated transfer of data regarding providers, consumers and services. Otherwise, true system-wide analysis will not be possible and multiple redundant analysis systems are likely to be developed to analyze different components of the Medicaid program in different ways.

Ohio ranks near the bottom nationally with regard to the percentage of program spending devoted to Medicaid administration (3% compared to a national average of about 5%).

**Impact:** Other states have received an almost immediate return on investment for the data warehouse. Michigan has had one for 10 years, which yields \$150 million-plus in annual Medicaid savings. New York, which has the nation's largest Medicaid program, has had a fully operational data warehouse for just over one year and expects first year savings to amount to over \$70 million.

Ohio could achieve similar savings with a net up-front expenditure (for a data warehouse costing \$6 million) of \$600,000 to \$1.5 million due to its eligibility for a 90% federal match.

**Action Step 3: Establish a paperless system for submitting and paying provider claims.**

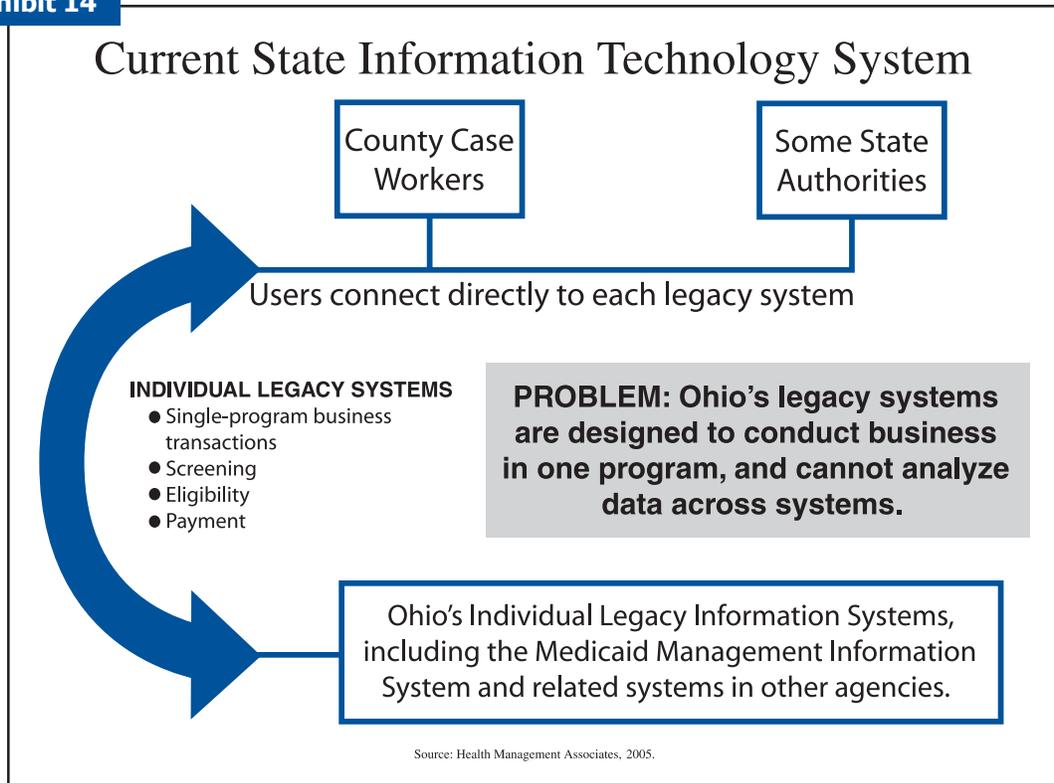
**Rationale:** The day-to-day operations of Ohio's Medicaid claims processing system are run on a 20-year-old IT system that is

the third-oldest technology platform in the country. The system is inflexible and increasingly unable to meet the rapidly changing needs of a modern health plan. As a result, claims processing and systems maintenance are inefficient; claims processing edits are limited resulting in overpayments; many data fields are either unused or contain poor quality data; and policy makers are unable to gather reliable system-wide data on Medicaid's operations.

Ohio ranks near the bottom nationally with regard to the percentage of program spending devoted to Medicaid administration (3% compared to a national average of about 5%). According to ODJFS, much of this difference is explained by Ohio's inadequate investment in IT support.

**Impact:** A system for paperless "real-time" claims will produce more accurate and timely payment of claims and resolution of

**Exhibit 14**



claim disputes. A state-of-the-art system also could extend to health care delivery arenas such as electronic prescribing (discussed in the Pharmacy Section), and with appropriate patient confidentiality safeguards, patient records and clinical decision support.

The technologies used for this system also could be applied to an integrated eligibility determination process. This process should be consumer-friendly and potentially encompass all programs offering state public assistance, not just Medicaid. Look to best practices, such as the Texas eligibility system.

**Recommendation 3: Restructure Ohio Medicaid through a two-step process.**

**Action Step 1: Immediately appoint a Medicaid Transition Council.**

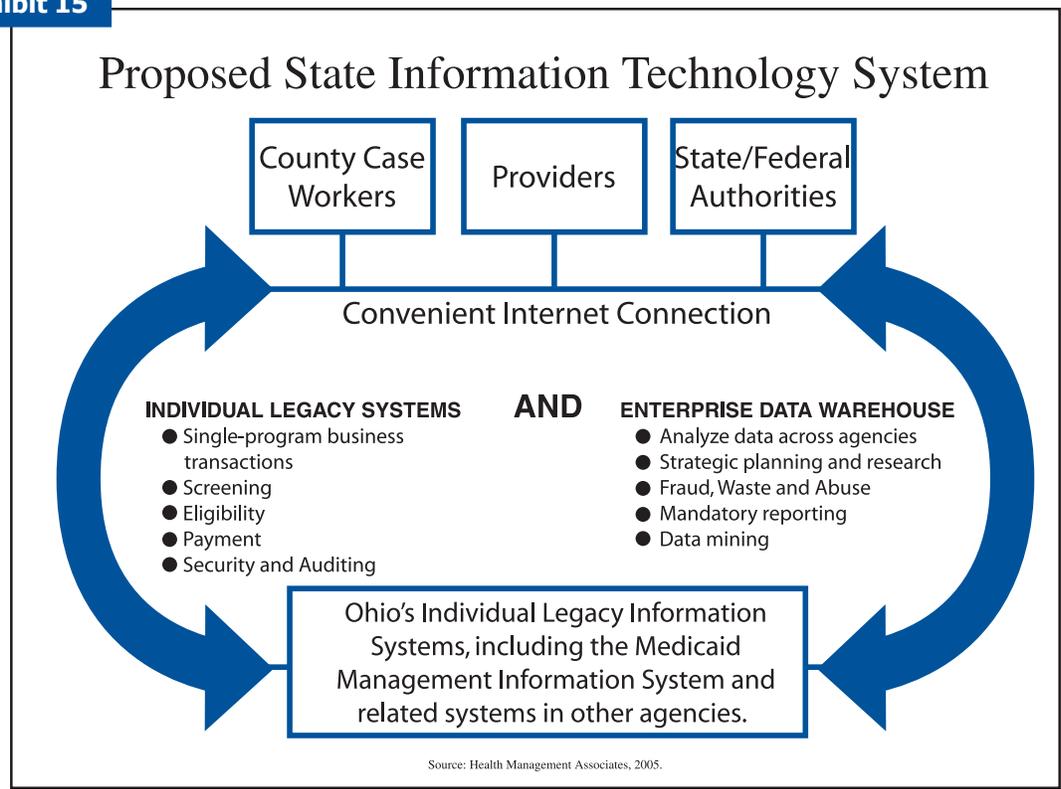
**Rationale:** Transformation of the Medicaid system will not occur without assigning the

authority and responsibility to an entity to make it happen. A Medicaid Transition Council, reporting to the Governor, should be created for a two-year period to oversee the restructuring Ohio’s Medicaid system.

The Medicaid Transition Council, consisting of government officials, including members of the General Assembly, will be responsible for monitoring, evaluating and reporting on the recommendations adopted by the Administration and/or the General Assembly. The Council should focus first on establishing a centralized, coordinated Medicaid financing function across all departments of state government that deliver Medicaid services.

The Commission recognizes that ODJFS does not have sufficient resources in information technology, human resources, and other central support areas to

**Exhibit 15**



adequately support the current needs of the program, let alone make the investments necessary for this transformation. The Medicaid Transition Council will be charged with developing a business plan and securing the resources needed to implement that plan.

**Impact:** The Council will enable a smooth, timely transition to a transformed Ohio Medicaid program.

Without such a Council, the Commission's recommendations will experience the fate of some past commissions, whose recommendations were never implemented because no organized body was created to initiate and oversee action steps.

**Action Step 2: Create an Ohio Department of Medicaid to be effective July 1, 2007.**

**Rationale:** Given the size, complexity and expense of Ohio Medicaid, it is time to create a cabinet level agency responsible for Medicaid program management. The state should create a Department of Medicaid in the SFY 2008-2009 biennial budget. The Medicaid Transition Council will design the scope and structure of this department.

In developing this recommendation, Commission staff evaluated state government services and organizational structures for Ohio and all other states. While the authority and structure of the systems varied considerably from state to state, the Commission believes that given Ohio's unique home rule status, structure of state government and dedicated state budget dollars, establishing a state Medicaid department makes practical sense.

The Department of Medicaid will perform many of the functions now performed by the Office of Health Plans and absorb other

agency functions to the extent that it will drive efficiencies in the program. The new department will focus primarily on health care finance and contract management. Some of the most significant challenges facing restructuring will involve staffing changes and the complexities associated with merging program philosophies and funding streams. Nevertheless, changes in organizational culture, work processes, administrative functions and decision-making are essential.

The Department of Medicaid will follow and create a Medicaid system-wide strategic plan and continually update the business plan initiated by the Medicaid Transition Council. The department will have the authority to continue implementing the recommendations contained in this report, such as transforming the information technology system and changing payment systems and health care purchasing. It should work with the Department of Administrative Services and other agencies, organizations to maximize state health care purchasing power.

**Impact:** An Ohio Department of Medicaid will provide efficient program management that will streamline cabinet agencies, improve the quality and efficiency of Medicaid services for consumers and providers, as well as reduce costs.

**Recommendation 4: Leverage Ohio Medicaid's buying power through greater use of care management, selective contracting and pay for performance.**

**Action Step 1: Replace the practice of doing business with everyone ("any willing provider") with selective contracting to the extent permitted by federal law.**

*The Department of Medicaid will follow and create a Medicaid system-wide strategic plan and continually update the business plan initiated by the Medicaid Transition Council.*

ODJFS has initiated selective contracting by submitting to CMS a one-time certification to CMS to competitively bid eyeglasses. The existing certification will allow the state to conduct selective contracting in a broader context. To lower the prices it pays and enforce specific criteria and access standards, ODJFS should expand its selective contracting to services and items such as laboratory services, medical devices, durable medical equipment, non-emergency transportation, specialty in-patient care and all other services.

**Rationale:** Medicaid is the single largest state purchaser. With the exception of managed care plans operating in 15 counties, the Ohio Medicaid program conducts business through a fee-for-service (FFS) program, which requires it to do business with “any willing provider” under an established fee schedule.

Becoming a Medicaid provider or supplier requires nothing more than signing up with the state. Ohio’s “any willing provider” model is a barrier to care management, which can rein in unpredictable costs: it is difficult to manage cost and quality when any provider can furnish, and receive payment for, unlimited services. Combined with FFS payment, there is an inherent financial incentive to perform and bill for the maximum levels of service.

Oregon uses a transportation brokerage to increase access with 15% cost savings, and Vermont, Idaho, and Kansas have selectively contracted for oxygen and respiratory equipment, transportation and nursing facility services, respectively, and have experienced significant cost savings. California uses selective contracting for hospital services and other providers. States often contract for capacity that exceeds the actual amount needed by some percentage.

This helps to ensure that beneficiaries have choice.

**Impact:** States with a “high intensity” of “any willing provider” regulation had:

- 2.7% higher spending on physicians
- 2.1% higher spending on hospitals
- 1.8% higher health spending overall.<sup>54</sup>

Ohio could reduce its Medicaid spending by at least this much through selective contracting. If fully implemented in SFY 2005, the state could have saved \$189 million (1.8% of overall costs.)

**Action Step 2: Implement a pay-for-performance strategy for providers to maximize state return on investments.**

**Rationale:** Pay-for-performance is an innovative strategy for improving the performance of plans and providers, with the ultimate goal of lowering costs and improving health outcomes. The state as a purchaser can play an important role in promoting a system redesign to successfully implement a quality and outcome-measured system.

The current FFS system fails to reward providers who invest in quality improvements that lead to fewer office visits or less expensive care. Making contracting decisions based on plan and provider performance, along with financial incentives for positive outcomes, constitute an important philosophical shift from the current FFS system.

The current system penalizes providers for investing in quality improvements that lead to fewer office visits or less expensive care. The state should develop and implement pay-for-performance by collaborating with a wide range of other public agencies and private organizations who have a common goal of improving quality and avoiding unnecessary health care costs, including the National Quality Forum, the Joint Commission of Accreditation of

*States should not need to obtain a waiver to implement selective contracting to control cost and ensure quality.*

*Pay-for-performance is an innovative strategy for improving the performance of plans and providers, with the ultimate goal of lowering costs and improving health outcomes.*

54 Vita 2001.

Health Care Organizations, the National Committee for Quality Assurance, the American Medical Association, the Agency for Health Care Research and Quality, and other state organizations. Seek CMS technical assistance and examine best practices, such as the Hospital Quality Initiative, Premier Hospital Quality Incentive demonstration, Medicare chronic Care Improvement Program<sup>55</sup> and CHAPS (See Care Management Section) to use incentive payments to further improve the quality of health care available to patients.

**Impact:** A statewide pay-for-performance strategy for providers will promote quality of care, lower costs and improve health outcomes through the following actions:

- Making contracting decisions not exclusively based on price, but also on plan and provider performance and outcomes.
- Using an outcome-based payment structure that encourages quality improvement and discourages poor performance.

**Recommendation 5: Increase Medicaid’s access to clinical and analytical resources for the improvement of health care delivery and financing through collaborations with the state’s Academic Medical Centers (AMC).**

**Rationale:** Ohio Medicaid could benefit from a formal collaborative arrangement with its public Academic Medical Centers (AMCs). Ohio is fortunate to have many outstanding AMCs capable of working with Medicaid to enhance its capacity for policy and program planning, review and analysis. The Medicaid agency has only limited access to the state university system’s existing clinical resource base to improve administration of Ohio’s most expensive and comprehensive health care program better.

The public AMCs’ current capabilities include clinical faculty expertise to provide

specific clinical services (such as utilization review) and design and test new models of health care delivery and financing. The AMCs also have programmatic expertise and knowledge necessary to help improve the efficiency and effectiveness of Medicaid administration. Because of their public status, many of the functions that the AMCs perform for Ohio Medicaid can qualify for federal financial participation.

The Commission received testimony from representatives of the University of Massachusetts Medical School (UMMS) outlining their collaborative services to the Massachusetts Medicaid program, including third party liability coordination and recovery; policy and program analysis; disability evaluation; community case management; nursing facility initiatives; and the use of clinical pharmacists in prospective and retrospective drug utilization review (DUR).

The DUR activities alone helped Massachusetts save \$167 million in SFY 2004, and concurrently contributed to the quality of health outcomes for Medicaid program consumers. In addition, UMMS provides for all of the clinical affairs staffing needs of the Medicaid agency.

During calendar year 2005, Ohio Medicaid should seek out and develop at least one multi-year collaborative relationship with one or more of Ohio’s Academic Medical Centers.

**Impact:** Collaborative relationships with the state’s AMCs will enable Ohio to take advantage of the capabilities of Ohio’s academic health sciences community to improve the health care delivery and financing capacity of the Ohio Medicaid program.

Because of the public status of the Ohio AMCs, this capability can be accomplished with little or no expenditure of additional state GRF resources, yet it has the potential to yield substantial savings depending upon the extent of the collaboration.

55 Retrieved January 2005, see, <http://watchdog.ohio.gov/investigations/2004210.pdf>.

# Conclusion



**M**edicaid must change. The costly and inefficient program requires decisive action that cannot be timid or tentative. The change must fundamentally transform relationship responsibilities and economic incentives.

The Commission is optimistic that solutions do indeed exist. After a year of intense research, analysis, discussion and vision, the Commission is confident that its recommendations and implementation strategies will lead to a cost-effective transformation of Ohio's Medicaid program while continuing to provide health care to Ohio's most vulnerable citizens.

The Governor, General Assembly, providers, and other stakeholders in the health care system must move forward with pragmatism, determination, and optimism to transform the program. The result will be a better quality Medicaid program with reduced, and ultimately, sustainable costs.

The time for transformation of Ohio's Medicaid program is now.

## **FURTHER CONSIDERATION**

There are two complex remaining issues that require detailed data and program analysis. That data were not available during Commission's timeframe. Consequently, it was unable to review the issues in detail. However, examination of these two issues is critical for a complete transformation of the system.

### **A. Medicaid in the local social service delivery system**

The Commission received testimony from countless individuals who fully appreciate the tremendous gains that have been made over the past two decades by expanding Medicaid to refinance services previously paid for solely with local or state dollars. After years of unprecedented growth, the state, counties and local systems are struggling to keep up with the demand for non-federal Medicaid matching funds. Though they do not draw upon the state revenue dollars dedicated in the ODJFS Medicaid account, which was the focus of the Commission studies, the local service delivery system is essential to the overall Medicaid program.

The number of mandates placed on community systems often converge in such a way that makes it difficult, if not impossible, to establish, fund and maintain a balanced system of public health care for our citizens. In exchange for the refinancing of these local burdens, federal Medicaid funding policy also brings the entitlement mandate on local systems to serve all eligible consumers and to match all Medicaid claims without limit or control. This is local jurisdictions' single greatest fiscal problem today.

Further, under current circumstances in many local areas, meeting the needs of those

with currently enrolled on Medicaid or having a chronic illness consumes all the available resources.

Another management challenge is that the systems are highly variable. Ohio's MR/DD, MH, and AOD systems are funded and managed through a web of boards that use local levies to generate the funds that match Medicaid expenditures on behalf of eligible consumers, as well as providing funding for those ineligible for Medicaid. These systems have evolved in such a fashion that they have numerous idiosyncrasies and an array of management challenges that vary considerably from area to area across the state.

The MR/DD system consumes on average more resources per person than any other part of the Medicaid system, and the population of children with significant disabilities is growing faster proportionately than any other eligible population group. The growing demands on the MH system are well-known, particularly as the "de-institutionalization" movement of the last two decades has taken hold.

The Commission did receive limited testimony from representatives of providers, consumers and administrators in both systems. The issues ranged from problems of access and the unavailability of some kinds of services in some parts of the state to sky rocketing costs and serious accusations about the integrity of some parts of the system in others. In addition, the Commission was informed of inquiries and efforts at reform already underway. Due to the complexity of and structural obstacles to these issues, the Commission concluded it was not possible to investigate all of them fully. Further, the legal and jurisdictional complexities of the MR/DD, MH, and AOD systems mean that these parts of the Medicaid system are the parts least

amenable to state administrative and legislative action.

The Commission strongly recommends that the Governor and General Assembly create either a group similar to the Commission or charge the Transition Council to review and bring local community Medicaid costs under control. As a start, the following system changes should be pursued:

1. Implement a Medicaid Business Plan designed to present a unified vision for how the local systems can improve the administration and management of the community mental health, drug and alcohol and mental retardation and developmental disabilities programs under Medicaid.

2. Give local boards and systems the ability to selectively contract with service providers based on community needs and the Medicaid business plan with regard to demand, quality and cost.

3. Create a mechanism to ensure that state agencies are more stringent in their certification of Medicaid eligible providers.

**B. Nursing facility admissions of people diagnosed with mental illness other than dementia and prescription rates for antianxiety, antidepressant and antipsychotic drugs in nursing facilities.**

**Exhibit 16**

Mental Illness And Psychotropic Drug Use In Ohio Nursing Homes								
	6/30/2001		6/30/2002		6/30/2003		6/30/2004	
Total Assessments	80,244		81,058		79,736		80,185	
Over 65	70,459		70,426		68,666		68,281	
Under 65	9,785		10,632		11,070		11,904	
Mental Illness indication (excl. Alz. or dementia)*	10,534	13.1%	10,733	13.2%	10,988	13.8%	11,311	14.1%
Over 65	7,720		7,559		7,550		7,457	
Under 65	2,814		3,174		3,438		3,854	
Antianxiety, antipsychotic, or antidepressant in the last 7 days (excl. Alz. or dementia)	21,472	26.8%	23,314	28.8%	24,765	31.1%	25,718	32.1%
Over 65	16,250		17,494		18,585		18,920	
Under 65	5,222		5,820		6,180		6,798	
Antianxiety or antipsychotic in the last 7 days (excl. Alz. or dementia)	11,055	13.8%	12,376	15.3%	13,146	16.5%	13,760	17.2%
Over 65	7,603		8,441		9,087		9,196	
Under 65	3,452		3,935		4,059		4,564	
*Mental illness indication includes all assessments with indication of anxiety disorder, manic depression (bipolar), schizophrenia, delusions or hallucinations in the absence of Alzheimer%or dementia								
SOURCE: Based on 6/30/01 and 6/30/04 MDS 2.0 data queried on 11/23/04								

Data about nursing facility residents that may suffer from mental illness show some trends warranting examination. Further work is required in order to help explain these trends, as well as others that might be identified over time. It will also be necessary to determine whether the Minimum Data Set 2.0 (MDS) can be validated as a tool for identifying the prevalence of mental illness in Ohio nursing facilities.

The data appear to indicate that the number of non-dementia residents with mental illness is increasing. Additionally, the data indicate that the number of nursing facility patients receiving antianxiety, antidepressant and antipsychotic prescriptions are significantly greater than the number of patients with a specific

diagnosis of mental illness, and that the use of such medications is increasing at an even greater rate than the apparent increase in mentally ill nursing facility patients. (See Exhibit 16.)

Based on these data, the Commission recommends that ODJFS, in consultation with the Ohio departments of Health and Mental Health, conduct a thorough review of nursing facility utilization for treating people with mental illness as well as factors contributing to the increasing rate of administering psycho-pharmaceutical drugs to nursing facility residents. A written report of the departments' findings should be provided prior to preparation of the SFY 2008-2009 executive budget.

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**Combined Estimated Savings from  
Implementing Recommendations from the  
Ohio Commission to Reform Medicaid**  
(State and Federal Savings in millions)<sup>1</sup>

Conservative Estimated Savings if Fully Implemented in State Fiscal Year (SFY) 2005

1	p.59-60	Reduce nursing home rates by -3% in SFY 2006, flat in SFY 2007.	\$ 81.7
2	p.59-60	Reduce ICF/MR rates by -3% in SFY 2006, flat in SFY 2007. p.	\$ 13.5
3	p.59-60	Hold hospital inpatient rates flat for two years. <sup>2</sup>	\$ 122.3
4	p.28	Expand managed care to all Covered Families and Children consumers. <sup>3</sup>	\$ 80.0
5	p.28	Expand managed care to non-dual, non-waiver, and for persons over age 21. <sup>4</sup>	\$ 105.1
6	p.32	Expand enhanced care management program	\$ 9.0
7	p.32	Apply care management to all other Aged, Blind and Disabled consumers. <sup>5</sup>	\$ 360.0
8	p.33	Expand financial incentives for outcome-based protocols in managed care rates prenatal care only (25% reduction in first year; 50% in second year).	\$ 18.9
9	p.22	Expand estate recovery – (est. on 2% of paid nursing facility SFY 2004 benefits). <sup>6</sup>	\$ 38.2
10		- outside probate- (no estimates possible because no reference point available)	
11	p.22	- State savings from FFP based on 9% finder’s fee to Attorney General of Ohio	\$ 2.93
12	p.19	Offer assisted living as a long-term care option.	\$ 28.0
13	p.38	Consolidate state pharmaceutical purchasing.	\$ 45.0
14	p.39	Collect supplemental rebates on mental health and HIV drugs.	\$ 43.6
15	p.39	Collect rebates on physician office and Disability Medical Assistance drugs.	\$ 33.0
16	p.39	Create a transparent, competitive priced Preferred Drug List.	\$ 115.0
17	p.41	Move to a 60% generic drug use.	\$ 160.0
18	p.42	Reduce dispensing fee to \$2.50.	\$ 36.6
19	p.42	Pay “WAC” plus 5% for trade name Rx (now WAC+9%).	\$ 17.41
20	p.42	Utilize drug management vendor .	\$ 30.0
21	p.45	Implement \$1 co-payment on patented drugs.	\$ 15.7
22	p.45	Implement electronic prescribing.	\$ 25.2
23	p.45	Do not provide Medicare Part D wrap-around.	\$ 7.0
24	p.51	Terminate duplicative disability determination process.	\$ 46.9
25	p.53	Collect premiums for transitional Medicaid adults.	\$ 5.0
26	p.54	Provide premium assistance.	\$ 4.0
27	p.60	Optimize payment and cash flow (state savings only). <sup>7</sup>	\$ 100.0
28	p.61	Coordinate home health care benefits (16-24% of SFY 2005).	\$ 27.2
29	p.61	Switch to prospective diagnostic and risk-adjusted capitated rate for long-term acute and rehabilitation hospitals.	\$ 2.65
30	p.72-73	Implement selective contracting (1.8% of overall costs). <sup>8</sup>	\$ 189.0
31	p.65	Strengthen the audit program (1-5% of overall costs).	\$ 105.0

**Total Minimum Savings: \$1.9 Billion<sup>1</sup>**

**Non-Duplicative Savings in First Full Year of Implementation: \$1.3 Billion**

Savings estimates are taken from the respective lower ranges in the report had policies been in place during SFY 2005.

Savings will lower spending growth and remove inefficiencies within the system, without cutting services.

Savings estimates are based on figures provided to the Ohio Commission to Reform Medicaid by Ohio Medicaid program managers, national experts, and other states. Several estimates are interdependent or alternative, and not meant to be cumulative. For example, implementation of managed care (lines 4-7) would reduce cost savings estimated for pharmacy (lines 12-22) and for selective contracting (line 29). The Commission cannot anticipate all these inter-relationships. Actual savings may be higher or lower in individual categories, and are based on implementing each recommendation for an entire state fiscal year (SFY). Savings would be less for partial-year implementation. Additionally, many of the recommendations will require significant work and time to implement. However, if at the start of SFY 2005 Ohio were to have fully implemented only the shaded categories, (which are believed to be non-interactive), the estimated savings would have been approximately **\$ 1.3 Billion**.

1 The full range of potential savings contained in the impact statements exceeds this estimated minimum savings.

1 Actual savings will be shared between Ohio and the federal government on about a 41%-59% ratio.

2 Assumes that rates were held flat during SFY 2004-2005.

3 Savings estimates in lines 4, 5 and 6 take into account overlapping payments during transition from the current retrospective payments to prospective payments.

4 See note 3.

5 See note 3.

6 ODJFS reported total 2004 collections of nearly \$16 million, which was subtracted from the \$54.2 million that would have been recoverable to arrive at the \$38.2 million projected estimated savings.

7 This is a one-time cost savings only. It should be invested to information technology.

8 Based on savings experienced by other states.

# References

## **The Lewin Group Study of Policy and Programmatic Considerations of Converting to Section 1634 Status Modeling Results**

The Lewin Group modeled the enrollment and cost impacts of three eligibility scenarios, which were determined in conjunction with OCRM. Under Scenario 1, Ohio converts to 1634 status, maintains the special income rule at 300 percent of SSI, and does not implement the optional medically needy coverage group. In Scenario 2, Ohio converts to 1634 status, reduces the special income rule standard to 200 percent of SSI, and adopts the optional medically needy coverage group with a medically needy income level (MNIL) of 100 percent of SSI. Finally, in Scenario 3, Ohio converts to 1634 status, maintains the special income level standard at 300 percent of SSI, and adopts the optional medically needy coverage group with an MNIL of 64 percent of the Federal Poverty Level (FPL).

Under each of the conversion scenarios, individuals who receive SSI benefits but are not eligible for Medicaid under Ohio's current Medicaid standards would gain eligibility. Effects of other potential eligibility features vary across scenarios. Each of the scenarios modeled would increase overall Medicaid enrollment, with Scenario 1 resulting in the smallest increase. Estimated Medicaid costs would decrease under Scenario 1 but increase somewhat in Scenarios 2 and 3.

Under Scenario 1, Medicaid enrollment of individuals with disabilities is estimated to rise to 428,032, an increase of 8,620 recipients. Costs are estimated to fall by \$251 million, to \$8.0 billion. Because Scenario 1 does not include coverage through the mandatory 209(b) spenddown or the optional medically needy coverage groups, an estimated 23,465 individuals currently enrolled through the mandatory 209(b) spend-down would lose Medicaid eligibility.

Scenario 1 would produce savings to Medicaid, because individuals newly eligible for Medicaid, community-dwelling non-long-term care users with lower than average medical needs, are expected to cost substantially less than the individuals losing coverage, many of whom are long-term care users with relatively high Medicaid costs. Whether savings would be realized under Scenario 1 is most dependent on whether the long-term care users losing coverage remain ineligible for Medicaid.

In Scenario 2, estimated Medicaid enrollment increases to 452,809, an increase of 33,397 recipients, and estimated Medicaid costs increase by \$133 million, to \$8.4 billion. Under Scenario 2, effectively no one would lose coverage, because the optional medically needy coverage helps to

preserve coverage, but some individuals (149,620) would experience a shift in their eligibility category. In addition, a small number of pregnant women and children (1,312) with incomes too high to qualify for the State Children's Health Insurance Program (S-CHIP) in Ohio would now qualify under the optional medically needy program by spending down. Costs for this population are expected to be relatively small.

Medicaid enrollment in Scenario 3 is identical to enrollment in Scenario 2, because the difference in the spend-down level is too small to significantly affect enrollment. Like Scenario 2, the adoption of the optional medically needy would allow current recipients to maintain their coverage. An estimated 136,318 individuals would retain Medicaid coverage through a different eligibility category. The main difference between Scenarios 2 and 3 is that Scenario 3 would require recipients to spend down further, to 64 percent of FPL, offsetting some of the costs to Medicaid seen in Scenario 2. Costs under Scenario 3 are estimated to increase \$115 million, to \$8.4 billion.

**Policy and programmatic considerations and the 1634 status conversion steps are outlined in The Lewin Group report located at <http://ohiomedicaidreform.com>.**

## **The Ohio State University - College of Pharmacy Analysis of the Pharmacy Program**

The objective of the study was to propose alternatives for long-term structural reform in order to increase the efficiency of the Ohio Medicaid pharmaceutical program. The study analyzed trends in Ohio Medicaid's pharmaceutical expenditures. Expenditures for the years 2004-2010 were estimated based on the projections of the authors and the Ohio Department of Job and Family Services. An extensive bibliographic review was performed concerning Medicaid's and other national and international programs' experiences in managing pharmaceutical programs. A comprehensive list of possible alternatives to improve the efficiency of the Ohio Medicaid pharmaceutical program is presented in the report. The study estimates the potential savings for Ohio Medicaid's pharmaceutical program that could be derived from the implementation of the main alternatives. The study is based on state drug utilization and claims data (February 2000-2003) and other public private source data.

**The analysis of the Medicaid pharmacy program and alternatives for reform reports are located at <http://ohiomedicaidreform.com>.**





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