



Modernize Medicaid

Reset Medicaid payment rules to reward value instead of volume.

1. Extend Medicaid coverage and automate enrollment
2. Fight Medicaid fraud and abuse
3. Reform health plan payments
4. Reform hospital payments
5. Reform nursing facility payments
6. Reform other provider payments

Rebalance Long-Term Care

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

7. Prioritize home and community based services
8. Rebuild community behavioral health system capacity
9. Enhance community developmental disabilities services

Streamline Health and Human Services

Share services across jurisdictions to improve operational efficiencies and related outcomes.

10. Create a unified Medicaid budgeting and accounting system
11. Create a cabinet-level Medicaid department
12. Consolidate mental health and addiction services
13. Coordinate health sector workforce programs
14. Coordinate programs for children
15. Implement *Public Health Futures* recommendations

Balance the Budget

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

16. Overall Medicaid budget impact

Office of Health Transformation

Extend Medicaid Coverage and Automate Enrollment

Background:

Eligibility determination for health and human services programs in Ohio are fragmented, overly complex, and reliant on outdated technology. For example, Ohio has more than 150 categories of eligibility just for Medicaid. Variation in Medicaid income eligibility creates gaps in coverage that result in unnecessary costs for local government, uncompensated costs for hospitals, and cost-shifting to private sector insurance premiums, all of which are paid for by taxpayers and businesses. Eligibility reforms in the budget have the potential to significantly improve care for vulnerable Ohioans, increase program efficiencies, and reduce costs for Ohio's taxpayers.

Applying for Medicaid is confusing and time consuming. More than 2.3 million Ohioans were enrolled in Medicaid in December 2012. Many families came through the front door of one of the 88 local County Department of Job and Family Services (CDJFS) service centers and had to physically meet with a caseworker to get through the application process, providing information whenever it was determined more was needed, and often requiring multiple repeat visits to the county office. These families qualified through a myriad of requirements, computations, and verifications. Income disregards or special income treatment was used as needed with each family or, in some cases, different individuals in the same family.

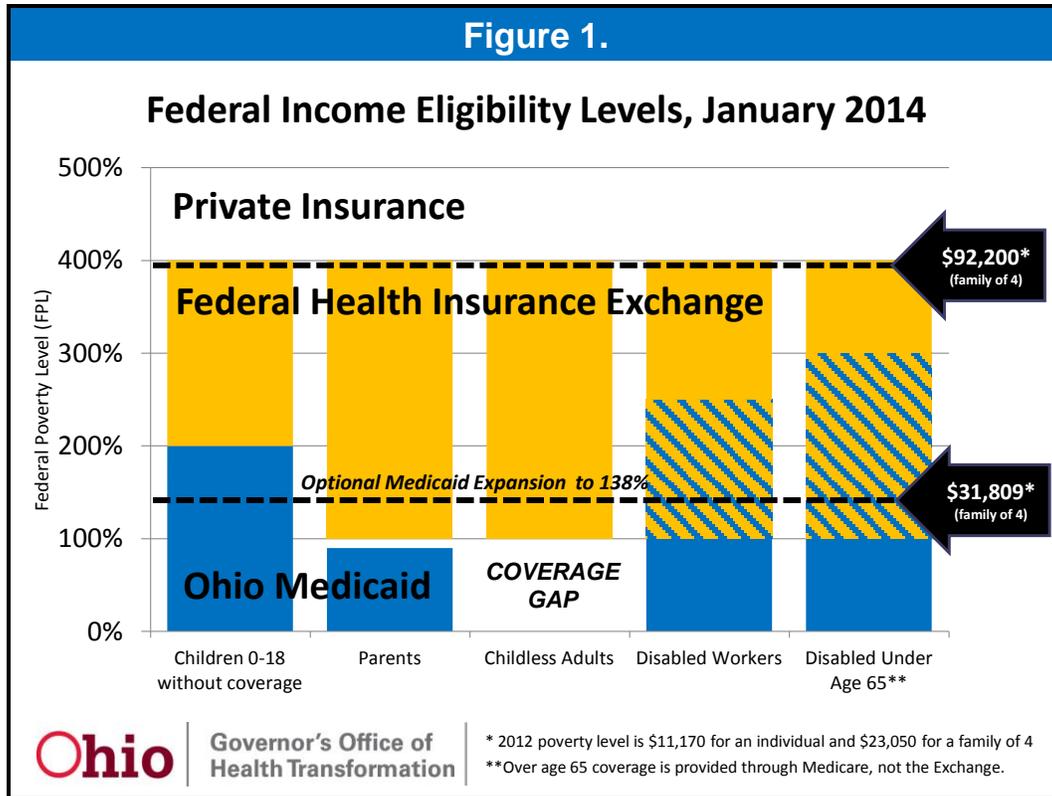
Current Medicaid eligibility policies leave gaps in coverage. An estimated 1.5 million Ohioans do not have health insurance, most of them from working families, and some of them very poor (Appendix C shows the number of low-income uninsured Ohioans by county).¹ Medicaid plays a critical role in protecting the health of low-income Ohioans, but it leaves out many people (see Figure 1). Like many states, Ohio does not extend Medicaid coverage to adults unless they have children or are disabled. Beginning in January 2014, the federal government will establish a Health Insurance Exchange to offer tax credits for insurance premiums to Ohioans with incomes between 100 percent and 400 percent FPL, but no credits will be provided below 100 percent FPL. As a result, parents between 90 percent and 100 percent FPL and childless adults with income below 100 percent FPL will be caught in a "coverage gap" without access to Medicaid or tax credits on the Exchange (Figure 1).

Federal funding is available to eliminate the coverage gap. In June 2012, a U.S. Supreme Court ruling gave states the option to increase Medicaid eligibility for all adults to 138 percent FPL,² with the federal government paying 100 percent of the costs for the newly eligible population during the first three years, decreasing to 90 percent by 2020. States have flexibility to decide

¹ US Census Bureau, [Health Insurance Coverage Status by State for All People](#) (2011).

² The Affordable Care Act requires eligibility for adults to be set at 133 percent FPL but also establishes a 5 percent income disregard, so the effective eligibility level is up to 138 percent FPL.

whether or not and when to extend coverage, but the years of federal funding are fixed³ and enhanced federal funding is not available for a partial expansion.⁴



Federal funding also is available to simplify and automate eligibility systems. In August 2011, the federal government announced a time-limited opportunity for states to use enhanced (90 percent) federal matching funds to integrate eligibility determination functions across programs based on income eligibility.⁵ The new policy allows health and human services programs – including Temporary Assistance for Needy Families, Supplemental Nutrition Assistance Program and Child Care and Development Fund – to utilize systems designed for determining a person’s Medicaid eligibility without sharing in the common system development costs, so long as those costs would have been incurred to develop systems for Medicaid. States may access the 90-percent enhanced federal funding up to but not after December 31, 2015.

Ohio law requires eligibility modernization. Governor Kasich’s Jobs Budget (HB 153), enacted June 2011, directed Ohio Medicaid “to reduce the complexity of the eligibility determination processes for the Medicaid program caused by different income and resource standards for the

³ The Federal Medical Assistance Percentage (FMAP) for the expansion is fixed at 100 percent in 2014, 2015 and 2016, and then decreases to 95 percent in 2015, 94 in 2018, 93 in 2019, and 90 percent in 2020 and beyond.

⁴ CMS, [Frequently asked questions on Exchanges, market reforms, and Medicaid](#) (December 10, 2012), page 12.

⁵ Joint USDA, CMS, ACF [Guidance on developing integrated eligibility determination systems](#) (August 11, 2011).

numerous Medicaid eligibility categories” and “obtain to the extent necessary the approval of the United States Secretary of Health and Human Services.”⁶ The Governor’s Office of Health Transformation prepared an application to modernize Ohio’s eligibility systems, but put the waiver on hold pending a decision about whether or not to change Medicaid eligibility levels.⁷

Executive Budget Proposal and Impact:

The Executive Budget includes a comprehensive package of reforms to simplify eligibility based on income, streamline state and local responsibility for eligibility determination, and update eligibility systems technology. The goal is for most enrollees to become eligible for Medicaid and other programs based on income tax information without needing to undergo any additional eligibility tests. The two major features of the plan are to simplify eligibility policy and to automate eligibility determination systems.

SIMPLIFY ELIGIBILITY POLICY

Consolidate Medicaid eligibility into three basic groups. As a first step, Ohio will map the state’s current 150+ Medicaid eligibility categories into three groups: (1) children and pregnant women, (2) individuals who are age 65 or older, who have Medicare coverage, or who need long-term services and supports, and (3) community adults (non-pregnant adults who do not need long-term services and supports), including individuals eligible as parents or caretaker relatives.⁸ The eligibility criteria and standards for the first two simplified groups will not change (income, resources, spend-down, disability determination, and other creditable coverage will be treated the same). Only the third group, community adults, will see significant changes in eligibility standards for Medicaid. All three groups will benefit from simplified processes, including for most applicants conversion to a new federally mandated modified adjusted gross income (MAGI) standard that will allow for real-time eligibility determination.⁹

Simplify eligibility standards and increase coverage for community adults. Beginning January 1, 2014, community adult applicants will qualify for Medicaid with MAGI at or below 138 percent FPL. There will be no application of spend-down processes, no resource test, and no state or federal disability determination requirement, although there will be other qualifying criteria such as legal residency. The new policy is expected to impact the following populations:

- **Newly eligible.** Community adults with MAGI below 138 percent FPL, including parents with MAGI between 90 percent and 138 percent FPL, will be newly eligible to enroll in Medicaid. Ohio Medicaid estimates 366,000 individuals will enroll, including 270,000 previously uninsured Ohioans (Figure 2). The total cost of services for this group is

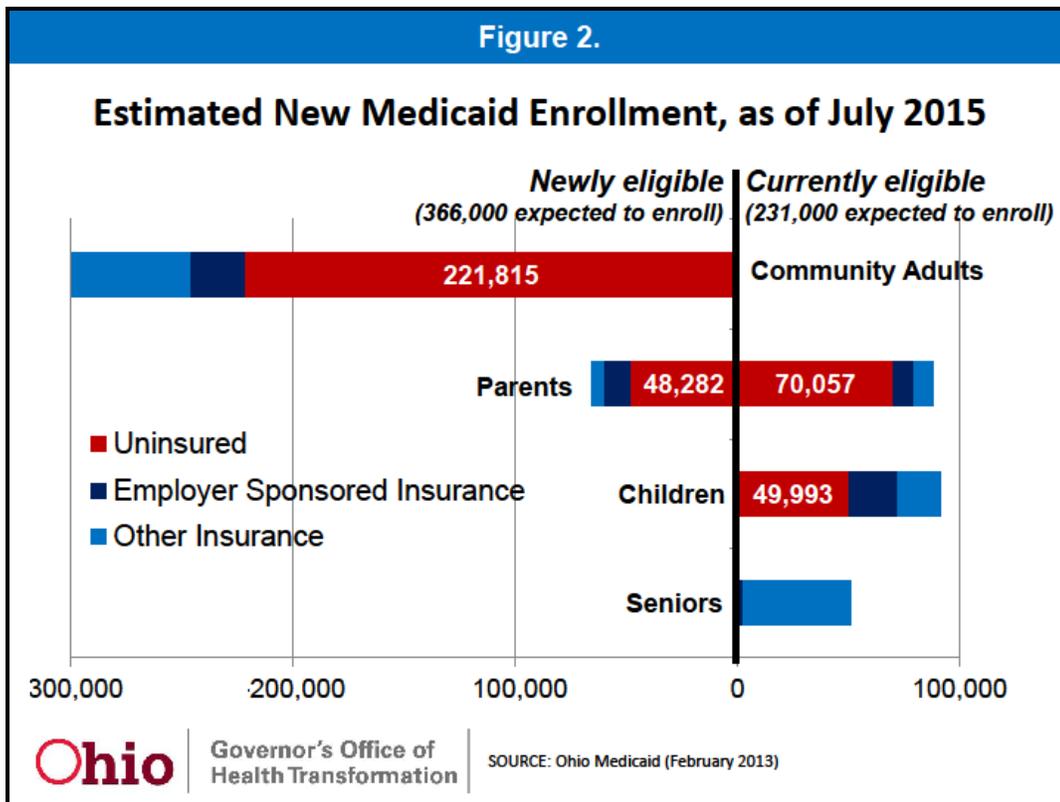
⁶ [ORC 5111.0123](#)

⁷ Office of Health Transformation, [Proposed Section 1115 Demonstration: Eligibility Modernization](#) (June 2012).

⁸ Community adults include the expansion population called “Group VIII” by the federal government based on the section of law that defines the group; CMS, [New option for coverage of individuals under Medicaid](#) (April 9, 2010).

⁹ CMS, [Conversion of net income standards to MAGI equivalent income standards](#) (December 28, 2012).

estimated to be \$2.6 billion over the biennium, all of which will be paid by the federal government. In some cases, state and local government will see savings result when Ohioans who are covered by other programs move onto Medicaid. For example, the Ohio Department of Rehabilitation and Correction estimates it will save \$27 million over the biennium on inpatient hospital costs for prisoners, and the county community mental health and addiction services system is expected to save \$105 million over the biennium on services that shift to Medicaid, primarily for adults who do not currently have access to coverage. (Appendix B summarizes the newly eligible impact on federal, state and local resources.)



- Currently eligible but not enrolled. Some people who are currently eligible but not yet enrolled in Medicaid are expected to enroll in January 2014, regardless of whether or not eligibility expands. This “woodwork effect” results from the new federal requirement to have health insurance, easier access to insurance through the federal Health Insurance Exchange, and increased awareness about the availability of health coverage. Ohio Medicaid estimates an additional 92,000 children, 88,000 parents, and 51,000 seniors will enroll in Medicaid as a result of the woodwork effect (Figure 2). Ohio will receive the regular federal match rate for this population, resulting in higher state Medicaid costs. Ohio Medicaid estimates the cost of these individuals will be \$1.5 billion

(\$521 million state share) over the biennium.¹⁰ (Appendix B summarizes the impact of woodwork on federal, state and local resources; the woodwork effect is *not included* in the estimated cost of eligibility simplification and automation because it is expected to occur with or without changes in Medicaid income eligibility policy).

- **Previously eligible.** Some community adults qualify for Medicaid today at income levels above 138 percent FPL as a result of income disregards, transitional medical assistance, and other exceptions. Ohio Medicaid estimates that 90,863 individuals who would have qualified for Medicaid under current policies will not under the new MAGI policy (Figure 3). However, these individuals will have access to tax credits on the Health Insurance Exchange, up to 400 percent FPL. Ohio Medicaid estimates the savings from not covering this group on Medicaid will be \$246 million over the biennium, and because the state would have paid the regular match for this population, the state will save \$91 million over the biennium. (Appendix B summarizes the impact of this group on federal, state and local resources.)

Figure 3.
Estimated Medicaid Enrollment from Eligibility Simplification

Newly Eligible Population	Estimated Gain/(Loss) as of June 2015
Previously uninsured	270,097
Previously had other insurance	95,519
Subtotal new enrollment	365,616
Previously had Medicaid	(90,863)
Total change in enrollment	274,753
Source: Appendix A provides more detail about estimated enrollment.	

Eligibility simplification will result in some Ohioans becoming newly eligible for Medicaid, and some who would have been eligible under the old rules not being eligible in the future. The federal, state and local financial impact of these changes is summarized in Figure 4.

¹⁰ Ohio Medicaid’s earlier estimates of woodwork were higher than current estimates because: (1) the earlier estimate counted eight quarters of expanded enrollment and spending beginning January 2014 when the Medicaid expansion takes effect, but the budget estimate is for the period beginning July 2013, which begins six months prior to the expansion, so the budget estimate counts six quarters of expanded enrollment and spending not eight; and (2) the earlier estimate was based on the 2010 Family Health Survey (FHS) and the current estimate is based on the 2012 FHS.

Figure 4.
Estimated Financial Impact Resulting from Eligibility Simplification

Source of Funds	SFY14-15 Costs/(Savings)
Federal	
Newly eligible enrollment cost	\$2.6 billion
Previously eligible enrollment savings	<u>(\$155 million)</u>
Total	\$2.4 billion
State	
Newly eligible enrollment cost	\$0
Previously eligible enrollment savings	(\$91 million)
State inpatient hospital for prisoners	(\$27 million)
Net HIC and sales tax revenue	<u>(\$117 million)</u>
Total	(\$235 million)
County	
Service costs that shift to Medicaid	(\$105 million)
Net sales tax revenue	<u>(\$25 million)</u>
Total	(\$130 million)
Source: Appendix B provides more detail about estimated enrollment.	

Expect personal responsibility from Ohioans who benefit from Medicaid. In order to ensure individuals in the Medicaid program take personal responsibility for their health care services and also become ready to move off of Medicaid and into private insurance, Medicaid is proposing new cost sharing requirements for every adult above 100 percent of poverty. This proposal is in line with proposed federal regulations on cost sharing. Ohio will require an \$8 co-payment for use of an emergency room for non-emergency conditions, \$8 co-pays for non-preferred drugs, and \$3 co-pays for preferred drugs. Certain long-term maintenance drugs (such as insulin) will have no co-pay. Also, under new federal rule changes, a provider can deny a service if the person does not pay the co-pay. For example, a pharmacist could deny the person the non-preferred drug for not paying the \$8 co-pay but instead offer the preferred drug at the \$3 co-pay.

Opt out if federal funding is reduced. The federal government has made it clear that states may opt in and out of covering newly eligible populations at any time.¹¹ The Executive Budget codifies an automatic opt out trigger so that if for any reason the federal government reduces its financial participation for expanded coverage, then the program for newly eligible groups shuts down, and Ohio taxpayers are not stuck holding the bill. In addition, Ohio Medicaid may

¹¹ CMS, [Frequently asked questions on exchanges, market reforms and Medicaid](#) (December 2012), question 24

turn off eligibility for newly eligible populations if the state is required as a result of federal action to reduce or eliminate any tax that provides financial support for the Medicaid program.

AUTOMATE ELIGIBILITY DETERMINATION SYSTEMS

Replace Ohio's 34-year-old eligibility determination system. Ohio's Enhanced Client Registry Information System (CRIS-E) provides intake and eligibility determination support for several of Ohio's health and human services programs and provides some case management functions for several Ohio Department of Job and Family Services programs. When CRIS-E was implemented in 1978, it was able to meet the needs of the counties by allowing for 18,000 users to manually enter cases for Ohio citizens. As time went by, many processes were added to allow the original system to do more, but all of the additions were built on the original foundation, which could only extend so far and long ago reached its limit of new applications. The problem is so severe that Ohio Medicaid estimates 60 percent of CRIS-E's eligibility determinations for Medicaid need to be manually overridden to prevent eligible applicants from being denied coverage. CRIS-E is so fragile and technically obsolete that it is no longer practical or cost effective to invest in enhancing the system.

Replace CRIS-E with a new integrated eligibility system. The Ohio Department of Administrative Services is contracting with a vendor to replace CRIS-E with a new, integrated, enterprise solution that supports both state and county operations.¹² The new system will provide the technology necessary for integrating eligibility across Ohio's health and human services agencies. The project will focus first on Medicaid eligibility, then expand to other programs that currently depend on CRIS-E (this phase will retire CRIS-E), and finally expand to support other health and human services programs. The new system will give individuals and families seeking Medicaid coverage an option to apply online and provide real-time determination for most people who apply. The budget includes \$230 million for this system (\$26 million state share) over the biennium.

Change eligibility processes and workflow to be more efficient. In addition to the CRIS-E replacement, the Ohio Department of Administrative Services will release a second request for proposals (RFP) in February 2013 to acquire an organizational change management (OCM) vendor to coordinate the transition from the current business environment to a new, more efficient and effective business environment. Combined with the simplification of eligibility policy, the new integrated eligibility system provides the opportunity to improve the business processes involved with enrolling Ohio citizens in HHS programs. The state is working with county agencies to improve the processes at both the county and state levels. The Executive Budget includes funding for this project and leverages 90 percent federal funds.

Updated January 31, 2013

¹² DAS, [Integrated eligibility and HHS business intelligence procurement](#)

Appendix A.				
Projected Medicaid ENROLLMENT for Newly Eligible, Currently Eligible but not Enrolled, and Previously Eligible Medicaid Populations				
	Current Source of Coverage	Ultimate Take-Up Rates	Best Estimate of Participation	
			SFY 2015	SFY 2020
NEWLY ELIGIBLE				
	Parents (19-64 years)			
	Uninsured	70%	48,282	58,981
	Individual	70%	3,459	4,225
	Employer	20%	11,994	14,658
	Other/unknown	20%	2,076	2,538
	<i>Newly eligible parents</i>		65,811	80,402
	Childless Adults (19-64 years)			
	Uninsured	55%	221,815	271,082
	Individual	55%	36,986	45,200
	Employer	15%	25,025	30,583
	Other/unknown	15%	15,979	19,527
	<i>Newly eligible childless adults</i>		299,805	366,392
	NEWLY ELIGIBLE TOTAL ENROLLMENT		365,616	446,794
CURRENTLY ELIGIBLE NOT ENROLLED (WOODWORK)				
	Children (up to age 19)			
	Uninsured	80%	49,993	83,134
	Individual	80%	13,057	21,721
	Employer	15%	22,141	36,833
	Medicare Only	15%	914	1,521
	Other/unknown	15%	5,469	9,098
	<i>Woodwork children</i>		91,574	152,307
	Parents (19-64 years)			
	Uninsured	65%	70,057	116,549
	Individual	65%	3,239	5,389
	Employer	20%	9,112	15,153
	Medicare Only	20%	2,376	3,953
	Other/unknown	20%	3,535	5,879
	<i>Woodwork parents</i>		88,319	146,923
	Aged (65 and over)			
	Uninsured	20%	1,189	1,999
	Individual	20%	1,149	1,932
	Employer	20%	1,506	2,531
	Medicare Only	20%	45,190	75,933
	Other/unknown	20%	1,865	3,133
	<i>Woodwork aged</i>		50,899	85,528
	WOODWORK TOTAL ENROLLMENT		230,792	384,758
PREVIOUSLY ELIGIBLE				
	Breast and cervical cancer		6	8
	Family planning		26,378	27,516
	Transitional Medicaid to six months		54,123	55,419
	Parent coverage		10,356	10,671
	PREVIOUSLY ELIGIBLE TOTAL ENROLLMENT		90,863	93,614
2020 number based on June 2015 participation estimate (caseload trend information is not available)				
2015 is average monthly enrollment				

Appendix B.				
Federal, State and County COST AND REVENUE IMPACTS				
of Newly Eligible, Currently Eligible not Enrolled,				
and Previously Eligible Medicaid Populations				
COST/(SAVINGS) in millions				
	SFY 2014	SFY 2015	SFY 2014-2015	SFY 2014-2020
ALL FUNDS				
Newly eligible enrollment cost*	\$ 562	\$ 2,000	\$ 2,561	\$ 14,481
Woodwork enrollment cost*	\$ 529	\$ 952	\$ 1,481	\$ 9,188
Previously eligible enrollment savings	\$ (62)	\$ (184)	\$ (246)	\$ (1,289)
Total Medicaid spend (all funds)	\$ 1,029	\$ 2,768	\$ 3,796	\$ 22,380
FEDERAL SHARE				
Newly eligible enrollment cost*	\$ 562	\$ 2,000	\$ 2,561	\$ 13,895
Woodwork enrollment cost*	\$ 343	\$ 617	\$ 960	\$ 6,171
Previously eligible enrollment savings	\$ (39)	\$ (116)	\$ (155)	\$ (812)
Total Medicaid spend (state share)	\$ 865	\$ 2,501	\$ 3,366	\$ 19,253
STATE SHARE				
Newly eligible enrollment cost*	\$ -	\$ -	\$ -	\$ 586
Woodwork enrollment cost*	\$ 186	\$ 335	\$ 521	\$ 3,018
Previously eligible enrollment savings	\$ (23)	\$ (68)	\$ (91)	\$ (477)
Total Medicaid spend (state share)	\$ 163	\$ 267	\$ 430	\$ 3,127
OTHER				
State inpatient hospital for prisoners	\$ 9	\$ 18	\$ 27	\$ 117
County behavioral health services	\$ 35	\$ 70	\$ 105	\$ 455
TAX AND FEE REVENUE in millions				
STATE SHARE				
Newly eligible (HIC + sales/use)	\$ 21	\$ 107	\$ 129	\$ 838
Woodwork (HIC + sales/use)	\$ 21	\$ 44	\$ 65	\$ 447
Previously eligible (HIC + sales/use)	\$ (3)	\$ (10)	\$ (12)	\$ (73)
Total State Tax and Fee Revenue	\$ 40	\$ 141	\$ 181	\$ 1,212
COUNTY SHARE				
Newly eligible (Sales/use)	\$ 5	\$ 23	\$ 28	\$ 176
Woodwork (Sales/use)	\$ 5	\$ 9	\$ 14	\$ 94
Previously eligible (Sales/use)	\$ (1)	\$ (2)	\$ (3)	\$ (15)
Total County Tax and Fee Revenue	\$ 9	\$ 30	\$ 39	\$ 255
* Costs include two-year primary care physician fee increase and prescription drug rebates.				

Office of Health Transformation **Fight Medicaid Fraud and Abuse**

Background:

Ohio Medicaid is committed to combating Medicaid provider fraud and abuse that take money from needy children, the elderly, and people with disabilities. The majority of providers and their billings are honest and accurate. However, one dishonest provider can take thousands of dollars over time by billing for services not rendered or medically necessary, or through organized crime take hundreds of thousands of dollars illegally in a few weeks or months.

Ohio Medicaid will spend \$19.6 billion in FY 2013 to provide health care to more than 2.3 million Ohioans. The size and scope of the program demand strong financial stewardship. Ohio Medicaid employs auditors, analysts, and fraud examiners, as well as private-sector experts and other professionals to identify, recover, and prevent overpayments. Through the collective and ongoing efforts of the Program Integrity Group, Ohio's Office of the Attorney General has become a national leader in convicting and indicting Medicaid fraud and abuse.

In addition to prosecuting fraud cases and chasing down overpayments, Medicaid program integrity also is about promoting a policy environment in which expectations and incentives are aligned to promote efficiency and quality, and prevent misuse of services. It also includes effective program management and ongoing monitoring. These efforts create a culture that drives better health outcomes and common-sense ways to eliminate fraud and abuse.

Executive Budget Proposal and Impact:

The Executive Budget includes numerous provisions to combat Medicaid fraud and abuse, and it reflects savings for some new initiatives that have been launched recently. The purpose is to promote economy, efficiency, accountability, and integrity in the management and delivery of Medicaid services. In combination, these provisions are projected to save \$74.3 million (\$27.4 million state share) over the biennium.

- ***Increase Medicaid audit capabilities.*** The Executive Budget adds five full-time positions to the Medicaid audit team to perform additional on-site monitoring reviews and to ensure the state's new recovery audit contract (RAC) is properly monitored and provider appeals are completed in a timely manner. Additional on-site monitoring of Medicaid providers will increase the amount of overpayments that Ohio Medicaid can recover, and is projected to save \$1.5 million (\$554,000 state share) over the biennium.
- ***Increase audit recoveries.*** The federal government requires states to contract with a recovery audit contractor in order to identify overpayments and underpayments by the state Medicaid program, and recoup overpayments. Ohio selected CGI in May 2011 to

serve as Ohio's recovery audit contractor. Based on projections provided by CGI, Medicaid expects to save \$48 million (\$18 million state share) over the biennium.

- **Manage hospital utilization.** Ohio Medicaid recently contracted with Permedion to perform both pre- and post-payment review of hospital services, and provide technical advice to the Ohio Medicaid program regarding coverage and utilization management policies. This provision is projected to save \$19 million (\$7 million state share) over the biennium. In addition to the hospital project, Permedion has identified other program integrity and cost avoidance activities that are estimated to save an additional \$6 million (\$2.2 million state share) over the biennium.

In addition to the initiatives described above, the Executive Budget makes other changes that are expected to improve program integrity and save taxpayer dollars, but actual savings are difficult to estimate and not included in budget estimates.

- **Involve providers in third-party recoveries.** Ohio Medicaid is the payer of last resort and contracts with a vendor to recover Medicaid payments when the beneficiary has other insurance coverage that should cover all or part of the medical expenses. In some cases, the other insurance pays better than Medicaid, so the provider has an incentive to seek payment from the other insurance, not Medicaid. The Executive Budget clarifies that Medicaid may involve the provider to identify and recover overpayments, and that the provider can bill the third party insurance versus Medicaid billing the third party directly. Also, the Budget requires legal representatives to cooperate with medical providers to reveal a client's third party insurance when that client has Medicaid.
- **Revalidate providers every five years.** The Executive Budget authorizes Ohio Medicaid to revalidate providers every five years instead of the current seven years, and includes incentives for providers to submit a complete application during the revalidation process. The five-year revalidation is a new federal requirement that is intended to identify and eliminate fraudulent providers.
- **Track trusts as part of recovery.** The Executive Budget requires Medicaid applicants to provide Ohio Medicaid with a copy of any trust of which they are a beneficiary. Currently, Medicaid does not have any mechanism for tracking trusts, and recoveries from trusts are missed. This provision will enable Medicaid to identify when a trust is involved and improve collection of payments when a Medicaid beneficiary dies.
- **Streamline the nursing facility claims review process.** Program integrity activities related to nursing facilities focus on accurate billings and payment, and the quality of the services purchased. The Executive Budget aligns the Medicaid claims review process for nursing facilities with that applied to other provider types, streamlining the process, and allowing nursing homes and Ohio Medicaid to resolve payment issues more quickly.

- **Terminate special focus nursing facilities.** The Executive Budget authorizes Ohio Medicaid to terminate the Medicaid provider agreement of nursing facilities with a history of providing poor quality care without improvement. The federal government operates a Special Focus Facility Program that identifies facilities with more deficiencies than most facilities, more serious deficiencies, and a pattern of serious deficiencies. They publish a list monthly identifying those facilities newly added to the list, those that remain on the list without improving, those that remain on the list but are improving, and those that recently graduated from the list. The budget gives Ohio Medicaid another tool to ensure the quality of long-term services and supports in Ohio by terminating the provider agreement of a facility that either fails to improve within 12 months of being placed on the list or fails to graduate from the list within 24 months of being placed on the list.
- **Medicaid access to Ohio's prescription monitoring program.** The Executive Budget clarifies that Ohio Medicaid "shall" (not "may") have access to the Ohio Automated Rx Reporting System (OARRS) and specifies that Medicaid is able to see information about prescriptions that were not paid for through Medicaid. This access will allow Medicaid to confirm that, if a consumer is assigned to a specific provider through the coordinated services program to curtail prescription drug abuse, the provider is not allowing the recipient to receive controlled substances outside the Medicaid program.
- **Expect personal responsibility from Ohioans who benefit from Medicaid.** In order to ensure individuals in the Medicaid program take personal responsibility for their health care services and also become ready to move off of Medicaid and into private insurance, Medicaid is proposing new cost sharing requirements for every adult above 100 percent of poverty. This proposal is in line with proposed federal regulations on cost sharing. Ohio will require an \$8 co-payment for use of an emergency room for non-emergency conditions, \$8 co-pays for non-preferred drugs, and \$3 co-pays for preferred drugs. Certain long-term maintenance drugs (such as insulin) will have no co-pay. Also, under new federal rule changes, a provider can deny a service if the person does not pay the co-pay. For example, a pharmacist could deny the person the non-preferred drug for not paying the \$8 co-pay but instead offer the preferred drug at the \$3 co-pay.

Updated January 31, 2013

Office of Health Transformation **Reform Health Plan Payments**

Background:

In December 2012, 1.6 million Ohioans received Medicaid health care benefits through a managed care plan and Ohio Medicaid paid those plans \$6.4 billion (SFY 2012) to arrange for care and provide a comprehensive set of medically necessary services. Ohio Medicaid pays the health plans monthly, per person, using a “capitation rate” similar to health insurance premiums. Health plan capitation rates are set annually using a combination of actual cost data and medical cost inflation data to establish reasonable costs for services and administration.

Over the last year, Ohio Medicaid initiated several significant changes to its managed care program. The following reforms represent the state’s commitment to using managed care as a core strategy to improve health outcomes for Medicaid beneficiaries and to reduce costs for taxpayers:

- ***Consolidate health plan regions and populations to be more efficient.*** Ohio Medicaid will reduce the number of managed care service regions from eight to three, and within each region combine coverage for families and children and aged, blind and disabled populations. This new design will increase individual choice and competition by offering five plan choices, up from two or three currently. This change will also deliver efficiencies envisioned in the state budget because having fewer service regions reduces the administrative burden on the state and on health plans. It also increases competition in the managed care marketplace. In June 2012, Ohio Medicaid announced the health plans competitively selected to serve the new regions beginning July 2013.¹
- ***Link health plan payments to performance.*** New health plan contract language, based on model health plan contract language created by Catalyst for Payment Reform, will move the Medicaid health plans from paying for volume to paying for value.² To accomplish this, health plans will be required to develop incentives for providers that are tied to improving quality and health outcomes for enrollees. Additionally, the new contracts will increase expectations around nationally recognized performance standards health plans must meet to receive financial incentive payments.
- ***Integrate care delivery for Medicare-Medicaid enrollees.*** In December 2012, Ohio Medicaid reached agreement with the federal government to implement a new Integrated Care Delivery System (ICDS) for individuals who are eligible for both Medicare (because they are over age 65 or disabled) and Medicaid (because they have low income). Ohio will implement the ICDS as a three-year demonstration project in

¹ Ohio Medicaid, [Medicaid Managed Care Procurement](#) (updated June 7, 2012)

² [Catalyst for Payment Reform Website](#).

seven geographic regions covering 29 Ohio counties and approximately 114,000 individuals. In August 2012, Ohio Medicaid announced the health plans competitively selected to serve the new ICDS regions beginning September 2013.³

- **Provide more accountable care for children with disabilities.** Beginning July 2013, approximately 37,000 Ohio children who are currently served in the Medicaid fee-for-service system will have a choice among five health plans that were competitively selected to serve this population. These children often have long-term, complex conditions but currently receive little assistance in accessing services or with care coordination. In a managed care delivery system, these children will continue to have access to all medically necessary services but also benefit from the availability of a 24/7 nurse advice line, support from member services, and access to care management for children and families who need extra assistance.

Executive Budget Proposal and Impact:

Medicaid managed care enrollment through private-sector health plans is expected to increase 37 percent to 2.3 million by June 2015.⁴ The related economies of scale, combined with efficiency-minded changes described above, are expected to generate significant administrative savings per enrollee, and the Executive Budget proposes to adjust capitation rates accordingly, resulting in total savings of \$646 million (\$239 million state share) over the biennium.

- **Reduce the administrative component of the rate.** Given the maturity of Ohio's Medicaid managed care program and the economies of scale expected to result from increased enrollment, health plan rates will reflect a one percent adjustment in the component of the capitation rate that is driven by projected administrative costs. This provision is expected to save \$140 million (\$52 million state share) over the biennium.
- **Reduce the prescription drug component of the rate.** The Executive Budget will provide health plans with greater flexibility to manage pharmacy costs and make a five percent adjustment in the component of the capitation rate that is driven by projected prescription drug costs. This provision is expected to save \$136 million (\$50 million state share) over the biennium.
- **Cap the overall growth in capitation rates.** The Executive Budget holds the overall growth in capitation claims trend to three percent per year. This provision is expected to save an additional \$370 million (\$137 million state share) over the biennium.

³ Ohio Medicaid, [Ohio's Integrated Care Delivery System Procurement](#) (updated August 27, 2012)

⁴ Ohio Medicaid estimates Medicaid managed care enrollment will increase from 1,641,989 enrollees in December 2012 to 2,250,269 enrollees in June 2015 as a result of Medicaid expansion, woodwork, eligibility simplification, and implementation of an Integrated Care Delivery System for Medicare-Medicaid enrollees.

- ***Link more health plan payments to performance.*** The Executive Budget authorizes Ohio Medicaid to increase up to two percent the amount of health plan payments it withholds pending the plan's ability to demonstrate certain performance outcomes are met. The performance payment withhold will be implemented for both the current children and families program and the new Integrated Care Delivery System (ICDS) for Medicare-Medicaid enrollees. Because the ICDS involves Medicare services, the federal government will have input on the design of ICDS quality incentives. This provision is budget neutral.

Updated January 31, 2013

Office of Health Transformation **Reform Hospital Payments**

Background:

Ohio Medicaid currently uses prospective payment methods developed in the late 1980s to pay for inpatient and outpatient hospital services provided to Medicaid consumers. Prospective payment methods were designed to contain costs, permit providers to operate in a less regulated environment, and allow sharing of savings for those providers who identify ways to provide quality services more efficiently and economically. However, these types of payment methodologies are volume-based and do not have the ability to reward providers for improved outcomes. For these reasons, both inpatient and outpatient hospital reimbursement methodologies need to be revised to support provider reimbursement reforms as a component of Medicaid modernization and movement towards improved outcomes.

Governor Kasich's first budget directed Ohio Medicaid to update its hospital diagnosis-related group (DRG) reimbursement system. Currently, Ohio is using DRG version 15, even though Medicare is on version 30, and more modern versions can assign up to two and a half times as many DRGs as Ohio's system, which allows for more accurate and efficient reimbursement. For example, the current outdated version 15 limited Ohio Medicaid's ability to enforce non-payment for "never events" (e.g., hospital acquired infections) because the system is not granular enough to detect when those events occur. The updated DRG system, which goes into effect in April 2013, is budget neutral statewide, but individual hospitals may gain or lose revenue as a result of the new system. Ohio Medicaid will implement a stop-loss policy to ensure no individual hospital is reduced more than five percent under the new system.

Executive Budget Proposal and Impact:

The Executive Budget includes several provisions that impact hospitals. It reauthorizes temporary assessment programs and supplemental payment programs that would otherwise expire, makes several significant changes in hospital payment policy, and expands Medicaid eligibility to adults with income below 138 percent of the federal poverty level, many of whom might otherwise be a source of uncompensated care for hospitals.

ASSESSMENT PROGRAMS

- ***Hospital franchise permit fee program.*** The Executive budget reauthorizes the hospital franchise permit fee program, which otherwise would sunset June 30, 2013. The budget incorporates the franchise fee allocation methodology developed by the Ohio Hospital Association, which collects \$524 million in annual fees that are used to draw federal funds and make payments back to hospitals totaling \$840 million (Figure 1).

- **Hospital care assurance program.** The Ohio Hospital Care Assurance Program (HCAP) is Ohio's primary means of implementing the federal disproportionate share hospital (DSH) payment program, which provides additional payments to hospitals that provide care to a disproportionate share of indigent patients. Ohio hospitals fund the state share of this program through a provider assessment. Ohio's program sunsets every two years and must be reauthorized. The Executive Budget reauthorizes HCAP until October 2015, which will result in hospitals receiving approximately (depending on federal allotments) \$1.1 billion in DSH payments over the biennium, \$726 million net of HCAP assessments.¹

PAYMENT CHANGES

The Executive Budget makes several Medicaid hospital payment changes that reduce overall hospital spending 3.8 percent in FY 2014 and 7.4 percent in FY 2015 (Figure 1). Over the biennium, the following payment changes save \$500 million (\$185 million state share):

- **Create a children's' hospital quality improvement program.** The Executive Budget redirects the temporary special children's hospital funding that was authorized in the last budget (line item 600-537) to financially support delivery system changes that improve outcomes for children enrolled in Medicaid. Examples include reducing nonemergency use of the emergency room and reducing admissions to neonatal intensive care units. As a result, \$33 million (\$12 million state share) over the biennium will be redirected (the provision is budget neutral) to support payments to children's hospitals for developing programs that achieve specific performance outcomes.
- **Reduce hospital readmissions.** The Executive Budget will limit Medicaid payments to hospitals for readmissions within 30 days by establishing percentage-based benchmarks for readmission reductions. These readmission reductions will be 25 percent of total readmissions based on stays for all non-psychiatric hospitals per fiscal year. Hospitals will be provided with a report that tracks their readmission rates over a seven-year period and will have the responsibility to implement hospital-developed approaches to reducing their readmission rates by 25 percent. Failure to achieve this will result in the state recovering 25 percent of the value of Medicaid payments to the hospital for readmissions from the base year. The base year will be the prior year's readmissions and payments for readmissions. If hospitals meet the benchmark each year, readmissions will be reduced by 44 percent in total and result in substantially fewer program payments for readmissions. This provision is expected to save \$103 million (\$38 million state share) over the biennium. Over the long term, Ohio Medicaid will incorporate "potentially preventable readmissions" and "potentially preventable complications" into the DRG system. These groupers use clinical information from historical claims to determine the appropriateness of paying a current claim if it is related to a readmission.

¹ HCAP payments are projected to be \$577 million in FY 2014 and \$570 million in FY 2015, and assessments are projected to be \$210 million in FY 2014 and \$211 million in FY 2015.

- **Improve direct medical education.** The Executive Budget does not change the current level of Medicaid direct graduate medical education funding – about \$200 million over the biennium – but it does propose to target those funds to support health sector workforce priorities related to primary care and recruiting minorities into health professions. (See also “Coordinate workforce and training programs.”) Today, Medicaid direct medical education payments are made as an add-on to inpatient hospital claims. Beginning July 1, 2014, Medicaid direct medical education payments will be allocated based on rules that will be developed to support: a workforce trained in comprehensive primary care with a commitment to serve all Ohioans; dollars following residents into community practices; primary care placements in recognized patient-centered medical homes; a residency mix that recognizes and supports the needs of Ohio; and strategies that mitigate underserved areas in Ohio. While budget neutral, the opportunity to focus \$200 million over the biennium to positively improve workforce priorities is significant.
- **Eliminate the five-percent rate add-on for inpatient and outpatient services.** The Executive Budget will allow the temporary five percent rate increase for hospitals authorized in the last budget to expire on December 31, 2013. Ohio currently uses franchise fee proceeds to fund the rate add-on. Eliminating the add-on will save \$260 million (\$96 million state share) over the biennium.
- **Reduce the rate taxpayers pay for hospital capital projects.** The budget will reduce inpatient capital rates from 100 percent of cost to 85 percent of cost for both fee-for-service and Medicaid managed care plans. Historically, Medicaid health plans have reimbursed hospitals using the same capital rate as calculated for fee-for-service inpatient capital costs. Beginning January 1, 2012, Ohio Medicaid set specific Medicaid managed care capital rates for hospitals and, as a result of that process, determined that further adjustment to the capital rates is needed to reduce the extent to which Ohio taxpayers subsidize hospital building campaigns through Medicaid. The budget also eliminates fee-for-service capital cost settlement. This provision will save \$58 million (\$21 million state share) over the biennium.
- **Adjust DRG-exempt hospital rates.** Ohio Medicaid currently reimburses hospital services provided by DRG-exempt hospitals at 100 percent of cost, which is higher than what Medicaid pays for other inpatient hospital services through the DRG system. The Executive Budget will adjust reimbursement for DRG-exempt hospitals to pay 90 percent of cost. The budget also eliminates fee-for-service cost settlement. This provision will align reimbursement for DRG-exempt hospitals with Ohio Medicaid’s strategic pricing goals and save \$12 million (\$5 million state share) over the biennium.
- **Control the cost of outpatient services.** The Executive Budget will set fixed prices for all outpatient services currently reimbursed at cost. Ohio Medicaid reimburses most hospitals for outpatient services based on predetermined fee schedules. Although the majority of services have a set reimbursement rate, there are a few services, such as unlisted surgeries, drugs administered with IV therapy, and independently billed drugs

and medical supplies that are reimbursed at cost. This results in large variations in payment for these services. Reimbursement for independently billed drugs and medical supplies will be set at 60 percent of costs, and the hospital laboratory fee schedule will be recalibrated to align payment rates to prescribed Medicare ceilings. These changes will save \$67 million (\$25 million state share) over the biennium.

FEDERAL LAW CHANGES

- ***Extend Medicaid coverage to more low-income Ohioans.*** Extending Medicaid coverage to more adults will convert some otherwise uncompensated care into Medicaid payments. Ohio Medicaid estimates that, as a result of increased enrollment from more currently eligible individuals coming onto the program (woodwork) and Ohio's decision to extend Medicaid coverage to adults with income below 138 percent of poverty, hospitals will receive an additional \$1.6 billion in Medicaid payments over the biennium. Taking into account the net impact of the franchise fee, payment reforms, and new revenue from woodwork and Medicaid expansion populations, overall Medicaid hospital spending increases 15 percent in FY 2014 and 28 percent in FY 2015 (Figure 1).

Figure 1. Executive Budget Medicaid Impact on Hospitals

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

Updated January 31, 2013

Office of Health Transformation

Reform Nursing Facility Payments

Background:

Governor Kasich's first budget (HB 153) enacted several significant reimbursement reforms related to nursing facilities, described below. The Administration's goal is to achieve better health, better care and reduced costs, and create incentives to continuously improve service features and characteristics to meet or exceed customer needs and expectations for quality.

- **Convert Medicaid Nursing Facility Reimbursement to a Price-Based System.** HB 153 completed the transition from a cost-based Medicaid payment system for nursing facilities to a price-based system, a change that was initiated by the legislature in 2005 to reward efficiency. The final budget reduced nursing facility rates 5.8 percent on average in 2012 and saved Ohio taxpayers \$360 million over two years.
- **Reduce Payments for Low Acuity Individuals.** HB 153 modified the method to calculate payments for services provided to the lowest acuity individuals in Ohio's nursing facilities. Instead of using facility-specific rates, all nursing facilities are paid \$130 per day for each of these individuals. This better connects reimbursement to the services needed by these individuals and incents discharge planning to community settings.
- **Link Nursing Facility Reimbursement to Quality Outcomes.** HB 153 also linked more of the Medicaid payment to direct care for residents and quality. It increased Medicaid quality incentive payments for nursing facilities from 1.7 percent of the average Medicaid nursing facility rate in 2011 to 9.7 percent in 2013. A Nursing Facility Quality Measurement Subcommittee was created and achieved consensus recommendations on 20 specific accountability measures, which were enacted by the General Assembly in December 2011 (SB 264).¹ The goal was to create a system that rewards performance on specific quality measures and gives all facilities a fair opportunity to earn the full incentive payment.
- **Integrate Care Delivery for Medicare-Medicaid Enrollees.** HB 153 authorized Ohio Medicaid to seek approval through the federal Center for Medicare and Medicaid Integration (CMMI) to design and implement a Medicare-Medicaid Integrated Care Delivery System (ICDS). Currently Medicaid and Medicare are managed with almost no connection, and services are poorly coordinated. The result is a diminished quality of care, which is reflected in high costs to the Medicaid system and to taxpayers. Ohio's ICDS program will convert separate Medicaid and Medicare fee-for-service programs into an integrated managed care program for Medicare-Medicaid enrollees in seven regions of the state. Under ICDS, nursing facilities and other health care providers will

¹ Ohio Nursing Facility Quality Measurement Subcommittee, [Final Report](#) (September 2011)

contract with health plans to provide long-term services and supports to participating Medicare-Medicaid enrollees. CMMI approved Ohio's ICDS program on December 12, 2012 and Ohioans will begin enrolling in the new program September 1, 2013.

- **Study Medicaid reimbursement for nursing facilities.** In HB 153, the Ohio General Assembly re-established a Unified Long-Term Care System Advisory Workgroup and instructed it to convene a subcommittee to study Medicaid reimbursement for nursing facility services. The Nursing Facility Reimbursement Subcommittee identified guiding principles for payment innovation, reviewed recent payment changes that impact nursing facilities, made recommendations for additional Medicaid fee-for-service reimbursement reforms, and reported findings and recommendations to the Ohio General Assembly in December 2012.²

Executive Budget Proposal and Impact:

In December 2012, the Nursing Facility Reimbursement Subcommittee recommended – and the Kasich Administration agrees – there should be a period of adjustment for HB 153 reforms to stabilize, and significant additional disruptions should be avoided in the next budget. However, this budget includes some modest adjustments to the current Medicaid nursing facility fee-for-service reimbursement system that the Subcommittee recommends implementing to improve system performance. These recommendations are identified in the headings below, with a description about how the Executive Budget acts to operationalize each recommendation.

FEE-FOR-SERVICE PAYMENT CHANGES

- **Update the quality incentive rate component.** The Subcommittee recommends and the Executive Budget includes language to: increase the level of attainment for some of the existing 20 accountability measures, replace others, and leave some the same; require that at least one of the quality points a nursing facility uses to claim its full incentive payment must be a clinical measure; and deny quality points for certain special focus facilities related to certification surveys conducted by the Ohio Department of Health. Otherwise, the Executive Budget keeps the existing nursing facility quality incentive payment program intact. This provision is budget neutral.
- **Provide post-acute rehabilitation in nursing facilities.** Currently, Ohio's nursing homes have significant unused and underutilized capacity. In some cases, these facilities could serve a population that is otherwise served in more expensive rehabilitation hospitals and long-term, acute-care hospitals (LTACHs), including some individuals with traumatic brain injury, some individuals on ventilators who could be weaned, and some individuals in need of intensive rehabilitation services. The average cost to serve these individuals in an LTACH is \$1,388 per patient day compared to \$740 per patient day at the highest rate Medicare pays in nursing facilities for “ultra-high rehabilitation services.”

² Nursing Facility Reimbursement Subcommittee, [Report to the Ohio General Assembly](#) (December 21, 2012).

The Nursing Facility Reimbursement Subcommittee recommends, and the Executive Budget includes, payment changes that prioritize post-acute rehabilitation in nursing facilities, not hospitals. It creates a specialty nursing facility service category in Ohio for individuals who would otherwise be served in rehabilitation hospitals and LTACHs, and authorizes a new ventilator weaning program. With regard to hospital payments, the Executive Budget reduces payments for LTACHs and rehabilitation hospitals from 100 percent of costs to 90 percent of costs.

- **Enhance community mental health benefits.** The Subcommittee recommends and the Executive Budget includes several initiatives to assist nursing home residents under age 60 with mental illness who want to move back into the community. As a group, these initiatives emphasize that recovery requires community, and they make that possible by providing financial assistance during the transition, creating new opportunities for affordable housing and avoiding inappropriate nursing facility placements on the front end of the process. (See “Rebuild community behavioral health system capacity.”)
- **Convert veterans who reside in nursing facilities to federal benefits.** The Subcommittee recommends identifying veterans who currently reside in nursing homes on Medicaid and connecting them to federal veterans’ benefits without uprooting them from their current residences. On January 29, 2013, the Office of Health Transformation approved \$260,000 for a pilot project to identify veterans on Medicaid and connect them to VA benefits. The pilot is not written into the budget, but has the potential to save money every time a veteran who currently receives Medicaid services (36 percent paid by Ohio) converts to veterans services (100 percent paid by the federal government).
- **Consider some modifications in the base rate methodology.** The Executive Budget maintains the current nursing facility rate structure, including historic price growth (without any additional increases) and continues flat pricing for low acuity individuals. However, the Budget proposes three changes in the current methodology: (1) reclassify Stark and Mahoning Counties from rural (peer group 3) to urban (peer group two) for the purposes of rate setting; (2) shift the determination of the facility-specific leave day pricing percentage to a fiscal year to eliminate the need for retroactive adjustments; and (3) extend the current five-percent rate boost to “critical access” nursing facilities in federally designated empowerment zones that meet minimum occupancy and Medicaid utilization requirements, but with an additional requirement that they earn the maximum quality incentive payment and at least one clinical quality point to qualify for the critical access rate add-on. The peer group change costs \$40 million (\$15 million state share) over the biennium and generates \$4 million in franchise fee revenue.

OTHER RELATED INITIATIVES

In addition to reimbursement, the Nursing Facility Reimbursement Subcommittee recommends, and the Administration agrees, the state should align other regulatory and programmatic incentives to ensure that Ohioans have access to the long-term services and

supports they need in the settings they choose. Some of these recommendations impact home and community based services (see also, “Prioritize home and community based services”). The list below includes the recommendations that specifically impact nursing homes.

- **Clarify definitions for facilities that specialize in care.** The Subcommittee recommends, and the Executive Budget requires, the Ohio Department of Aging (ODA) to update the Ohio Long-Term Care (LTC) Consumer Guide to be more accurate in its description of specialized facilities. Currently there are no requirements for nursing facilities that self-identify as “specializing” in care for specific diagnoses or conditions. ODA will define the services featured in the LTC Consumer Guide and create an online attestation for facilities that claim a specialization.
- **Strengthen the survey process through plans of correction.** The Subcommittee recommends, and the Executive Budget includes, provisions to clarify existing requirements for plans of correction to ensure alignment with current federal requirements and to emphasize the need to focus on the reason for the failure to provide quality services. Plans of correction for all deficiencies that resulted in harm to individuals or immediate jeopardy will be more detailed and focus on an examination of the underlying cause(s) of the poor quality care. In addition, the Ohio Department of Health, which oversees plans of correction, will consult with the Ohio Department of Aging, the State of Ohio Long-term Care Ombudsman, and Ohio Medicaid in reviewing plans of correction for deficiencies where harm to residents occurred or an immediate jeopardy resulted. This incorporates the interagency approach to administering programs providing long-term services and supports in the regulatory framework and brings multiple perspectives to the process, ensuring more effective identification of opportunities for quality improvement, including access to state resources that may provide technical assistance in addressing the root cause of the poor quality care.
- **Update nursing facility licensure requirements.** Currently, there are no requirements within state nursing facility licensure to improve quality. The Subcommittee recommends, and the Executive Budget requires, nursing facilities to demonstrate during licensure inspections that they are engaged in at least one quality improvement project from a list maintained by the Ohio Department of Aging. Also, beginning in state fiscal year 2016, the Executive Budget moves two current quality incentive payment measures (“prohibit the use of overhead paging systems” and “ensure advance care planning for all residents”) onto the list of licensure requirements.
- **Consider additional regulatory relief.** The Subcommittee recommends, and the Administration agrees, to consider additional reforms throughout the budget process, much as it did during consideration of HB 153, which in that case led to the enactment of 16 significant items of common sense regulatory relief.

ADMINISTRATION INITIATIVES

The Executive Budget also includes the following provisions that are recommended by the Administration but not included in the Nursing Facility Reimbursement Subcommittee report.

- ***Automatically update the nursing facility franchise fee.*** The Executive Budget modifies the method that is used to calculate the nursing facility franchise permit fee assessment rate. In place of actual fee amounts, which have to be recalculated based on projected net patient revenue each biennium and amended to statute to reflect revised rates, the Executive Budget requires the franchise fee per bed per day assessment amount to be calculated each year at the maximum percentage allowed by federal law (not to exceed six percent), eliminating the need for routine biennial budget amendments.
- ***Remove custom wheelchairs from the nursing facility rate.*** The Executive Budget defines custom wheelchairs and removes custom wheelchairs from the calculation of the nursing facility per diem (the per diem is reduced 32 cents). The budget also gives Medicaid the authority to use alternative purchasing models for custom wheelchairs, including selective contracting, competitive bidding, or a manufacturer's rebate program. This combination of changes will ensure that individuals in nursing facilities have access to medically necessary custom wheelchairs while giving Medicaid the tools to effectively manage utilization and expenditures.
- ***Streamline the claims review process.*** Program integrity activities related to nursing facilities focus on accurate billings and payment and the quality of the services purchased. The Executive Budget aligns the Medicaid claims review process for nursing facilities with that applied to other provider types, streamlining the process and allowing nursing homes and Ohio Medicaid to resolve payment issues more quickly.
- ***Terminate special focus facilities.*** The Executive Budget authorizes Ohio Medicaid to terminate the Medicaid provider agreement of nursing facilities with a history of providing poor quality care without improvement. The federal government operates a Special Focus Facility Program that identifies facilities with more deficiencies than most facilities, more serious deficiencies, and a pattern of serious deficiencies. They publish a list monthly identifying those facilities newly added to the list, those that remain on the list without improving, those that remain on the list but are improving, and those that recently graduated from the list. The budget gives Ohio Medicaid another tool to ensure the quality of long-term services and supports in Ohio by terminating the provider agreement of a facility that either fails to improve within 12 months of being placed on the list or fails to graduate from the list within 24 months of being placed on the list.

Updated January 31, 2013

Office of Health Transformation **Reform Other Provider Payments**

Executive Budget Proposal and Impact:

The Executive Budget makes other provider payment changes that save \$165 million (\$61 million state share) over the biennium. These savings are in addition to changes described separately for health plans, hospitals, nursing facilities, and home and community based long-term services and supports.

PHYSICIAN

- **Primary care rate increase.** The federal government requires states to raise Medicaid fees at least to Medicare levels for family physicians, internists and pediatricians for many primary care services. Physicians in both fee-for-service and managed care will get the enhanced rates. In Ohio, primary care physicians will see their Medicaid payments increase 82 percent on January 1, 2013, and receive an estimated \$700 million more in Medicaid payments over the two-year period ending December 31, 2014, all of which is paid for by the federal government. The physician fee increase does not appear as an additional state share cost in the Executive Budget.
- **Physician services.** Currently, Medicaid reimburses physicians, advanced practice nurses and physician assistants the same amount for some services, regardless of where the service is delivered. The expenses actually incurred by the provider, however, vary depending on the site of the service. The provider bears the full practice expense for services performed in the office setting, but not in hospitals, ambulatory surgery centers, and nursing facilities – these facilities bill the practice expense separately. Medicaid currently enforces “site differential payments” when some services are performed in a hospital. The Executive Budget extends site differential pricing to a greater number of settings and a broader array of covered services, consistent with federal Medicare policy. This provision will save \$12.2 million (\$4.5 million state share) over the biennium.
- **Close payment loopholes.** Since 1992, the Holzer Clinic has been reimbursed at 140 percent of the Medicaid physician fee schedule. The enhanced reimbursement was originally considered appropriate because the Holzer Hospital did not provide outpatient hospital services, and the enhanced payment approximated what the total payment amount would have been had claims for service been billed by both the hospital and the physician group practice. The enhanced rate supported one rural clinic, but over time the Holzer Clinic expanded to ten new delivery sites and expansion continues, with every new site receiving enhanced reimbursement. Continuance of this payment methodology and the competitive advantage it provides cannot be justified in the current environment – no other physician group besides Holzer has ever qualified

for this payment methodology since it was implemented. The Executive Budget eliminates the enhanced reimbursement rate for the Holzer Clinic Network and reverts payment to the standard Medicaid physician fee schedule beginning January 1, 2014. This provision will save \$3.0 million (\$1.1 million state share) over the biennium.

- **Radiology.** Currently, Medicaid reimburses imaging services the same amount, regardless of whether single or multiple procedures are performed at the same session. The practice expense cost of providing multiple procedures to the same patient at the same time is less than the cost of providing these same procedures individually at different times to different patients. In recognition of this practice expense differential and consistent with federal Medicare policy, the Executive Budget reduces reimbursement amounts for physician offices and independent diagnostic testing facilities when two or more imaging procedures are performed by the same provider on the same patient on the same day. Full reimbursement is made for the imaging procedure with the highest reimbursement rate, but reimbursement for the technical component of the second and each subsequent procedure is reduced by 50 percent. This provision will save \$5.0 million (\$1.9 million state share) over the biennium.

PHARMACY

- **Specialty pharmacy.** The Executive Budget will add a pharmacist to Ohio Medicaid to monitor utilization and implement cost containment strategies related to specialty pharmaceuticals, which include high-cost biological medications – \$34,500 per person per year on average – for serious chronic conditions such as hemophilia, cancer, and rheumatoid arthritis. Appropriate use of these products can slow or halt disease progression, preventing further disability and other medical costs. Specialty pharmacies that dispense these drugs can provide additional clinical and administrative support to ensure the drugs are used at the proper point in therapy, administered in the best setting, and used consistently and correctly by the patient. The Executive Budget gives Ohio Medicaid the tools it needs to work with specialty pharmacies to contain costs, including contracting with a limited number of pharmacies to ensure high quality service and clinical support or implementing minimum standards that current participating specialty pharmacies must follow. This provision will save \$4.8 million (\$1.8 million state share) over the biennium.
- **E-prescribing.** The Executive Budget provides resources to contract with a private sector vendor to update connections between the Medicaid pharmacy claims system and eligibility files to e-prescribing applications. By providing claims history to Medicaid providers, the prescriber can quickly find out what prescriptions the patient has filled to ensure that duplicative therapy and drug interactions can be avoided. Providing drug coverage information through the e-prescribing application will enable the prescriber to choose a medication that is covered without prior authorization so there is no delay in the patient beginning therapy. The resulting efficiency and improved quality in prescribing will save \$2.2 million (\$814,000 million state share) over the biennium.

- **Improve survey compliance.** Since 1986, the federal government has required states to conduct a survey of pharmacy cost of dispensing biennially. However, there is no requirement that pharmacy providers participate. Many pharmacies, particularly chain pharmacies, have said they only participate in surveys that are required by law. The 2011 survey had a 17 percent response rate. The information from the survey is important for any future changes in dispensing fees the state wants to consider, so the budget makes participation a requirement in law. This provision is budget neutral.

MEDICARE PART B

- **Cost sharing.** For consumers enrolled in Medicaid and Medicare, states have the option to pay the patient's Medicare cost sharing amount (typically 20 percent) or reimburse up to the Medicaid maximum amount. Ohio has elected to only reimburse up to the Medicaid maximum for institutional categories of services and for services paid by a Medicare Advantage plan. However, there is an exemption for dialysis clinics and non-institutional providers. These providers are paid the full Medicare cost sharing, which can result in the provider being paid more than the Medicaid maximum amount. The Executive Budget authorizes Ohio Medicaid to reimburse only up to the Medicaid maximum for all remaining Part B categories of service, not including physician services. This provision will save \$97.2 million (\$35.9 million state share) from non-institutional services and \$40.0 million (\$14.8 million state share) from dialysis clinics over the biennium.

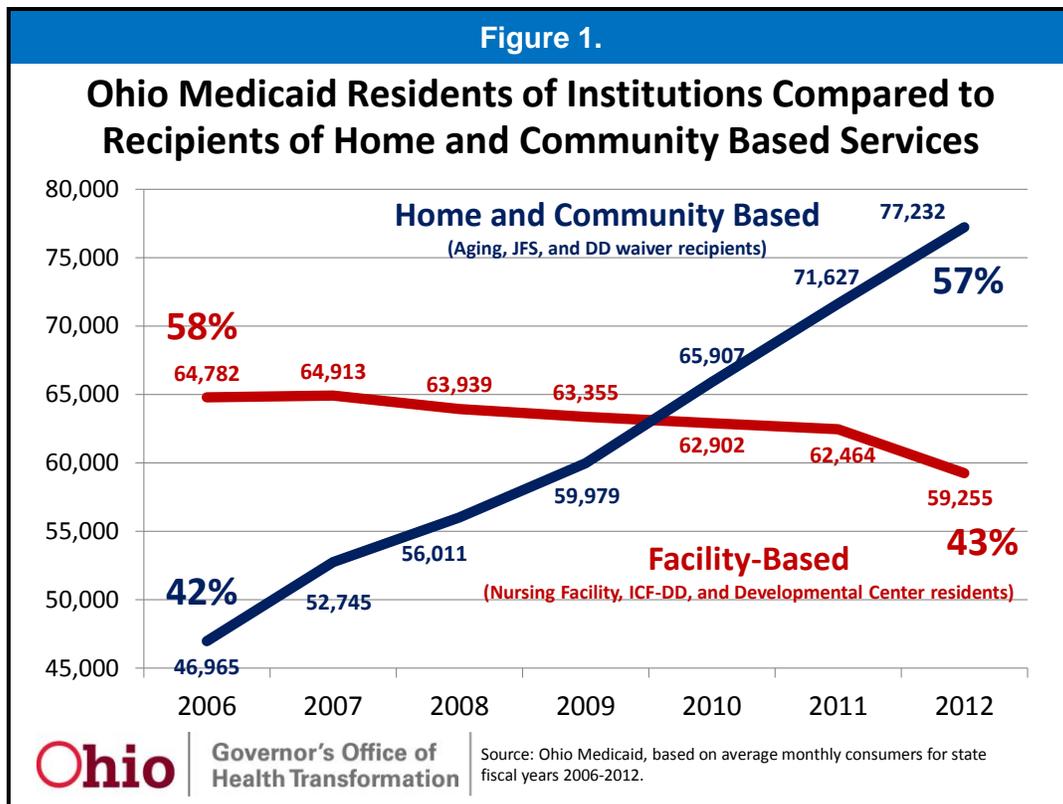
Updated January 31, 2013

Office of Health Transformation Prioritize Home and Community Based Services

Background:

When Governor Kasich took office, Ohio was spending more of its Medicaid budget on high-cost nursing homes and other institutions than all but five states, and Ohio taxpayers were spending 47 percent more for Medicaid long-term care than taxpayers in other states. The Governor’s Office of Health Transformation is working to “rebalance” Medicaid spending toward less expensive home and community based long-term services and supports. The ultimate goal is for Ohio seniors and people with disabilities to live with dignity in the setting they prefer, especially their own home, instead of a higher-cost setting like a nursing home.

Governor Kasich’s first budget increased spending on home- and community based services for seniors and people with disabilities \$200 million over two years. As a result, an additional 7,600 Ohioans will receive Medicaid long-term care in their own home or community setting. This continues a trend that, over the past six years, reversed the proportion of residents in institutions compared to recipients of home and community based services – from 58 percent institutional in 2006 to 57 percent home and community based in 2012 (Figure 1).



Despite significant gains, barriers to rebalancing the system remain. Potentially eligible consumers and their families must navigate multiple state systems (addiction services, aging, job and family services, developmental disabilities, Medicaid, mental health), local systems (area agencies on aging, county job and family services, and county boards of developmental disabilities and mental health and addiction services) and program options (including nine separate Medicaid home and community based services programs¹). Ohio's new Integrated Care Delivery System will make it easier to navigate these programs for Medicare-Medicaid enrollees, but more must be done to benefit everyone.

Executive Budget Proposal and Impact:

The Executive Budget increases Medicaid payments related to home and community based long-term services and supports by \$30.8 million (\$11.4 million state share) over the biennium. It also aligns other related initiatives to ensure Ohioans have access to services in the settings they prefer, and to provide better care while also reducing costs.

MEDICAID PAYMENT CHANGES

- ***Increase rates for aide and nursing services.*** The Executive Budget increases aggregate spending for Medicaid aide and nursing services three percent in SFY 2015. The increase will take into account labor market data, education and licensure status of providers, whether providers are independent or home health agencies, and the length of time of service visits. As part of the rate design, Ohio Medicaid will create incentives to improve the quality of clinical care by paying in a way that better assures appropriate involvement of registered nurses when licensed practical nurses are providing care. This provision costs \$23.0 million (\$8.5 million state share) over the biennium.
- ***Increase rates for adult day care and assisted living.*** In the continuum of long-term services and supports, adult day services and assisted living serve a critical function for individuals who choose not to receive care in a nursing facility. The demand for these programs is increasing but, absent a rate increase, the supply of providers is likely to decrease, particularly in adult day services. The Executive Budget increases adult day services rates 20 percent in the Ohio Department of Aging's PASSPORT and Choices programs to mirror the current rate in Medicaid's Home Care Waiver (\$49.47 for an enhanced full day and \$64.94 for an intensive full day). The Budget increases assisted living rates three percent (to \$49.93 for the first tier, \$59.95 for the second tier, and \$69.96 for the third tier). These provisions cost \$5.4 million (\$2.0 million state share) over the biennium. The budget also requires Ohio Medicaid and the Department of Aging to study and potentially overhaul the assisted living reimbursement structure.
- ***Make changes in patient liability.*** Nursing facility residents are required to contribute to their nursing facility costs, but may retain an amount of their personal funds for items not covered by Medicaid, such as clothing, personal items, and newspapers. The current

¹ Ohio HCBS Programs: <http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=4tMQIFzWt8k%3d&tabid=125>

personal needs allowance, \$40 per month, has not been increased or adjusted since 1997. The Executive Budget increases the personal needs allowance to \$45 per month in calendar year 2014 and \$50 per month in calendar year 2015. This provision costs \$6.4 million (\$2.3 million state share) over the biennium.

- **Limit the daily rate for a caregiver living with a consumer.** It is not uncommon for a provider to be a relative or live-in friend of a consumer receiving services in their home or community setting. Operational and administrative expenses for a provider living with a consumer are lower than other providers of similar services. This initiative establishes a unique daily rate for a caregiver living with a consumer rather than reimburse such a provider on individual hourly or quarter-hourly rates. This provision saves \$1.0 million (\$370,000 state share) over the biennium.
- **Implement a shared savings initiative for home health.** In late 2010, the Ohio Council for Home Care and Hospice began a campaign to reduce avoidable hospitalizations, and participating agencies demonstrated they were able to reduce hospitalizations. Ohio Medicaid estimates that as much as 12 percent of the cost of hospital care provided to non-dual eligible recipients of home and community based services (HCBS) and other Medicaid home health benefits may be avoidable. Based on this evidence, the Executive Budget authorizes Ohio Medicaid to implement a quality incentive program to reduce the number of avoidable admissions to hospitals or nursing facilities of individuals who receive HCBS waiver services and other Medicaid home health benefits. The incentive program will save \$6 million over two years and allow Ohio Medicaid to distribute 50 percent of the savings back to participating providers, for net savings of \$3.0 million (\$1.1 million state share) over the biennium.

OTHER RELATED INITIATIVES²

- **Join the Balancing Incentive Program.** The Balancing Incentive Program provides federal grants to states that make structural reforms to increase nursing home diversions and access to non-institutional long-term services and supports.³ To qualify, states must implement structural changes – including a “no wrong door” single entry point, standardized assessment instruments, and conflict-free case management – and commit to spend at least 50 percent of the state’s Medicaid long-term care budget on non-institutional services by 2015. States that make this commitment are eligible immediately for enhanced federal matching assistance percentage (FMAP) for non-institutional Medicaid long-term care. Ohio is eligible to receive two percent enhanced FMAP based on its current mix of spending. The Executive Budget appropriates \$20 million state share over the biennium to make the structural changes necessary to qualify Ohio for \$140 million in enhanced match, freeing up the same amount of state funds to reinvest in Medicaid. As a result, Ohioans will be able to access home and

² Nursing Facility Reimbursement Subcommittee, [Report to the Ohio General Assembly](#) (December 21, 2012).

³ Balancing Incentive Payment Program Website: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html>

community based services more easily, the process of rebalancing the system will accelerate, and taxpayers will save \$120 million state share over the biennium.

- **Ensure core competencies in the direct care workforce.** Currently, no standardized certification program exists for direct care workers providing care in the homes and residences of consumers receiving home and community based services reimbursed by Medicaid. While many of these workers are employed by agencies, many others provide these services as independent providers. These services are provided across all the aging and disability Medicaid waiver programs and in home health state plan services. Given the anticipated increasing demand for home and community based services, it is important to assure that direct care workers providing home and community based services in the homes and residences of consumers are trained, tested, and certified in the core competencies necessary to provide these services.

The Executive Budget will include Medicaid requirements for direct care services in consumers' homes and residences. Permanent law changes will: (1) define direct care workers; (2) require the directors of the Ohio Departments of Aging, Developmental Disabilities, Health, Medicaid, and Mental Health and Addiction Services to document the manner in which each department determines that direct care workers in programs administered by their respective agencies demonstrate core competencies to provide direct care services in consumers' homes and residences; (3) provide the option for each agency director to choose to establish requirements for direct care worker certification through a program developed and administered by the Ohio Department of Health; and (4) establish requirements for the operation of the certification program at ODH.

- **Modernize the Board of Examiners of Nursing Home Administrators.** The Ohio Board of Examiners of Nursing Home Administrators (BENHA) was created in response to the federal mandate that established licensure of nursing home administrators through state licensing authority. The structure and role of BENHA have changed little over the last 42 years despite dramatic change in how long-term services and supports are provided. Services and care are now provided in many different settings throughout the community. The emphasis of the administrator has shifted from a facility focus to enhancing quality of care and quality of life for individuals through person-centered care and caring. The Executive Budget renames BENHA the "Board of Executives of Long-Term Services and Supports," transfers the board from ODH to the Ohio Department of Aging, and expands its scope and authority to provide education, training, credentialing and, if directed to do so by the Ohio General Assembly, licensure opportunities for administrators and others in leadership positions who practice in all LTSS settings.

Updated January 31, 2013

Office of Health Transformation **Rebuild Community Behavioral Health System Capacity**

Background:

When Governor Kasich took office, Ohio's publicly funded system of mental health and addiction services was in turmoil. Significant cuts in state support for mental health and addiction services paired with increased demand for services in a period of economic recession significantly limited access to individuals in need of treatment. Governor Kasich's Jobs Budget increased state funding for mental health by 5.7 percent (\$26.8 million) over two years, reversing a downward trend since 2008 in which state funding was reduced nearly 20 percent (\$112.4 million). This allowed the state to hold all-funds spending for mental health close to 2011 levels, which were inflated that year with \$32.6 million in one-time federal stimulus funds.

During the past two years, Governor Kasich has taken several bold steps to stabilize Ohio's behavioral health funding and services structure:

- ***Free local systems from Medicaid match responsibilities.*** In the Governor's first budget, the state took responsibility for the non-federal share of Medicaid costs for mental health and addiction services. This action created a more sustainable financial future for local systems, some of which had been forced to eliminate most or all services that were not Medicaid-related in order to pay the growing cost of Medicaid within their community. As a result, local Alcohol, Drug Addiction and Mental Health (ADAMH) boards are able to direct any future resources which may become available through state appropriation or local levies to critical unmet needs, including access to housing, family respite, and peer or employment supports.
- ***Create Medicaid health homes for people with severe mental illness.*** Ohioans with mental illness represent about 10 percent of Ohio's Medicaid population but 26 percent of all Medicaid spending. In addition to serious and persistent mental illness (SPMI), these individuals commonly experience serious physical health conditions related to mental illness. Governor Kasich's first budget authorized Ohio Medicaid to design a person-centered system of care—called a "health home"—to improve care coordination for the SPMI population. Medicaid health homes aim to break down the silos that exist between physical health care benefits and providers and behavioral health services and funding streams. This is accomplished by offering comprehensive medical, behavioral, long-term care and social services that are timely, of high quality, integrated and coordinated by a core team of multidisciplinary professionals. Approximately 14,000 Ohioans are enrolled in the first phase of health home service availability.

- **Targeted investments to restore community mental health system capacity.** Governor Kasich has provided seed money to encourage local communities to pool their resources to address “hot spots” they have in common, and develop or restore services that would have been impossible if a single community acted alone. Examples include procuring access to telemedicine technology for psychiatry or other services that are in short supply locally, transitional housing for young adults, and additional crisis beds that can be shared among numerous county board jurisdictions to reduce the need for inpatient hospitalization whenever possible.
- **Consolidate mental health and addiction services.** During fiscal year 2012, the Ohio Department of Mental Health (ODMH) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) began to share specific administrative resources and eliminate duplication across departmental boundaries. The success of these early efforts resulted in Governor Kasich’s decision to consolidate the two agencies effective July 2013. The administrative savings that result from consolidation (\$1.5 million annually) will be reinvested in community services for individuals with mental illness and/or addiction disorders. (See also, “Consolidate mental health and addiction services.”)

Executive Budget Proposal and Impact:

The Executive Budget includes the most significant changes in community mental health and addiction services in decades. After years of erosion, it represents a genuine opportunity to restore prevention, early intervention and treatment capacity. The result has been a paradigm shift for Ohio’s system of behavioral health system that will enable greater integration with physical health care and transform care to have an outcome based, person-centered focus. Examples of this important shift include:

REBUILD COMMUNITY BEHAVIORAL HEALTH CAPACITY

- **Expand Medicaid and redirect existing resources to address recovery support gaps.** In Ohio, the state and 53 local boards partner to fund the safety net system for addiction and mental health services. This safety net exists for a wide variety of Ohioans, including but not limited to: childless adults who are struggling with substance use challenges that complicate their ability to work; people who have experienced significant trauma in childhood but, as adults, lack health care coverage necessary to access treatment; parents in families between 90 percent and 138 percent of the federal poverty level; and adults or children of any age who live with mental illness and/or addiction and lack access to treatment. Today, services for these individuals are funded 100 percent by state and local resources *to the extent that resources are available*. In many Ohio communities, basic behavioral health needs are unaddressed because there is a lack of funding and system capacity. Waiting lists are commonly weeks or months long, leading to crisis situations for individuals and families that could otherwise be avoided. People

in rural areas may have to travel hours in order to access basic services. This safety net is fragile at best, and the need for a sustainability plan has never been greater.

Governor Kasich's decision to expand Medicaid will have a direct benefit on Ohio's behavioral health system. Most uninsured Ohioans who receive services from county boards of mental health and addiction services will become eligible for Medicaid under the expansion. Once these newly eligible Ohioans are enrolled, Medicaid coverage for clinical services¹ will free up an estimated \$70 million annually statewide in county levy or state subsidy dollars – funds previously spent on these same services but without Medicaid or any other payer source. Now these funds can be spent on other recovery-oriented priorities such as housing and employment supports. Currently in most Ohio communities, there are insufficient resources to meet these basic needs, which are not part of the Medicaid benefit. By expanding Medicaid, local communities will, over time, be able to redirect existing state subsidy and local resources (as available) to fill gaps in the local service continuum, reduce waiting lists, place a greater emphasis on wellness and prevention, and improve overall health outcomes within the community.

- ***Make further targeted investments in community mental health.*** As described earlier, the consolidation of ODADAS and ODMH is anticipated to save Ohio taxpayers \$1.5 million annually, all of which is being redirected to a new Community Innovations program. The new Ohio Department of Mental Health and Addiction Services (MHAS) will use these resources to invest in targeted demonstrations that collaborate with partners and result in savings for other parts of government. Over the next two years, MHAS will focus on partnerships with the criminal justice system. Since April 2012, the MHAS and the Ohio Department of Rehabilitation and Correction have been meeting with the Buckeye State Sheriffs Association to develop a shared work plan to assist inmates with mental health and addiction challenges and reduce costs in jails. As a result of this work, specific demonstrations in 2014 and 2015 will provide inmate assessments, connection with effective treatment, and meaningful planning in advance of release to reduce recidivism and help support safety within Ohio's jails. It is anticipated that these efforts will improve client outcomes and help local jails to manage their health care costs.
- ***Finalize the consolidation of mental health and addiction services.*** Statutory changes will formally complete the consolidation of mental health and addiction services. As of July 1, 2013, the new department will promote a combined system of care that is centered on the best outcomes for the individual who needs care. (See also, "Consolidate mental health and addiction services.")

¹ Clinical services included within Ohio's community Medicaid behavioral health benefit include assessment, individual/group counseling, ambulatory detoxification, crisis intervention, intensive outpatient, partial hospitalization, pharmacologic management, laboratory urinalysis and several other services.

RECOVERY REQUIRES COMMUNITY

- **Assist nursing home residents who want to move back into the community.** The Executive Budget includes several initiatives – called *Recovery Requires Community* – to assist nursing home residents under age 60 who have a primary diagnosis related to mental illness who want to move back into the community. On average, Ohio Medicaid spends \$102,500 per year for Medicaid services in a nursing home for an individual under age 60 who is reasonably physically healthy but has a diagnosis related to severe and persistent mental illness. Many of these individuals could be served in less restrictive, clinically appropriate settings at lower taxpayer expense. Based on an analysis of more than four hundred successful HOME Choice placements in 2011, Ohio Medicaid and the Ohio Department of Mental Health estimate the average cost avoided by moving one of these individuals into a community based setting was approximately \$35,250 per year.² By proactively shifting funds to community based services, the state can achieve significant long-term savings to get more people out of nursing homes and into the settings they prefer.
- **Allow money to follow the person from a nursing home into the community.** The Executive Budget authorizes the MHAS, working with community partners and the Ohio Department of Medicaid, to assist 1,200 nursing home residents under age 60 with mental illness who want to live in the community. For each Medicaid beneficiary who makes the transition, the Executive Budget authorizes Medicaid to transfer the state share of the savings that otherwise would have been spent on nursing home costs to MHAS so a portion of the money can “follow the person” into a community service setting. MHAS plans to assist in the transition of at least 500 residents in the first year and 700 in the second, which will save \$9.2 million (\$3.3 million state share) in FY 2014 and \$34.7 million (\$12.7 million state share) in FY 2015. In addition, the budget provides \$1 million over the biennium for MHAS to pilot a similar program, called Access Success II, for individuals who are not Medicaid eligible and/or reside in institutional settings that are not reimbursed by Medicaid (for example, state psychiatric hospitals).
- **Increase access to safe and affordable housing.** Safe housing is critical for an individual who wants to reestablish community living, but often not affordable, particularly for persons with severe mental illness. The Executive Budget continues funding for the existing Ohio Residential State Supplement (RSS) program, which provides a monthly cash supplement to assist low income adults who have a disability and/or are over age 60 and want to exit a nursing home. The Budget also creates a new housing voucher program from a portion of the savings that result from moving more residents out of nursing homes. The new program, which is more flexible than RSS, will prioritize

² Helping Ohioans Move Expands Choice (HOME Choice) is a Medicaid program that provides a \$2,000 one-time stipend to assist seniors and people with disabilities move from nursing homes and other long-term care facilities into their own homes or community-based settings. The stipend can be used to cover the first month’s rent, previous bills, transportation and other expenses associated with reestablishing a person in the community.

individuals with mental illness and other disabilities who are living in an institutional housing, substandard housing, or are homeless but not eligible for the RSS program. The new voucher program, called Recovery Requires Housing, is set at an amount that ensures the participating tenant does not pay more than 30 percent of his or her income on rent. The voucher may be used for independent housing or in a group home that meets the Housing and Urban Development (HUD) definition of a licensed facility.

- **Improve care coordination in adult care facilities.** The current rate for adult care facilities (ACFs) has remained unchanged for many years (\$16 to \$28 per day depending on the kind of subsidy a resident receives). MHAS will use a portion of the savings that result from moving more residents out of nursing homes to enhance the rate for ACFs that connect residents to a Medicaid health home and appropriate case management. The enhanced rate will help stabilize housing options for residents of nursing homes who want to move into the community and others, particularly in cases that RSS is not available.
- **Reduce inappropriate admissions into nursing homes.** Current law allows an individual to move from a hospital into a nursing facility without a Preadmission Screening and Resident Review (PASRR) assessment to determine if the person meets criteria for a nursing home stay. The Executive Budget requires that residents of facilities licensed or operated by MHAS (psychiatric hospitals or units) be assessed before being admitted to a nursing facility. This does not mean a person cannot be admitted to a nursing home from a psychiatric hospital; rather, that an assessment must be conducted before an individual leaves a psychiatric hospital and moves to a nursing facility. Combined with the support for community housing described above, this proposal creates a powerful opportunity to properly direct individuals to community settings when exiting psychiatric treatment instead of improperly placing that person in a nursing facility.

Updated January 31, 2013

Office of Health Transformation **Enhance Community Developmental Disabilities Services**

Background:

In 2001, Ohio took historic steps that dramatically improved the availability and quality of home and community based services as an alternative to institutions for people with developmental disabilities. This was a profound change from the days when institutions were the only option.

Working together, consumers and advocates, county boards, private providers and the State of Ohio agreed on a developmental disabilities system redesign that enabled thousands more people to live and work in the community, instead of institutions. Redesign leveraged local levy dollars for use as Medicaid match, enabling an incredible growth in home and community based services (HCBS) with little additional state funding. As a result, thousands more Ohioans with developmental disabilities live and work in the community.

Governor Kasich's first budget continued the system transformation that began in 2001, and gave the Ohio Department of Developmental Disabilities (DODD) more authority to design and control programs that allow people with disabilities to move seamlessly from one setting of care to another. It moved two programs from Ohio Medicaid to DODD: intermediate care facilities for individuals with intellectual disabilities (ICF/IID) and Transitions/Developmental Disabilities Home and Community Based Services (HCBS) waivers. It authorized DODD to implement additional services under the Individual Options (IO) waiver program and create a new participant-directed self-empowered life funding (SELF) waiver program. The budget also continued the process of downsizing state-operated institutions and transitioning more individuals from ICF/IIDs into other community settings.

Today, nearly 30,000 individuals with developmental disabilities receive HCBS waiver services, with federal funds supporting two-thirds of the costs. Approximately 1,000 people reside in Ohio's state-operated institutions – compared to 10,000 residents in 1963. Another 50,000 individuals are receiving services using state and local funding, some of which is only available because of being able to earn federal reimbursement for home and community based services. In addition, with changes in policy and support structures, more and more individuals with developmental disabilities will have the opportunity to work, enriching the quality of their lives and the communities where they live.

Despite significant progress, challenges remain. For example, Ohio has more people living in large *private* facilities (greater than 16 beds) than any state in the nation, and Ohio ranks seventh in *public* ICF/IIDs. Some of the individuals living in these facilities are also on waiting lists for HCBS waiver services and would prefer to live in home and community based settings. Also, despite progress in community employment for individuals with developmental disabilities, Ohio is overly reliant on sheltered workshops as its main employment service.

Executive Budget Proposal and Impact:

The Executive Budget promotes further downsizing for large ICF/IIDs, the conversion of ICF/IID funded beds to home and community based waiver settings, an emphasis on supported employment, and an increase in autism services. Specifically, the budget authorizes DODD to:

- ***Set a flat rate for residents of institutions who are less profoundly disabled.*** The Executive Budget authorizes Ohio Medicaid to pay a flat rate for all individuals residing in an ICF/IID who are in the “typical adaptive needs and non-significant behaviors” classification of residents, which means they are less profoundly disabled than other residents. By prescribing a flat rate to be paid for the least resource-intensive individuals, this provision allows funds to flow to those most in need, support downsizing and conversion, and encourages facilities to actively consider the opportunity for those individuals with less profound needs to receive home and community based services instead of receiving services in an institution. (This policy parallels a similar program adopted in the Governor’s first budget that set a flat rate for the lowest-acuity residents in skilled nursing facilities.)
- ***Provide a financial incentive to convert institutional beds into HCBS waiver services.*** The Executive Budget authorizes DODD to create a payment incentive for ICF/IIDs to downsize or convert to smaller facilities. It allows DODD to redirect resources to support larger facilities that downsize to smaller ICF/IIDs and any facility that converts ICF/IID licensed beds to home and community based services. This change reflects the goal of improving the quality of service while connecting resources to the appropriate level of need.
- ***Increase rates for providers serving former residents of institutions.*** The Executive Budget permanently extends a temporary \$2.08 per hour rate increase that was enacted in the Mid-Biennium Review for HCBS waiver providers if the individual they are serving was a resident of a public hospital, developmental center, or converted ICF/IID facility immediately prior to enrollment in the waiver. This change extends the financial incentive to provide individualized service packages as an alternative to institutions.
- ***Support Employment First.*** In 2012, Governor Kasich issued an Executive Order making community employment the preferred outcome for working-age adults with developmental disabilities. The Executive Order created the Employment First Task Force that has reviewed policies and programs and made recommendations for increasing community employment opportunities in Ohio. The mid-biennium budget review (MBR) required all state agencies with connections to DD services and programs to align policies for supporting community employment, and required Individual Education Plans for youth with DD to include strategies for preparing for community

employment.¹ The Executive Budget authorizes additional strategies to eliminate barriers to employment. It improves data collection, makes permanent the Governor's Employment First Taskforce, and creates a presumption that all individuals with developmental disabilities can work unless determined otherwise, encourages local county boards to create Employment First policies, and creates a new Employment First line item in DODD to fund these efforts.

- **Increase access to autism services.** Governor Kasich also took steps to improve services for individuals with autism spectrum disorder (ASD). He authorized DODD to launch a new autism diagnostic education project to train pediatricians to correctly identify the early signs of autism, approved funding to train professionals serving infants and toddlers in a play-based approach that nurtures the critical early parent/child relationship,² and most significantly required autism services to be covered as an essential health insurance benefit in Ohio.³ As a package, these decisions create a continuum of services for families – from early detection and services, to employment and health coverage. The Executive Budget includes \$100,000 for the Ohio Center for Autism and Low Incidence (OCALI) to continue providing technical assistance to the Interagency Workgroup on Autism (IWGA) as state agencies work to coordinate autism services throughout the lifespan of an individual.

Updated January 31, 2013

¹ [Improve Job Opportunities for Individuals with Developmental Disabilities](#) (March 2012)

² [Helping Ohioans with autism lead meaningful and successful lives](#) (September 2012)

³ [Ohio's new autism policies](#) (December 2012)

Office of Health Transformation
Create a Unified Medicaid Budgeting and Accounting System

Background:

The Medicaid program spans multiple state agencies yet the accounting system and complex budget structure are not organized to track Medicaid budgets, expenditures, and performance across state agencies. This inability of the current structure to support an enterprise view of the program compels state staff to resort to time-consuming, manual, ad hoc reporting using multiple data sources – and the resulting product generally fails to accurately and transparently deliver the information necessary to track and manage the program.

Executive Budget Proposal and Impact:

The Executive Budget as introduced restructures Medicaid-related appropriations line items (ALIs) in a new way, so they can clearly roll up into an enterprise view of Medicaid for internal and external reporting purposes. The new structure captures ALL Medicaid spending across ALL agencies across ALL line items (see Figure 1). It removes non-Medicaid spending from Medicaid lines, so there is no confusion about the source or purpose of funding. The new structure also splits services from administration and support, which at first makes it seem as if administration costs have increased when in fact it is similar – but now administrative and support costs are being shown for what they are, providing greater budget transparency and a more accurate picture of how taxpayer dollars are actually being spent.

The new budget structure directly aligns with the Ohio Administrative Knowledge System (OAKS), which means actual spending can now be tracked, creating a real-time view of actual Medicaid spending statewide. The budgeting and accounting changes in this budget are a prelude to better performance tracking and reporting in the future. The new structure provides a foundation on which to build better analytic and reporting tools that will remake previously unusable data into business intelligence – the knowledge required to make better decisions about how to further modernize Medicaid and improve overall health system performance.

Updated February 2, 2013

Figure 1.
Medicaid Budget Crosswalk from Current to Proposed Appropriation Line Item Structure

	CURRENT STRUCTURE					PROPOSED STRUCTURE					
	Fund Group	Current Fund	Current ALI	Current ALI Name	Full or Partial Medicaid?	Service, Admin or Both?	Proposed Fund	Proposed ALI	Proposed ALI Name	Double Counting?	Service or Admin?
Office of Medical Assistance/ Department of Medicaid	GRF	GRF	600525	Health Care / Medicaid	Partial	Both	GRF	651525	Medicaid / Health Care Services	N	S
	GRF	GRF	600537	Children's Hospital	F	S					S
	SSR	GRF	600526	Medicare Part D		S	GRF	651526	Medicare Part D	N	S
	FED	3F00	600623	Health Care Federal	F	Both	3F00	651623	Medicaid Services - Federal	N	S
	FED	3F00	600650	Hospital Care Assurance - Federal	F	S	3F00	651624	Medicaid Program Support - Federal	N	A
	GSF	5DL0	600639	Health Care / Medicaid Support - Recoveries	F	Both	5DL0	651639	Medicaid Services - Recoveries / Rebates	N	S
	GSF	5P50	600692	Health Care / Medicaid Support - Drug Rebates	F	Both					
	GSF	5FX0	600638	Medicaid Payment Withholding	F	S	5FX0	651638	Medicaid Services - Payment Withholding	N	S
	SSR	5GF0	600656	Health Care / Medicaid Support - Hospital / UPL	F	S	5GF0	651656	Medicaid Services - Hospital / UPL	N	S
	SSR	5R20	600608	Long Term Care Support	F	Both	5R20	651608	Medicaid Services - Long Term Care	N	S
	SSR	4J50	600613	Nursing Facility Bed Assessment	F	Both					
	SSR	4K10	600621	DDD Support - Franchise Fee	F	S	4K10	No ALI	DDD Support - Franchise Fee	N	S
	SSR	6510	600649	Hospital Care Assurance Program Fund	F	S	6510	651649	Medicaid Services - HCAP	N	S
	GSF	5KW0		Managed Care Performance Payments	F	S	5KW0	651612	Managed Care Performance Payments	N	S
	SSR	4Z40	600625	HealthCare Compliance	F	Both					
	GRF	GRF	600425	Health Care Programs	F	A	GRF	651425	Medicaid Program Support - State	N	A
	GRF	GRF	600321	Program Support	Partial	A					
	GRF	GRF	600416	Information Technology Projects	Partial	A					
	GRF	GRF	600417	Medicaid Provider Audits	F	A					
	FED	3ER0	600603	Health Information Technology	F	Both	3ER0	651603	Medicaid Health Information Technology Grant	N	A
	SSR	5U30	600654	Health Care Program Support	F	A	5U30	651654	Medicaid Program Support	N	A
	SSR	5530	600629	Health Care Program and DDD Support	F	A					
	FED	3G50	600655	Interagency		Both	3G50	651655	Medicaid Interagency Pass-Through	Yes	Trans
	SSR	5AJ0	600631	Money Follows the Person		Both	5AJ0	651631	Money Follows the Person	N	A
	SSR	4E30	600605	Resident Protection Fund		S	4E30	651605	Resident Protection Fund	N	A
	FED	3FA0	600680	Health Care Grants Federal		Both	3FA0	651680	Health Care Grants - Federal	N	S
	SSR	5KCO	600682	Health Care Grants State		Both	5KCO	651682	Health Care Grants - State	N	A
	Mental Health and Addiction Services	GRF	GRF	333321	Central Administration	Partial	A	GRF	652507	Medicaid Program Support	N
GRF		GRF	333403	Pre-Admission Screening Expenses	Partial	A					
GRF		GRF	335501	Mental Health Medicaid Match	F	S					
GRF		GRF	038501	Medicaid Match	F	S					
SSR		5JW0	038615	Board Match Reimbursement	F	S					
FED		3B10	333635	Comm Medicaid Expansion	Partial	A	3B10	652636	Community Medicaid Legacy Costs	N	A
FED		3B10	335635	Comm Medicaid Expansion	F	S	3B10	652635	Community Medicaid Legacy Support	Yes	S
FED		3J80	038610	Medicaid	F	S	3J80	652609	Medicaid Legacy Costs Support	N	A
Department of Developmental Disabilities	GRF	GRF	320321	Central Administration	F	A	GRF	653321	Medicaid Program Support	N	A
	GRF	GRF	322407	Medicaid State Match	F	S	GRF	653407	Medicaid Services	N	S
	GSF	1520	323609	DC & Residential Operating Services	F	S	1520	653609	DC & Residential Operating Services	N	S
	FED	3G60	322639	Medicaid Waiver - Federal	F	Both	3G60	653639	Medicaid Waiver Services	N	S
	FED	3M70	322650	CAFS Medicaid	F	S	3M70	653640	Medicaid Waiver Program Support	N	A
	FED	3A40	323605	DC and Res Facility Svcs and Support	F	Both	3A40	653605	CAFSS Medicaid	N	S
	FED	3A40	322653	ICF Federal	F	S	3A40	653604	DC and Res Facility Svcs and Support	N	S
	FED	3A40	322653	ICF Federal	F	S	3A40	653604	DC & ICF/IID Program Support		A
	SSR	5GE0	320606	Operating and Services	Partial	Both	3A40	653653	ICF/IID	N	S
	SSR	5GE0	320606	Operating and Services	Partial	Both	5GE0	653606	ICF/IID & Waiver Match	N	S
	SSR	5CT0	322632	Intensive Behavioral Needs	F	S	5CT0	653607	Intensive Behavioral Needs	N	S
	SSR	5DJ0	322626	Targeted Case Management Services	F	S	5DJ0	653626	Targeted Case Management Services	Yes	S
	SSR	5EVO	322627	Program Fees	F	A	5EVO	653627	Medicaid Program Support	N	A
SSR	5Z10	322624	County Board Waiver Match	F	S	5Z10	653624	County Board Waiver Match	N	S	
SSR	4890	323632	DC Direct Care Support	F	S	4890	653632	DC Direct Care Services	N	S	
SSR	5S20	590622	Medicaid Admin & Oversight	F	A	5S20	653622	Medicaid Admin & Oversight	N	A	
Department of Health	GRF	GRF	440453	Health Care Quality Assurance	Partial	A	GRF	654453	Medicaid - Health Care Quality Assurance	N	A
	GSF	1420	440646	Agency Health Services	Partial	A					
	FED	3910	440606	Medicare Survey and Certification	Partial	A	3GDO	654601	Medicaid Program Support	N	A
	FED	3920	440618	Federal Public Health Programs	Partial	A					
Aging	GRF	GRF	490423	Long Term Care Budget - State	F	A	GRF	656423	Long Term Care Program Support - State	N	A
	FED	3C40	490623	Long Term Care Budget	F	A	3C40	656623	Long Term Care Program Support - Federal	N	A
Job and Family Services	GRF	GRF	600521	Family Assistance Local	Partial	A	GRF	655522	Medicaid Program Support - Local	N	A
	GRF	GRF	600525	Health Care / Medicaid	Partial	Both	GRF	655523	Medicaid Program Support - Local Transportation	N	A
	FED	3F00	600623	Health Care Federal	Partial	A	3F01	655624	Medicaid Program Support	N	A

Office of Health Transformation **Create a Cabinet-Level Medicaid Department**

Background:

Medicaid is the largest health payer in Ohio, spending \$19.6 billion in 2013 to provide health coverage for more than 2.3 million Ohioans through a network of 75,000 health care providers. Medicaid policy, spending and administration are split across multiple government jurisdictions. The program is jointly funded by the federal and state governments and, in Ohio, administered through five state departments, each with a local counterpart organized by county or region.

Medicaid accounts for a significant share of spending in the Ohio Departments of Aging (83 percent), Alcohol and Drug Addiction Services (28 percent), Mental Health (61 percent), Developmental Disabilities (91 percent), and Job and Family Services (73 percent) — yet the unit responsible for interacting with these agencies is subordinate to them, organized as a unit within the Ohio Department of Job and Family Services (ODJFS). Despite having responsibility for 73 percent of the ODJFS budget, Ohio Medicaid’s 388 staff account for only 10 percent of total employment within ODJFS. From this position, it is difficult for Medicaid to command the administrative resources necessary to manage the program, and to align Medicaid policy and control costs across state agencies.

The current Medicaid organizational structure is inappropriate for the prominent role Medicaid plays in state government. Back-to-back Medicaid study committees in 2005¹ and 2006² recommended that Ohio create a new, cabinet-level Medicaid department to provide the leadership and focus required to improve Medicaid program performance and get spending under control, and in 2006 the Ohio Auditor of State released a performance audit of the Ohio Medicaid Program that also concluded reorganization was essential.

Kasich Administration Action. From the outset of his Administration, Governor Kasich recognized the need for a comprehensive state health care strategy. On January 13, 2011, only three days into his Administration, Governor Kasich created the Office of Health Transformation (OHT) to “plan for the long-term efficient administration of the Ohio Medicaid program” and “recommend a permanent health and human services organizational structure and oversee transition to that permanent structure.”³ To date, the Governor and OHT have taken the following actions that are consistent with creating a cabinet-level Medicaid department:

- Governor Kasich hired Medicaid Director John McCarthy with the understanding that Director McCarthy would serve as a full member of the Governor’s cabinet. This decision was formalized in the Governor’s Mid-Biennium Review (HB 487). Effective September

¹ [Ohio Commission to Reform Medicaid](#) (2005).

² [Ohio Medicaid Administrative Study Council](#) (2006).

³ [Executive Order 2011-02K](#) (January 2011)

10, 2012, HB 487 created the Office of Medical Assistance (OMA) as a work unit within ODJFS and transferred legal authority for the program from the ODJFS director to the OMA Director. This structure is in effect until a cabinet-level Medicaid agency is in place.

- Governor Kasich's first budget (HB 153) previewed what the budget for a Medicaid department would look like by presenting all Medicaid spending across all state agencies in a single, unified budget.
- HB 153 also reorganized the funding and control of several Medicaid programs. For example, financial responsibility for the non-federal share of Medicaid matching funds for behavioral health benefits was transferred from community behavioral health boards to Medicaid; funding for Medicaid behavioral health services was transferred from the Ohio Departments of Mental Health and Alcohol and Drug Addiction Services to Medicaid; and funding for the Ohio Department of Aging's home and community based services was transferred to Medicaid. Each of these changes supports the creation of a state Medicaid agency.
- OHT is working with Ohio Medicaid and other state agencies to restructure and consolidate health and human services (HHS) operations to be more efficient. For example, OHT has launched initiatives to share information across state and local data systems, modernize eligibility determination systems to serve multiple HHS programs at the same time, and integrate claims payment systems through Ohio's new Medicaid Information Technology System. Medicaid is critical to the success of each project, and will be in a better position to provide leadership as a cabinet-level department.

Executive Budget Proposal and Impact:

The Executive Budget establishes Medicaid as a cabinet-level department effective July 1, 2013. This decision is consistent with previous Medicaid reviews and recent actions taken by the Kasich Administration, described above. The effective date is one year earlier than originally planned because the work to separate Medicaid functions from ODJFS has gone so well that both agencies agreed to pull forward the effective date.

The creation of a cabinet-level Medicaid agency will bring about many changes, but it is not intended to reduce the workforce or reduce Medicaid-related financial resources that are available to counties. The purpose behind creating a new department is to release the creative potential of the state's Medicaid team to push forward reforms already underway, and to position the program within state government commensurate with Medicaid's responsibility to improve overall health system performance, improve care for vulnerable Ohioans, and control costs for Ohio's taxpayers. The major issues related to creating a new department are described below, including a summary of budget language and a description of administrative costs.

Budget language. The new Medicaid department’s administrative and programmatic language will be separated from current provisions governing or implemented by the Department of Job and Family Services. Several new chapters will be created in Title 51 of the Revised Code to establish the new Department of Medicaid and its administrative functions. For the first time, these provisions will be organized according to subject matter (e.g., general Medicaid services, nursing facilities, managed care). In many instances, existing statutory language is being extracted or moved in its entirety from existing Chapters 5101, 5111, and 5112 of the Revised Code to the new chapters, with minimal changes. In addition, uncodified language will be included supporting the transition, including language ensuring the continuity of existing contracts, decisions, and other authorities governing Medicaid administration.

Administrative cost impact. The new Medicaid Department will report higher administrative costs in FY 2014 than in FY 2013 (Figure 1). The increase is driven by a combination of administrative costs shifting out of ODJFS into the new department, structural accounting changes to enhance transparency, and new initiatives to modernize the Medicaid program. More than 80 percent of the administrative increase will occur with or without the separation from ODJFS. Ohio Medicaid shares the cost of its administrative overhead with the federal government, so the state general revenue fund share of Medicaid administrative costs is only 23.5 percent and the rest is paid from federal or special revenue funds (Figure 2).

Figure 1.
ODJFS and Medicaid Operating Budget Summary

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

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

Figure 2.
Medicaid Operating Budget Summary by Funding Source

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

Updated January 31, 2013

Office of Health Transformation **Consolidate Mental Health and Addiction Services**

Background:

In May 2012, Governor Kasich announced plans to consolidate the Ohio Departments of Mental Health (ODMH) and Alcohol and Drug Addiction Services (ODADAS) into a single cabinet agency effective July 1, 2013. The new Department of Mental Health and Addiction Services (MHAS) will align state-level service delivery with the local system, where 47 of 53 county board systems already administer both types of services. According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), at least 25 percent of individuals with mental illness also have a substance abuse disorder and in Ohio's state-run psychiatric hospitals rates of 50 percent are common. Many providers are certified for both types of services and a significant percentage of consumers interact with providers in both systems. Nationally, 46 other states have agencies with a mission that crosses more than one system, and there is a combined federal Substance Abuse and Mental Health Services Administration (SAMHSA).

ODADAS and ODMH have much in common already. Mental illnesses and addictions are both biological brain disorders with genetic and/or neurobiological factors. Both are often unseen and may remain undetected for years before treatment is accessed, and denial and stigma are common barriers to getting treatment. Both addiction and mental illness can be treated successfully, and the social supports and community resources that people with both types of diseases need are very similar. The ultimate goal is to provide a system for prevention and treatment of mental illness and addiction with no wrong doors, shared resources, and combined expertise.

Significant work has occurred already to integrate the two departments. Most back office functions are now combined (fiscal, legislation, communications, information technology, legal, and Medicaid policy). A detailed transition plan is in place, and a Website devoted to the consolidation allows stakeholders to follow work in progress (www.adamh.ohio.gov). All that is left is to formally create a new consolidated department.

Executive Budget Proposal and Impact:

The Executive Budget consolidates mental health and addiction services in a single cabinet-level department effective July 1, 2013. Some budget line items have been restructured to reflect the broader scope of the new agency. The new structure will facilitate the Administration's support of local priorities that might vary from community to community, including housing, criminal justice partnerships, employment supports, prescription drug abuse, evidence-based prevention approaches, and services to families of youth in crisis.

The goal of the new Department of Mental Health and Addiction Services is to recognize and value what is unique in both systems while also providing better services through integration and, ultimately, improving overall health system performance. The major issues related to creating a new department are described below, including a summary of budget language and a description of administrative costs.

Budget language. The Executive Budget changes references to ODMH and ODADAS throughout the Ohio Revised Code to reflect the name change to the Ohio Department of Mental Health and Addiction Services. ODADAS Chapter 3793 has been incorporated into Chapter 5119, which currently governs mental health. Slight adjustments have also been made to Chapters 5122 (state-run psychiatric hospitals) and 340 (Alcohol, Drug and Mental Health Services Boards). Much of the language appears new based on how the Legislative Service Commission drafts language, but actual changes are minimal and were made in consultation with stakeholders.

Administrative cost impact. The Executive Budget reflects overall administrative savings from consolidating ODADAS and ODMH. While there are no plans for layoffs, the amount of administrative spending will decrease during the biennium as costs are streamlined and some positions are vacated but not replaced. The Executive Budget redirects \$1.5 million annually in administrative savings that result from consolidation to a new Community Innovations program. The goal of this program is to support projects that require collaboration and have the potential to generate future savings. For example, improvements such as tele-health services in jails and linkages made for inmates with the community treatment system will lessen the rate of recidivism, potentially saving significant government costs in the future.

Updated January 31, 2013

Office of Health Transformation **Coordinate Health Sector Workforce Programs**

Background:

Ohio's 540,000 health care practitioners directly influence the cost and quality of health care through their diagnoses, orders, prescriptions, and treatments.¹ These medical, mental health, dental and other health care providers labor every day to take care of their patients, but experts say there are too few of some types of health care professionals and some are not located where they are needed. Rural Ohioans and those living in other underserved areas across the state are especially vulnerable to health sector workforce shortages.

Ohio trains more physicians than it retains. The state's six public medical schools² enroll over 3,700 medical students, which ranks Ohio 5th among states in terms of the number of public medical school enrollees per capita.³ However, only 44 percent of physicians who graduated from public medical school in Ohio stay in Ohio. As a result, Ohio ranks 16th in terms of active physicians per capita and 24th in terms of active primary care physicians per capita.⁴ According to federal Health Professional Shortage Area designations, more than 1.1 million Ohioans reside in an area that is underserved for primary care, 1.4 million reside in an area that is underserved for dental care, and 2.7 million reside in an area that is underserved for mental health care. An additional 282 physicians, 283 dentists, and 194 psychiatrists are needed in these areas.⁵ The individuals who live in these underserved areas are disproportionately from minority and low-income populations within rural and urban areas throughout the state.

In February 2012, Governor Kasich created the Office of Workforce Transformation (OWT) to coordinate and align workforce policies, programs and resources across the state. OWT has authority to coordinate workforce activities across all state agencies, but relies on a core team that includes the Ohio Board of Regents, Ohio Development Services Agency, and Ohio Department of Job and Family Services. The goal is to create a unified workforce system that supports business in meeting its workforce needs. The Governor's Office of Health Transformation (OHT) also is involved to assist OWT by coordinating health sector workforce activities across Ohio's health and human services agencies.

¹ US Bureau of Labor Statistics, [Ohio Occupational Employment and Wage Estimates](#) (May 2011), including health care practitioners and technical occupations, and health care support occupations.

² The Ohio State University, the University of Cincinnati, Wright State University, The University of Toledo, Northeast Ohio Medical University, and Ohio University.

³ Association of American Medical Colleges, [2011 State Physician Workforce Data Book](#) (2011) page 24: students enrolled in public medical or osteopathic schools for the 2010-2011 academic year

⁴ Ibid. pages 8 and 12

⁵ Health Resources and Services Administration, Designated Health Professional Shortage Area Statistics (2012). The estimate of additional health professionals required to adequately serve currently underserved areas is based on population-to-provider ratios of 2,000:1 for physicians, 3,000:1 for dentists, and 10,000:1 for psychiatrists.

Executive Budget Proposal and Impact:

The Executive Budget includes several initiatives to coordinate health sector workforce programs. These initiatives support OWT and OHT activities already underway. Working together, OWT and OHT are coordinating 16 state agencies to identify health sector workforce needs, align existing workforce programs, reform higher education training programs, and change payments for health services to support workforce priorities.

IDENTIFY NEEDS

- ***Provide comprehensive health sector workforce data.*** OWT has made it a priority to forecast in-demand jobs using existing workforce data and, when data does not exist, by creating new forecasting tools. Individuals interested in health care careers and health professions training programs do not have a consistent way to identify current and future health sector job and skill needs. Assessing health workforce needs is difficult because there are many variables that determine its adequacy and no single entity in the United States is in charge of workforce planning. The state currently relies on local partners to survey providers to obtain data needed to identify health professional shortage areas. The Ohio Department of Health (ODH) is leading an initiative to obtain comprehensive state-level health sector workforce data. Working in collaboration with OWT and OHT, ODH will: (1) use the Department of Administrative Services e-licensure system to collect the nationally recognized Minimum Data Set (MDS) for all primary care disciplines, (2) add data elements to Ohio's MDS that are required for designation of federal Health Professional Shortage Areas, and (3) develop an advanced primary care workforce forecasting model to assist in planning for health professions education programs and recruitment and retention strategies. OHT is providing Health Transformation Funds to support these activities (there is no additional budget request).
- ***Prioritize advanced primary care.*** Various trends are projected to impact demand for the primary care workforce statewide. An aging population and expansion of health insurance coverage will impact a system that is already experiencing provider shortages and maldistribution. New models of advanced primary care will also bring about changes in the way care is delivered, calling for increased use of interdisciplinary care teams.⁶ Ohio is working to expand the patient-centered medical home (PCMH) model of care across the state. The PCMH model of care improves health outcomes, enhances the patient experience of care, and reduces expensive, unnecessary inpatient hospital admissions and emergency department visits.⁷ A strong primary care workforce is a critical element of the PCMH model and, given the current shortage, it is imperative to educate and retain a workforce to provide advanced primary health care services.

⁶ "Advanced primary health services" are health services related to family medicine, general internal medicine, general pediatrics, obstetrics/gynecology, geriatrics, mental health, oral health and clinical pharmacy provided by a patient-centered interdisciplinary team of health care professionals.

⁷ Patient-Centered Primary Care Collaborative, [Benefits of Implementing the Primary Care PCMH](#) (2012)

- **Prioritize underrepresented minorities in health professions.** National research indicates that health care providers originating from population groups and communities that are historically underserved for health care are more likely to choose primary care practice and to work in underserved areas. Underrepresented minority health professionals, particularly physicians, disproportionately serve minority and other medically underserved populations.⁸ Data generally support the notion that minority patients receive better interpersonal care from practitioners of their own race or ethnicity, particularly in primary care and mental health settings. Patient-practitioner language concordance similarly is associated with better interpersonal care, greater medical comprehension, and greater likelihood of keeping follow-up appointments, particularly in mental health care. These findings indicate that greater health professions diversity will likely lead to improved public health by increasing access to care for underserved populations.⁹

ALIGN PROGRAMS

- **Target scholarship, training and loan repayment programs to support workforce priorities.** Factors such as large educational debt and lack of training in community-based primary care settings negatively influence health professions students, residents and providers who might otherwise choose to practice primary care in underserved areas. While Ohio currently has various programs in place to recruit and retain primary care providers for shortage areas, the programs are not adequate to meet the growing need for an interdisciplinary and diverse workforce. Working together to overcome the currently misaligned and fragmented system, OWT and OHT will: (1) coordinate priorities and resources across existing scholarship and training programs, including Choose Ohio First Scholarships for primary care, Medicaid Technical Assistance and Policy Program Healthcare Access Initiative, and combined Board of Regents line items for family medicine, geriatric medicine, primary care residencies, and the Area Health Education Center program; (2) seek matching funds for the State Loan Repayment Program grant from licensure boards that represent eligible disciplines, including physician assistants, nurse practitioners, certified nurse midwives, psychiatric nurse specialists, health service psychologists, licensed professional counselors, licensed clinical social workers, marriage and family therapists, registered dental hygienists and pharmacists; (3) revise loan repayment program application scoring criteria to increase opportunities for underrepresented minorities and to support advanced primary care practices; and (4) revise Ohio Physician and Dentist Loan Repayment programs to address large educational debt and the need for community-based training. These activities use existing funds (there is no additional budget request).

⁸ “Underrepresented minorities in health professions” include racial and ethnic populations whose representation in their profession is disproportionately less than their proportion in the general population. Persons from rural or socioeconomically disadvantaged backgrounds are also considered to be underrepresented groups in the health care workforce.

⁹ US Health Resources and Services Administration, [The Rationale for Diversity in the Health Professions](#) (2006)

- **Define core competencies in the direct care workforce.** Currently, no standardized certification program exists for direct care workers providing care in the homes and residences of consumers receiving home and community based services reimbursed by Medicaid. The Executive Budget establishes a process to define core competencies for direct care workers across all of Ohio's health and human services agencies. This is important to ensure that direct care workers in the homes and residences of consumers are trained, tested, and certified in the core competencies needed to provide these services. (See also "Prioritize home and community based services.")

REFORM TRAINING

- **Target direct medical education to support workforce priorities.** The federal government pays for teaching hospitals to train physicians in residency programs and for the higher costs associated with teaching. The Executive Budget does not change the current level of Medicaid direct graduate medical education funding – about \$200 million over the biennium – but it does propose to target those funds to support health sector workforce priorities. Beginning July 1, 2014, Medicaid direct medical education payments will be allocated based on rules that will be developed to support: a workforce trained in comprehensive primary care with a commitment to serve all Ohioans; dollars following residents into community practices; primary care placements in recognized patient-centered medical homes; a residency mix that recognizes and supports the needs of Ohio; and strategies that mitigate underserved areas in Ohio. While budget neutral, the opportunity to focus \$200 million over the biennium to achieve workforce priorities is significant. (See also, "Reform hospital payments.")
- **Support training in promising models of care.** The existing state-funded Patient-Centered Medical Home (PCMH) Education Pilot Project provides technical assistance to convert 50 primary care practices, some in underserved areas, to PCMH status and use those sites for training in advanced primary care. These 50 sites have already been selected and begun their transformation. A statewide PCMH Education Advisory Group (EAG), comprised of various stakeholders from government agencies, educational, medical, and nursing organizations, provides input and guidance for the implementation of the project. All sites selected in the pilot have an affiliation with a medical or nursing school and will be training medical and nursing students, interns and residents on a patient-centered model of care using a curriculum developed by the EAG. The budget authorizes ODH to adopt standards and procedures for certifying PCMH, eligibility requirements for providers, and uniform health care quality and performance measures.

ALIGN PAYMENT

- **Primary care rate increase.** The federal government requires states to raise Medicaid fees at least to Medicare levels for family physicians, internists and pediatricians for many primary care services. In Ohio, primary care physicians will see their Medicaid payments increase 82 percent on January 1, 2013, and receive an estimated \$700

million more in Medicaid payments over the two-year period ending December 31, 2014, all of which is federally funded. (See also “Reform other provider payments.”)

- **Home and community based services rate increase.** The Executive Budget holds the line on spending for institutional services, but increases payment for home and community based services. The budget increases aggregate spending for Medicaid aide and nursing services three percent, increases adult day service rates 20 percent in the Ohio Department of Aging’s PASSPORT and Choices programs, and increases assisted living rates three percent. These provisions cost \$30.8 million (\$11.4 million state share) over the biennium. (See also, “Prioritize home and community based services.”)
- **Support payment innovation.** More than 40 percent of a primary care physician’s day is spent in essential but non-reimbursed tasks such as care coordination¹⁰ and 27 percent of their revenue is spent on administrative activities such as insurance company and government compliance and regulations.¹¹ New payment methodologies need to be developed to reward prevention, coordination of care, and management of chronic diseases. In January 2013, Governor Kasich convened an Advisory Group on Health Care Payment Innovation to align public and private health care purchasing power to reward the value of services, not the volume. The Advisory Council is exploring innovative payment models, including paying for better coordinated care and improved outcomes through patient-centered medical homes and accountable care organizations, which treat patients for “episodes” of care rather than on a per visit basis, and coordinate care as patients are discharged from the hospitals to prevent re-hospitalization.

Updated January 31, 2013

¹⁰ New England Journal of Medicine, [What’s Keeping Us So Busy in Primary Care?](#) (April 2010)

¹¹ Health Affairs, [Peering Into the Black Box: Billing and Insurance Activities in a Medical Group](#) (January 2013)

Office of Health Transformation

Implement Public Health Futures Recommendations

Background:

Currently in Ohio there are 125 county and city health departments. There is significant variation in the capacity of these local health districts (LHD): from 1 to 435 full-time employees, 6,441 to 854,975 residents served, and \$8 to \$232 in public health spending per capita.¹

For 50 years, experts have been recommending better ways to organize local health districts. A 1960 report recommended a minimum size for local health districts, and used as examples 100,000 residents for city health departments and 50,000 residents for all other health districts.² A 1993 report recommended that local public health jurisdictions be required to have the critical mass necessary to provide core public health functions and that, in most cases, county boundaries would provide the critical mass necessary.³ And a 2012 Institute of Medicine report recommended providing a “minimum package of public health services” in every community, and greater collaboration between public health and its clinical care counterparts to improve the outcomes of clinical care and the field’s contributions to population health.⁴

In 2011, the Association of Ohio Health Commissioners (AOHC) established a *Public Health Futures* project to explore new ways to structure and fund local public health. The project guided AOHC members through a critical look at the current status of local public health and a careful examination of cross-jurisdictional shared services and consolidation as potential strategies for improving efficiency and quality. Members defined the core public health services that each LHD should provide, and foundational capabilities that can be internal or accessed through cross-jurisdictional sharing (Figure 1). The project culminated in recommendations that linked future decisions about services, jurisdictional structure, and financing to each LHDs capacity to provide core public health services.⁵ The report concluded that most LHDs may benefit from cross-jurisdictional sharing, but LHDs serving populations of 100,000 residents or less would particularly benefit from pursuing cross-jurisdictional sharing or consolidation.

Executive Budget Proposal and Impact:

In October 2012, a Legislative Committee translated the AOHC Public Health Futures recommendations into specific legislative and fiscal policy recommendations for consideration in the 2014-2015 operating budget (Appendix A).⁶ The Executive Budget incorporates many of

¹ Ohio Department of Health, [Local Health Department Expenditures Report](#) (self-reported in 2011).

² Ohio Legislative Service Commission, [Organization and Financing of General Health Districts](#) (1960)

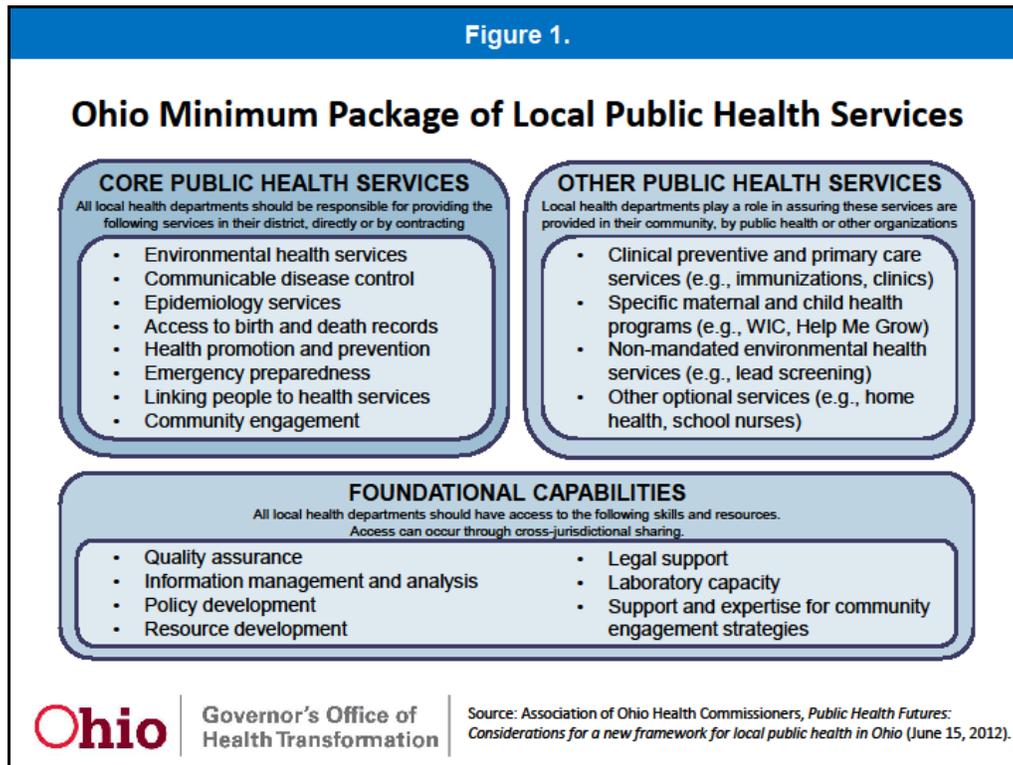
³ Ohio Public Health Services Study Committee, [Healthy People, Healthy Communities](#) (1993)

⁴ IOM, [For the Public’s Health: Investing in a Healthier Future](#) (2012)

⁵ AOHC, [Public Health Futures Final Report and Recommendations](#) (June 2012)

⁶ Ohio General Assembly, [Public Health Futures Recommendations](#) (October 2012)

the Legislative Committee’s recommendations, all of which are designed to give public health more tools to collaborate, integrate programs and services, and improve the assurance of services for all Ohioans. These recommendations do not require consolidation, but they do require that each LHD seriously consider whether or not it has the foundational capabilities to provide core public health services and, if not, to identify how it will gain access to those capabilities, either directly, through cross-jurisdictional sharing, or consolidation.



The Legislative Committee’s recommendations are identified in the headings below, with a description about how the Executive Budget acts to operationalize each recommendation.

REGIONALIZE GRANTS

- **Block grant funding.** The Committee recommends ODH advocate a “blended funding” approach that integrates all state and federal public health funding using block grants, when possible, to reduce fragmentation and leverage public health funding. ODH will begin a process of consolidating grant awards to LHDs to ensure that the most effective and efficient LHD or consortium of LHDs administers the program for an entire region. Moving all grants that are predominantly operated by local health departments to a regional basis will generate efficiencies and consolidate performance in the highest functioning jurisdictions. The Executive Budget creates a mechanism for ODH to shift authority to the jurisdiction assuming responsibility for the region. Beginning in July 2013, ODH will release a request for proposals to regionalize several targeted grants.

These regional RFPs will be awarded in January 2014 and include dental sealant, creating healthy communities, HIV prevention, STD prevention, immunization action plan, and injury prevention programs. This process will consolidate 180 separate grants into 47 regional awards. Later phases of implementation will involve working with federal partners to “block grant” the separate programs listed above.

IMPROVE MANDATORY PROGRAMS

- **Boards of Health.** The Committee recommends that local health district board members participate in continuing education requirements related to public health practice, ethics, and governance. The Executive Budget requires each member of a board of health to complete eight continuing education units annually. The Budget also requires each Board of Health to include an executive officer or medical director of a hospital or the largest medical facility in the district, to facilitate community health planning.
- **Performance Standards and Accreditation.** The Committee recommends that all local health districts meet Public Health Accreditation Board eligibility within five years. The Executive Budget authorizes the ODH director to require general or city health districts to be accredited beginning in 2018 as a condition for receiving funding from ODH. Beginning July 2013, accreditation standards will be incorporated into all regional grant deliverables to assist LHDs build capacity and knowledge of the accreditation process and prepare for successful accreditation.

Also, the Budget requires sanitarians of a city or general health district who perform inspections of food service operations or of retail food establishments to obtain and maintain certification from the United States Food and Drug Administration. The benefit to Ohio is a more uniform delivery of services throughout Ohio as well as holding sanitarians to the highest performance standards available. LHDs meeting these requirements will receive less frequent surveys from ODH. Later phases of implementation will include similar standards for other mandated programs.

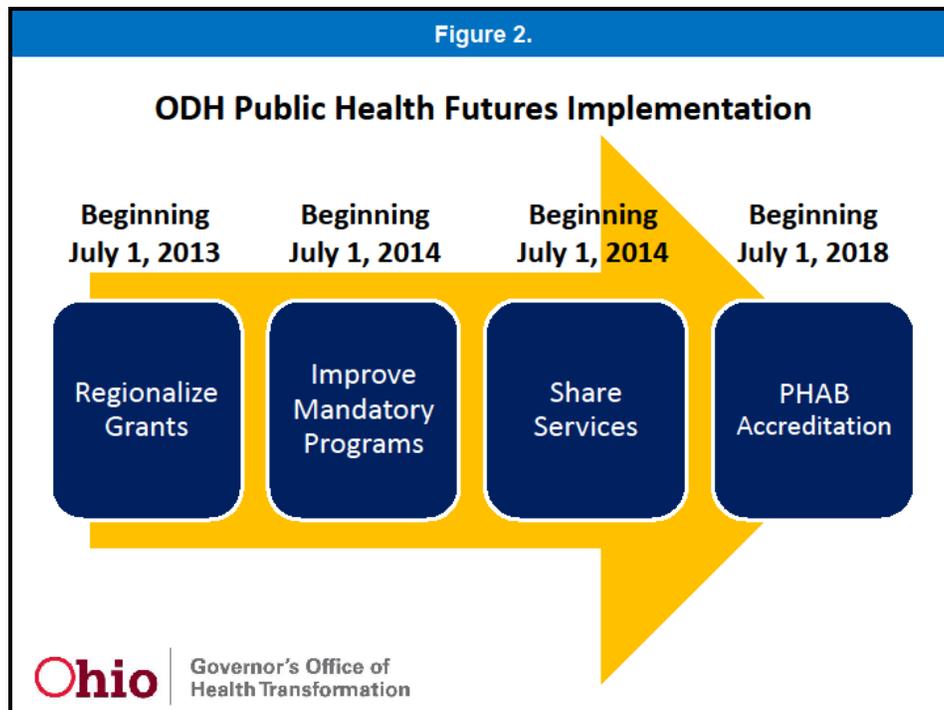
SHARE SERVICES

- **Shared services resources.** The Committee recommends that ODH encourage and enhance shared services by local health districts. Beginning in July 2014, ODH will expect LHDs to demonstrate movement toward regional shared service hubs for foundational capabilities such as human resources, payroll processing, information technology, and financial management. This item will be included in the fiscal monitoring activities included in LHD regional grants, and grant applications that fail to demonstrate movement or contractual relationships with the regional hubs will result in points off in scoring. The Executive Budget authorizes ODH to reassign authority for mandatory programs from an LHD that cannot demonstrate it has the foundational capability to provide core public health services to another LHD that has that capability. This does

NOT entail ODH taking over any non-compliant jurisdiction, but rather a shifting authority from a non-compliant jurisdiction to a compliant jurisdiction.

- **Sharing across contiguous and non-contiguous cities or counties.** Current law limits certain cross-jurisdictional sharing opportunities to “two or more contiguous” health districts “not to exceed five.” The Committee recommends and the Executive Budget includes provisions to remove these restrictions, thus allowing cross-jurisdictional sharing among an unrestricted number of contiguous and non-contiguous counties. Also, the Committee recommends and the Executive Budget authorizes permissive multi-county levy authority for public health services.
- **Outcomes and data.** The Committee recommends that ODH create a standardized process of specific data collection and identification of common public health indicators. The Executive Budget requires the health commissioner of a general health district to develop a comprehensive community assessment for the county, in collaboration with city health districts, private health care providers, hospitals, other medical facilities or medical services, behavioral health providers, and members of the general public.

In combination, these strategies create new incentives to improve public health system performance and increase efficiency by sharing foundational capabilities across local health districts. These changes do not occur all at once, but over time, and tie services, jurisdictional structure, funding, and accreditation to providing core public health services (Figure 2).



Appendix A.
Legislative Committee on Public Health Futures
Approved Recommendations and Concepts

Performance Standards and Accreditation. All local health districts shall meet PHAB eligibility within five years. Such documentation shall be independently verified.

Outcomes and Data. The Ohio Department of Health and local health districts shall create a standardized process of specific data collection and identification of common public health indicators to include quality, quantity, comparables and efficiency. The sharing of de-identified health related data among payers, providers and public health is encouraged.

Boards of Health. Local health district board members shall participate in continuing education requirements related to public health practice, ethics, and governance.

Multiple Agency Program Administration. Identify and refer programs currently administered by two agencies (Ohio Department of Agriculture and Ohio Department of Health) such as food safety and waterpark / swimming pools to the Common Sense Initiative (CSI) for further review and recommendations related to the program efficiency.

Multi-District Public Health Levy. Revise Ohio Revised Code 3709.29 to allow for permissive multi-county levy authority for public health services.

Shared Services Resources. The Ohio Department of Health shall encourage and enhance shared services by local health districts such as, but not limited to, the sharing of model contracts, memorandums of understanding, financial, and other technical assistance, that are easily adaptable by local boards.

Contract/Consolidate/Merger of Contiguous and Non-Contiguous Cities or Counties. Revise Ohio Revised Code sections 3709.051 and 3709.10 to allow contiguous and non-contiguous city and county health districts to contract/consolidate/merge together within a “reasonable” geographic distance (consider AOHC regions).

Reimbursable Services. The Ohio Department of Insurance should work to enhance the ability of local health districts to contract and credential with private payers and Medicaid for services such as immunizations and other public health and clinical services, integrated health management and other care models. This recommendation is not to be interpreted as supporting new legislative mandates or the placing of mandates upon local health districts.

Chronic Disease Block Grant Funding. The Ohio Department of Health shall initiate review and advocate federal, state and regional authorities for a “blended funding” approach that integrates all state/federal public health funding using block grants (when/where possible) to reduce fragmentation in an effort to increase public health funding.

Sustainable Funding. Ohio should explore sustainable funding to achieve Ohio’s public health mission and responsibilities. This work should include steps to: implement standard measures of outcomes, examine the link between funding disparities at the health district level and health outcomes, identify any additional opportunities for operational efficiencies, review incentives to drive outcomes at the local level and pursue federal funding opportunities.

Reconvene Committee. The Director of Health shall reconvene a similar committee no later than three years after report submission of October 31, 2012 to review its purpose and implementation of recommendations.

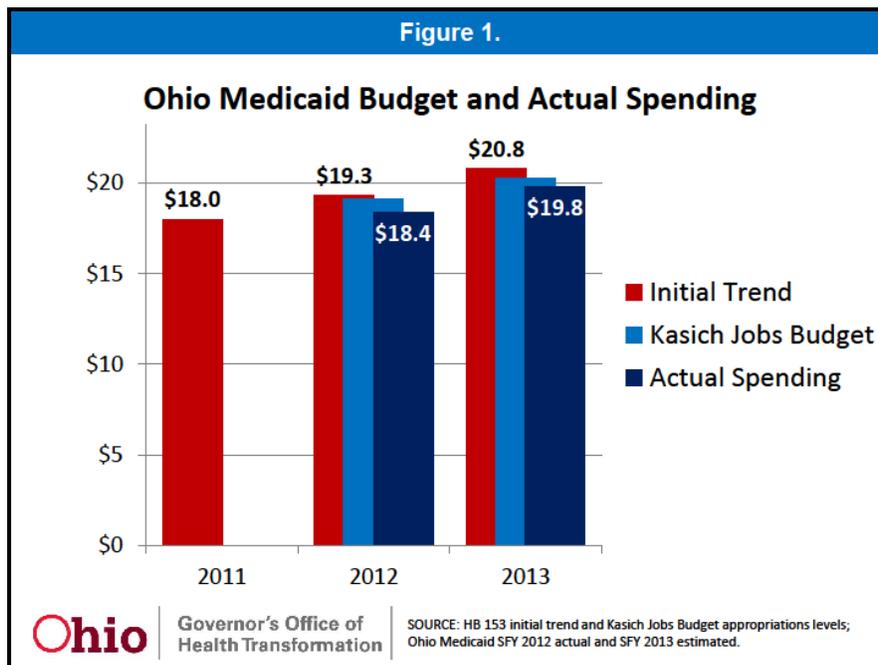
Office of Health Transformation Overall Medicaid Budget Impact

Background:

From a budgeting perspective, Medicaid is always a challenge. It currently represents approximately 25 percent of the state share of the general revenue fund (about 45 percent of GRF when you add in the federal reimbursement). The program historically has been associated with high growth rates due to demographic and economic factors that impact the number of people covered and to health care inflation rates that greatly impact the cost of their services.

In January 2011, Governor John Kasich created the Office of Health Transformation to address Medicaid spending issues, plan for the long-term efficient administration of the Ohio Medicaid program, and act to improve overall health system performance.¹ The new Office organized existing staff in the state's six Medicaid-related agencies to advance the Administration's Medicaid modernization and cost-containment priorities in the operating budget.

Governor Kasich's first budget proposed spending \$500 million less than the trend in 2012 and \$942 million less in 2013. At the same time, the budget introduced new tools to improve care coordination, integrate behavioral and physical health care, rebalance long-term care spending, and modernize reimbursement to reward value instead of volume. Ohio Medicaid used these tools to drive Medicaid program improvements and deliver *additional* savings – resulting in actual spending nearly \$1 billion below the initial trend *in both years* (Figure 1).



¹ Executive Order 2011-02K, [Creating the Governor's Office of Health Transformation](#) (January 13, 2011).

Executive Budget Proposal and Impact:

The Executive Budget builds on the momentum of the first two years, both in terms of the design and delivery of the Medicaid program as well as the underlying administrative structure through which it is managed. It accomplishes this in the face of significant challenges resulting from the federal Affordable Care Act (ACA).

Medicaid Baseline. Medicaid currently provides health care services to over 2.3 million Ohioans per month at a projected cost of \$19.8 billion (all funds in FY 2013). The general revenue fund (GRF) accounts for \$12.7 billion of that spending, of which \$5.1 billion is the state's share after the federal government reimburses the state for the federal share of the program.² These are the Medicaid-related expenditures by all six agencies that are involved in the operation of the Medicaid program. These agencies include the departments of Job and Family Services, Aging, Alcohol and Drug Addiction Services, Developmental Disabilities, Health, and Mental Health.

The total Medicaid "baseline" – what the Medicaid program would cost in the upcoming biennium assuming current eligibility, benefit, and payment policies remain unchanged – is projected to grow 13.3 percent to \$22.4 billion in FY 2014 and grow 4.5 percent to \$23.4 billion in FY 2015 (Figure 2). There are several factors that account for this high baseline growth:

- **ACA Woodwork Enrollment Increase.** The ACA individual mandate to purchase health insurance is expected to result in some individuals seeking health coverage who were not previously seeking it, and some who might have been seeking it might not have found it. Under either circumstance, given the greater awareness of the need to have health coverage and the availability of Medicaid, more individuals who are currently eligible for Medicaid but are not enrolled are likely to do so. This is commonly referred to as the "woodwork effect." Given the fact that they will enroll without any changes in state policy, they must be included in the baseline estimates. Ohio Medicaid estimates more than 230,000 "woodwork" individuals will enroll in Medicaid by June 2015. This increases GRF baseline estimates by \$531 million (\$186 million state share) in FY 2014 and by \$996 million (\$335 million state share) in FY 2015.
- **ACA Physician Fee Increase.** Another ACA-related impact on the baseline budget is the mandated increase in physician fees that began on January 1, 2013. Although this required two-year increase of Medicaid rates to the level of Medicare receives 100 percent federal reimbursement, it still requires estimated GRF appropriations of \$320.9 million in FY 2014 and \$261.9 million in FY 2015.
- **Health transformation initiatives.** There are a few initiatives underway in the current biennium that have not been fully implemented and will continue being implemented in the next biennium, including implementation of health homes for people with serious

² The current, standard federal matching rate for Ohio is 63.58 percent in federal fiscal year 2013.

mental illness, and enrolling disabled children in health plans. The most notable example is that the implementation of the Integrated Care Delivery System (ICDS) will not be fully implemented in FY 2013 due to a delay in federal approval of our waiver request. ICDS was authorized in House Bill 153 and is intended to better coordinate the care of certain individuals who are enrolled in both Medicaid and Medicare. This initiative is expected to reduce the rate of spending growth after full implementation is achieved, but it has initial start-up costs associated with paying the “run-out” of fee-for-service claims at the same time prospective payments are made to the health plans that will provide integrated care. Although the state has since received federal approval and has selected health plans through a competitive process, and enrollment is projected to begin this July, the “run-out” cost was originally expected to largely occur in FY 2013 but is now delayed until FY 2014. This is a contributing factor to the under-spending in this fiscal year and must be accounted for in the baseline for the upcoming biennium.

Savings and Cost Avoidance. The Medicaid baseline growth rates described above are not sustainable. While such rates would be of concern under any circumstances, they are particularly troubling after all of the Medicaid modernization and cost containment efforts in the current biennium that helped return Ohio’s budget to structural balance. Therefore, the Executive Budget includes a number of cost avoidance initiatives intended to again emphasize value and establish the right incentives for cost-effective, quality care. These initiatives, generally payment methodology changes, are largely targeted at providers that benefit the most from the projected enrollment growth, such as health plans and hospitals. This package of savings and cost avoidance totals \$517 million (\$191 million state share) in FY 2014 and \$801 million (\$296 million state share) in FY 2015 (Figures 2 and 3).

Extend Medicaid Coverage. Governor Kasich’s decision to extend Medicaid eligibility to adult Ohioans with income up to 138 percent of poverty will increase overall Medicaid appropriations but decrease the state share of GRF. The new income eligibility test will result in approximately 366,000 Ohioans becoming “newly eligible” for Medicaid, but it will also result in approximately 91,000 Ohioans who are eligible for Medicaid today moving off the program (they will have the option to seek coverage on the new federal Health Insurance Exchange). These enrollment changes are expected to increase Medicaid spending \$500 million in FY 2014 and \$1.9 billion in FY 2015 (Figure 2) – but the state share actually *decreases* \$23 million in FY 2014 and \$68 million in FY 2015 because the state saves from current enrollees leaving the program and the federal government covers 100 percent of the cost of the newly eligible population (Figure 3).

Executive Budget Appropriations. After factoring in baseline projects, savings and cost avoidance, and eligibility changes, the Executive Budget increases overall Medicaid spending 13.2 percent to \$22.4 billion in FY 2014 and 9.6 percent to \$24.5 billion in FY 2015 (Figure 2). The state share-only GRF appropriations reflect projected growth of 10.8 percent to \$5.6 billion in FY 2014 and growth of 2.7 percent to \$5.8 billion in FY 2015. Savings and cost avoidance, coupled with eligibility changes, were able to reduce state share GRF appropriations by \$213 million in FY 2014 and by \$365 million in FY 2015 relative to baseline projections.

Figure 2. Ohio Medicaid Spending (All Funds in millions)

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

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

Figure 3. Ohio Medicaid Spending (State Share of General Revenue Funds in millions)

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

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

Updated January 31, 2013