BLUEPRINT FOR
A NEW OHIO
GOV. JOHN R. KASICH'S FISCAL YEARS 2016-2017 BUDGET

Ohio Department of Medicaid: FY16-17 Budget Priorities

House Finance Subcommittee on Health and Human Services
February 26, 2015

John McCarthy, Medicaid Director

Today's Topics

- Overview
- Medicaid Enrollment Overview
  - Newly Eligible Population
- Simplification and Consistency in Eligibility Policy
- Changes in Long-term Care Enrollment
- Changes in School-based Services Benefits
- Reform Hospital Payments
- Reform Nursing Facility Reimbursements
- Reform Managed Care Payments
- Reform Non-Institutional Provider Reimbursement
- Fight Fraud, Waste, and Abuse
- Payment Innovation

2011 Ohio Crisis

- $8 billion state budget shortfall
- 89-cents in the rainy day fund
- Nearly dead last (48th) in job creation (2007-2009)
- Medicaid spending increased 9% annually (2009-2011)
- Medicaid over-spending required multiple budget corrections
- Ohio Medicaid stuck in the past and in need of reform
- More than 1.5 million uninsured Ohioans (75% of them working)

2011 Ohio Crisis	vs.	Results Today
$8 billion state budget shortfall		Balanced budget
89-cents in the rainy day fund		$1.5 billion in the rainy day fund
Nearly dead last (48th) in job creation (2007-2009)		One of the top ten job creating states in the nation
Medicaid spending increased 9% annually (2009-2011)		Medicaid increased 4.1% in 2012 and 2.5% in 2013 (pre-expansion)
Medicaid over-spending required multiple budget corrections		Medicaid budget under-spending was $1.9 billion (2012-2013) and $2.5 billion (2014-2015)
Ohio Medicaid stuck in the past and in need of reform		Ohio Medicaid embraces reform
More than 1.5 million uninsured Ohioans (75% of them working)		Extended Medicaid coverage

Additional Key Successes

- Procured and implemented a new Medicaid managed care program
- Designed and launched 'Ohio Benefits', the state's new integrated eligibility system
- Successfully implemented the MITS provider payment system
- Introduced a managed care approach to coordinating benefits for dual-eligible beneficiaries ('MyCare Ohio')
- Achieved 50-50 'balance' in long-term care spending
- Launched a stand-alone state Medicaid agency

Ohio Medicaid Annual Growth Projections

(calculated on a Per Member Per Month basis)

State Fiscal Year	JMOC (Optumas) Upper Bound	Medical CPI	JMOC (Optumas) Target	Executive Budget	
				(All Agencies)	(Excluding DD)
2016	3.00%	3.30%	3.00%	1.38%	0.75%
2017	3.60%	3.30%	3.30%	4.50%	4.05%
Avg.	3.30%	3.30%	3.15%	2.94%	2.40%

Ohio Department of Medicaid

Source: Ohio Department of Medicaid, Overall Budget Impact (January 2015).

Ohio Medicaid Spending (All Funds)

All Funds	SFY 2015	%	SFY 2016	%	SFY 2017	%
Baseline Total	$ 24,764	18.7%	$ 27,309	10.3%	$ 28,252	3.5%
Executive Budget Reforms						
Eligibility Reforms			$ (23)		$ (77)	
Benefit Reforms			$ 57		$ 137	
Reform Health Plan Payments			$ (73)		$ (270)	
Reform Physician Payments			$ -		$ 25	
Reform Hospital Payments			$ (66)		$ (167)	
Reform Nursing Facility Payments			$ -		$ 61	
Reform Home Care Payments			$ -		$ (19)	
Enhance Community Developmental Disabilities Services			$ 80		$ 219	
Program Integrity			$ 9		$ -	
Subtotal			$ (16)		$ (91)	
Subtotal with Budget Reforms	$ 24,764	18.7%	$ 27,293	10.2%	$ 28,161	3.2%
Include: Transfers	$ 1,895		$ 91		$ 91	
Executive Budget	$ 26,660	21.5%	$ 27,384	2.7%	$ 28,253	3.2%
Ohio Department of Medicaid			$ (96)		$ (310)	
Ohio Department of Developmental Disabilities			$ 80		$ 219	

Ohio Department of Medicaid

Source: Ohio Department of Medicaid, Overall Budget Impact (January 2015).

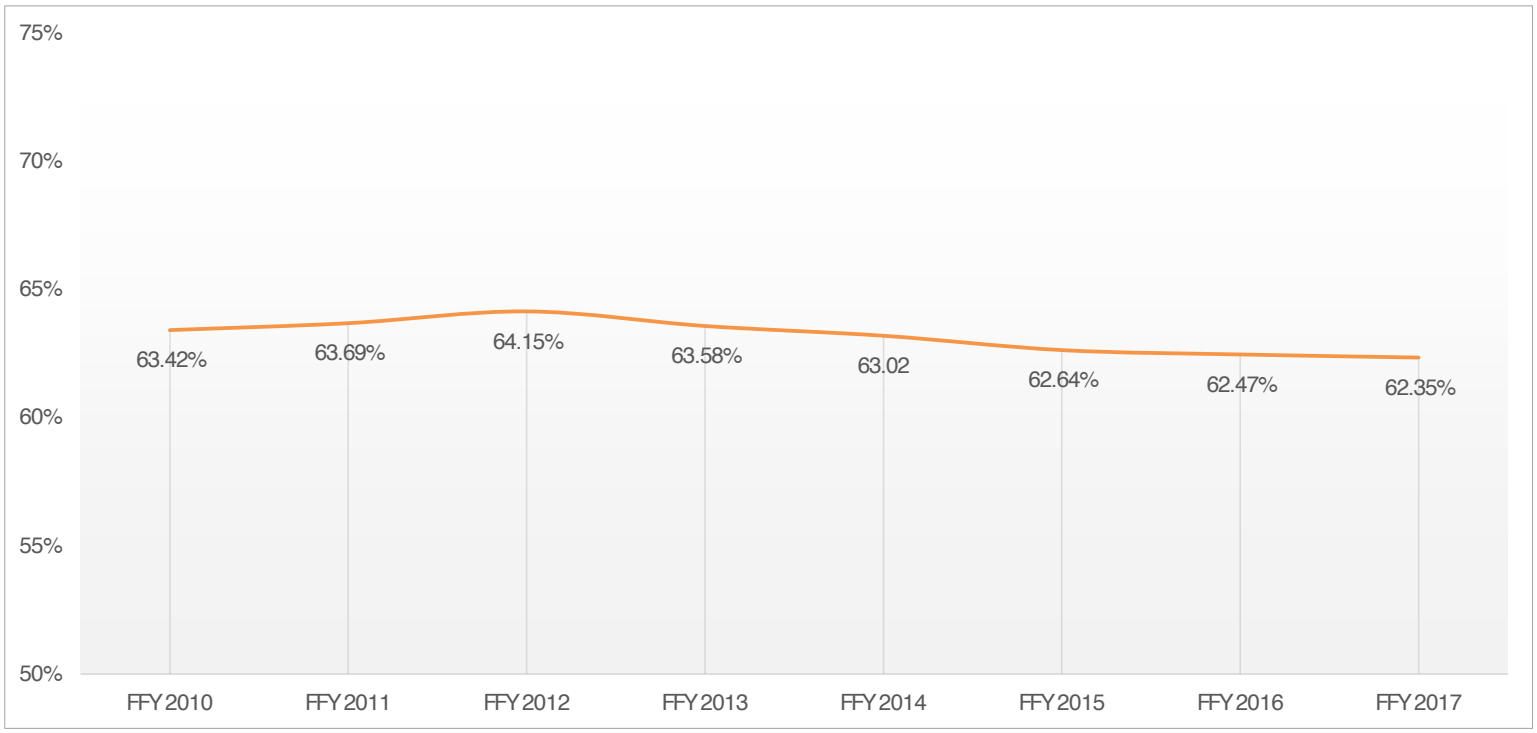
Ohio Medicaid Spending (GRF State Share)

GRF State Share	SFY 2015	%	SFY 2016	%	SFY 2017	%
Baseline Total	$ 5,715	6.8%	$ 6,095	6.7%	$ 6,527	7.1%
Executive Budget Reforms						
Eligibility Changes			$ (12)		$ (35)	
Benefit Changes			12.9		42.3	
Health plan changes			$ (27)		$ (103)	
Physician changes			$ -		$ 9	
Hospital changes			$ (132)		$ (204)	
Nursing Facility changes			$ -		$ 23	
Home care changes			$ -		$ (6)	
Developmental Disabilities System Redesign			$ 30		$ 82	
Fight fraud and Abuse			$ 2		$ (1)	
Subtotal			$ (127)		$ (193)	
Executive Budget	$ 5,715	6.8%	$ 5,968	4.4%	$ 6,334	6.1%
Ohio Department of Medicaid			$ (157)		$ (275)	
Ohio Department of Developmental Disabilities			$ 30		$ 82	

Ohio Department of Medicaid

Source: Ohio Department of Medicaid, Overall Budget Impact (January 2015).

Regular FMAP Over Time: SFY 2010-17



Ohio Department of Medicaid

Source: Ohio Department of Medicaid

Medicaid Enrollment Overview

- Current Enrollment: 2,979,563 (24,199 below estimates)
- Nearly 4 of 5 individuals covered by a managed care plan (78%)
- Children with special health care needs and dual-eligible individuals now have access to managed care benefits
- Coverage extended to 492,000 newly eligible Ohioans in 2014 (all enrolled in private managed care plans)
- Long-term care: approximately 86,500 served by HCBS waivers; 56,500 living in long-term care facilities

Medicaid Enrollment Overview

Newly Eligible Population:

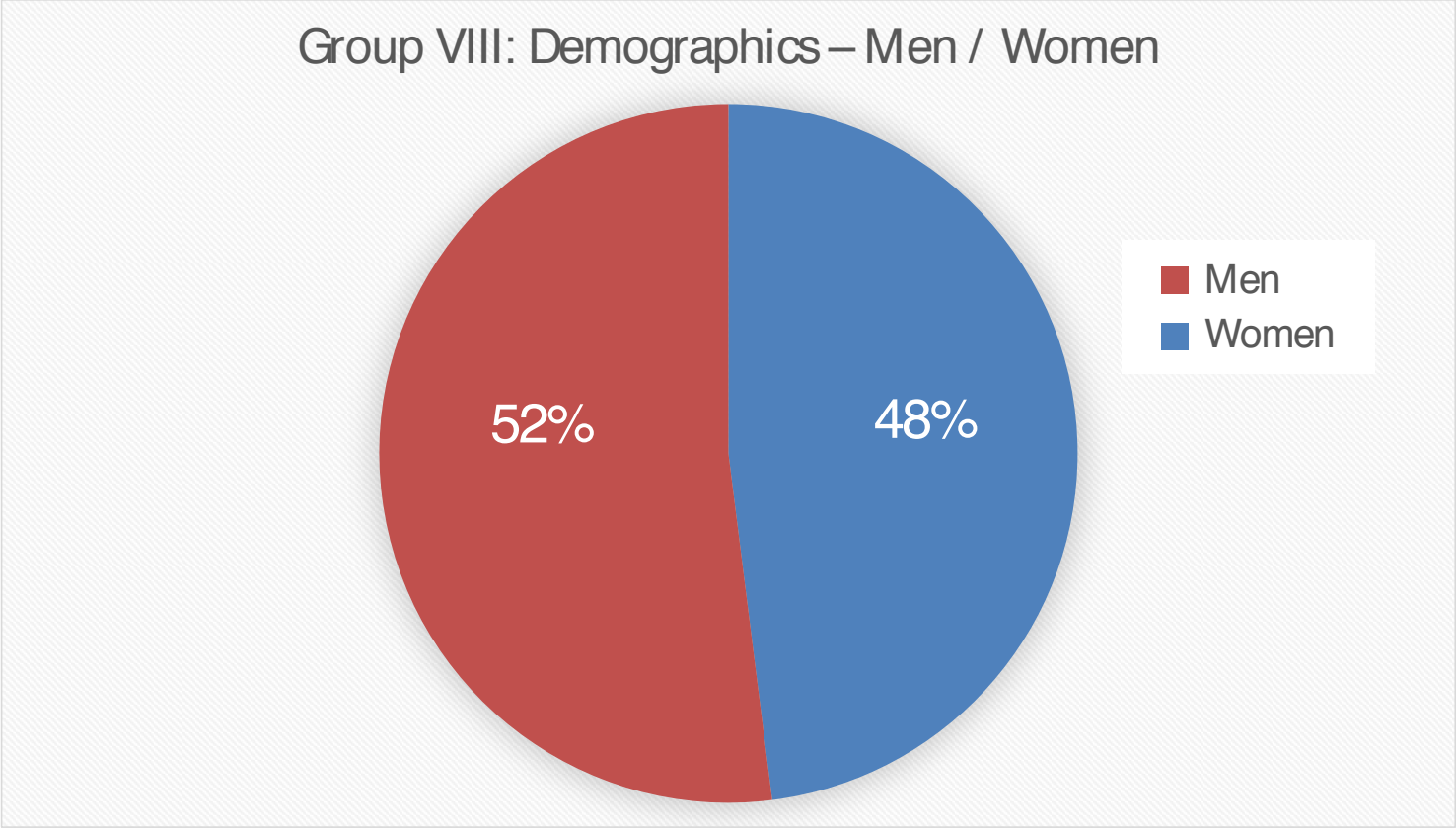
- Enrollment began in December 2013 with eligibility effective January 1, 2014.
- 138,000 individuals enrolled in first month of eligibility (January).
- Preliminary data (First 4-6 months) indicates:
  - Areas of pent-up demand
  - Near even split among men and women
  - Clear need for behavioral health care and services

Group VIII Enrollment by Month

Showing Retroactivity:

		Actually Enrolled Month													
		Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Total
Eligibility Month	Jan 2014	23,156	22,093	17,310	33,839	11,981	7,015	14,650	2,724	2,005	1,432	564	455	723	137,947
	Feb 2014		8,782	18,993	8,092	5,706	3,135	2,424	1,073	830	398	197	198	(640)	49,188
	Mar 2014			15,904	23,741	18,616	7,398	8,540	3,114	2,362	1,002	275	257	(1,204)	80,005
	Apr 2014				12,761	11,737	5,166	5,984	2,554	2,627	1,139	518	365	5	42,856
	May 2014					10,519	8,686	3,334	1,997	2,543	1,345	602	249	(19)	29,256
	Jun 2014						10,923	7,584	2,525	3,165	2,402	1,021	439	135	28,194
	Jul 2014							10,638	6,235	3,695	2,923	2,002	820	403	26,716
	Aug 2014								8,466	7,631	2,481	1,691	1,586	663	22,518
	Sep 2014									9,054	7,009	1,330	1,578	2,169	21,140
	Oct 2014										9,504	5,378	1,264	1,513	17,659
	Nov 2014											6,421	5,974	1,863	14,258
	Dec 2014												7,274	8,451	15,725
	Jan 2015													6,659	6,659
	Total	23,156	30,875	52,207	78,433	58,559	42,323	53,154	28,688	33,912	29,635	19,999	20,459	20,721	492,121

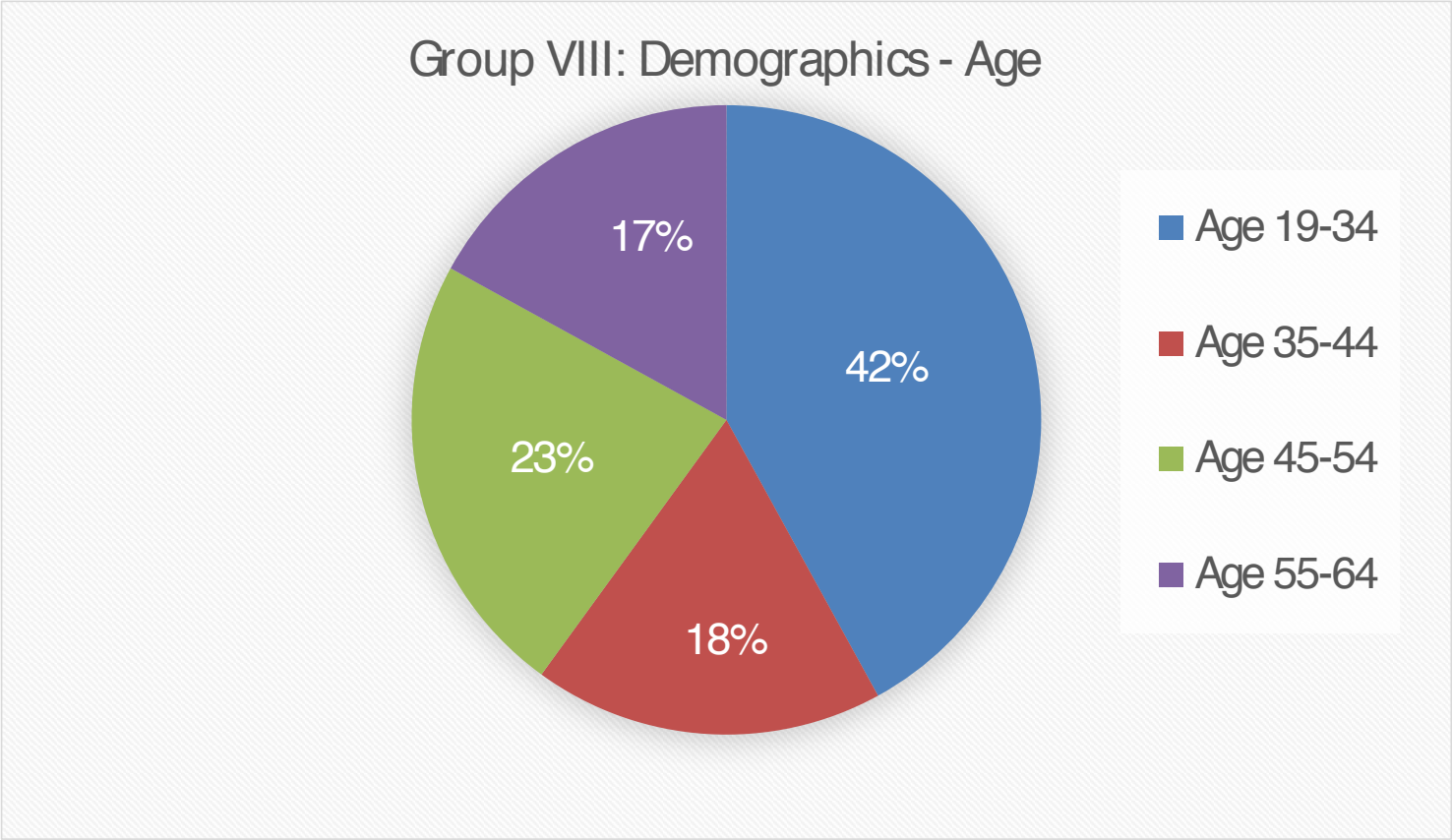
Medicaid Enrollment Overview



Ohio Department of Medicaid

Source: Ohio Department of Medicaid
Based on data through February 14, 2015

Medicaid Enrollment Overview



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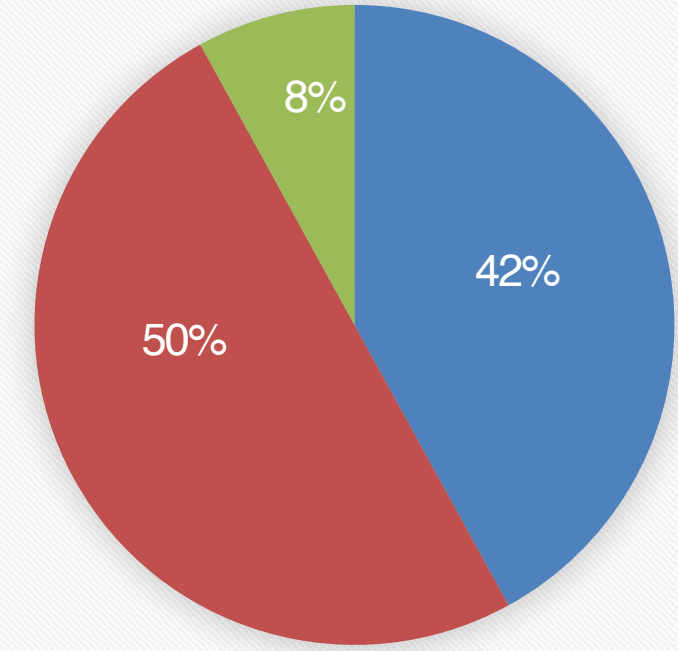

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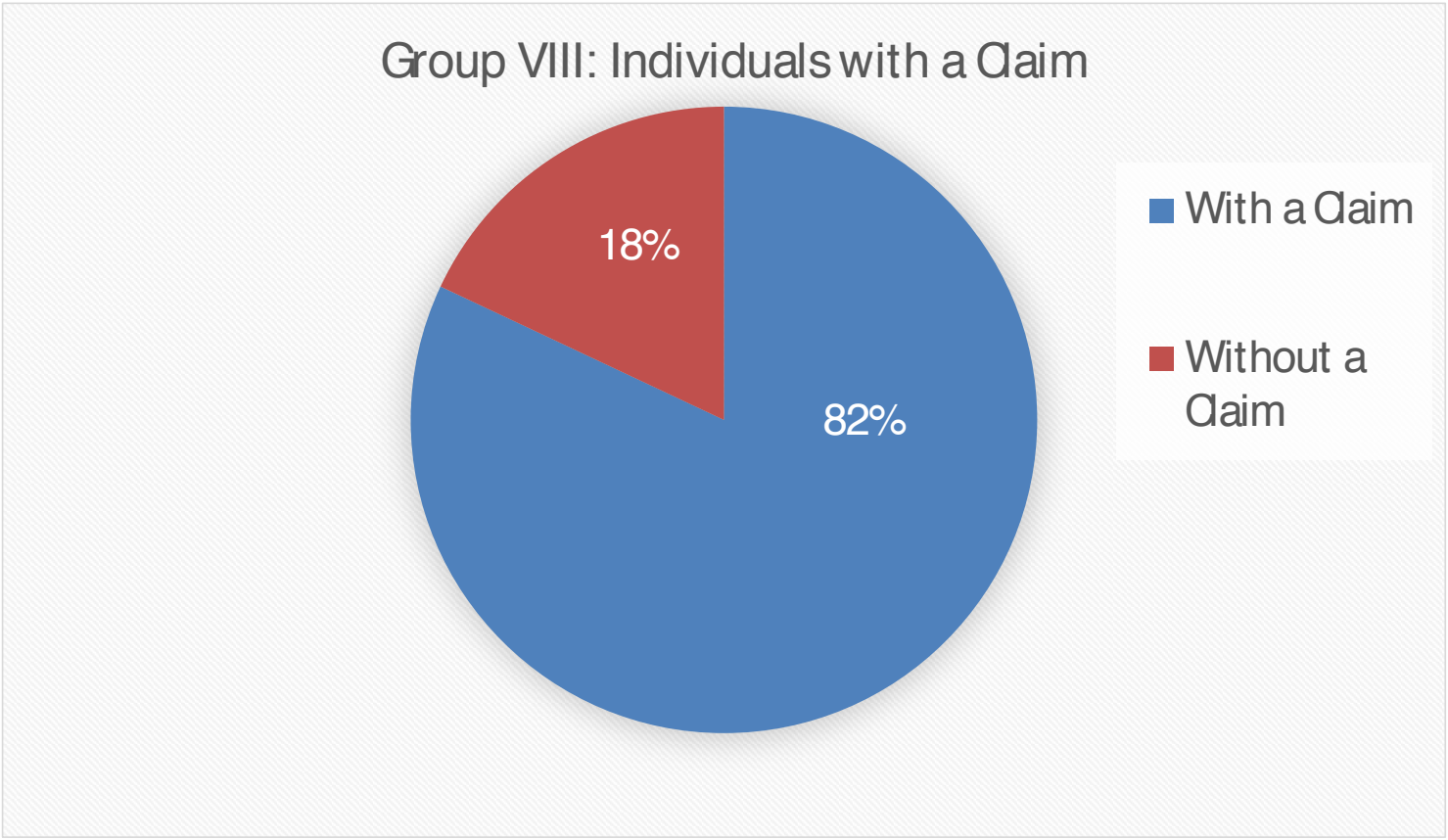

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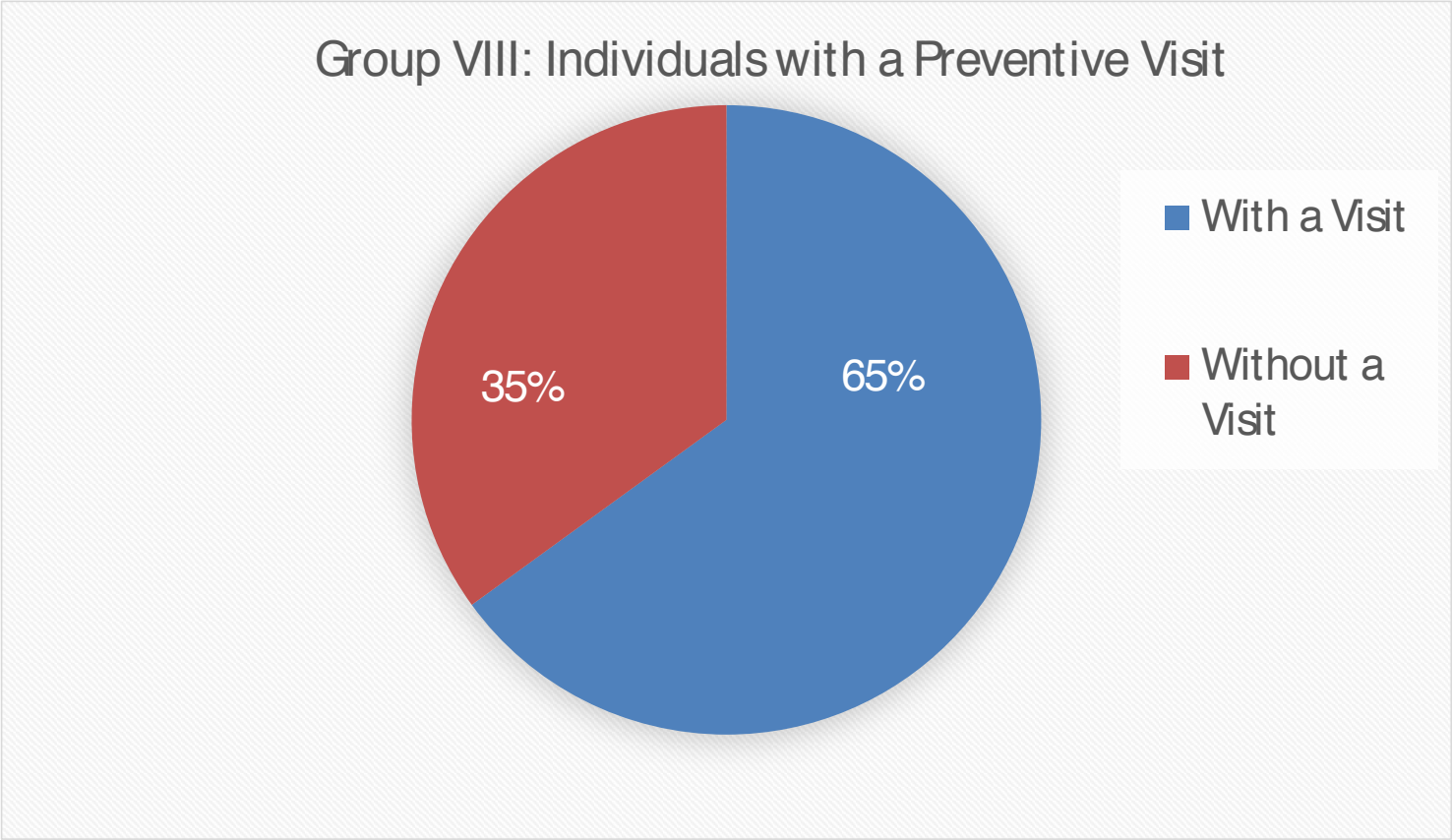

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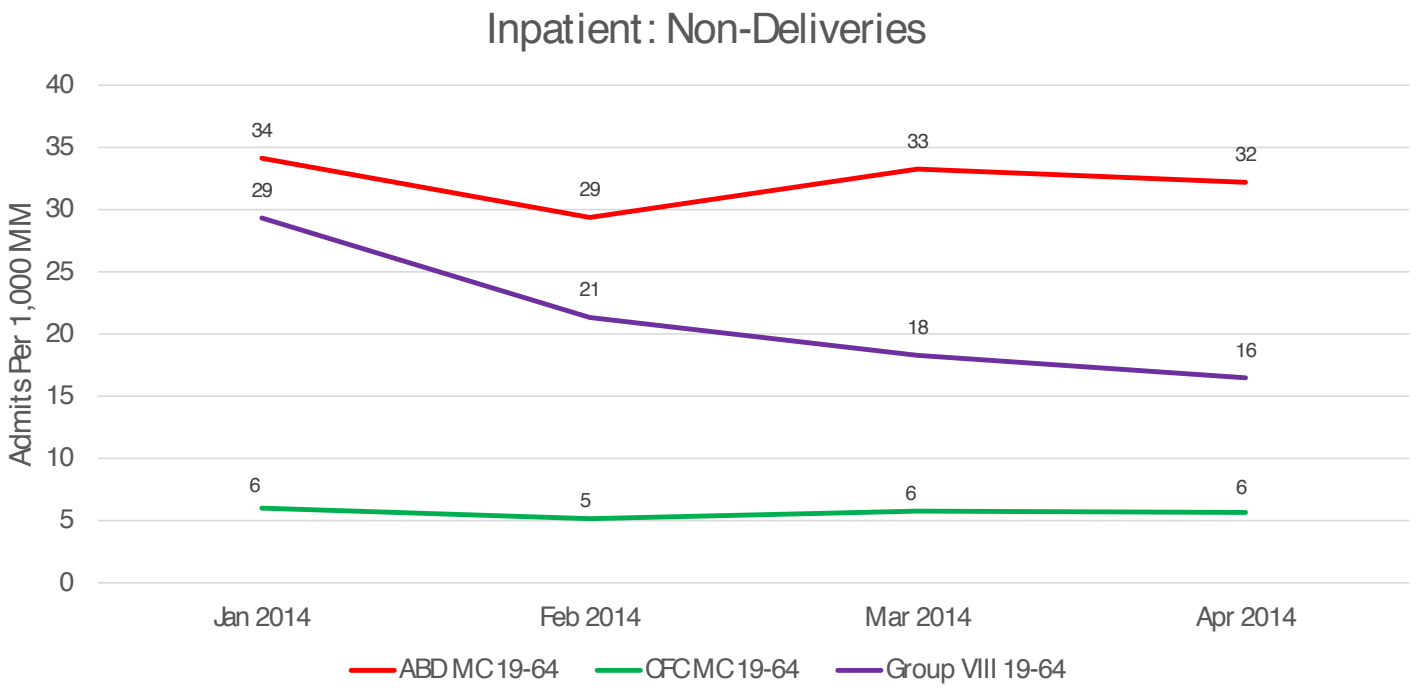
Based on data through February 14, 2015

Preliminary Utilization Comparison:
Group VIII vs. ABD and CFC Managed Care (ages 19-64)



Ohio Department of Medicaid

Source: Ohio Department of Medicaid
Claims data: QDSS; January-April 2014 dates of service, with claims to date in system as of January 2015.

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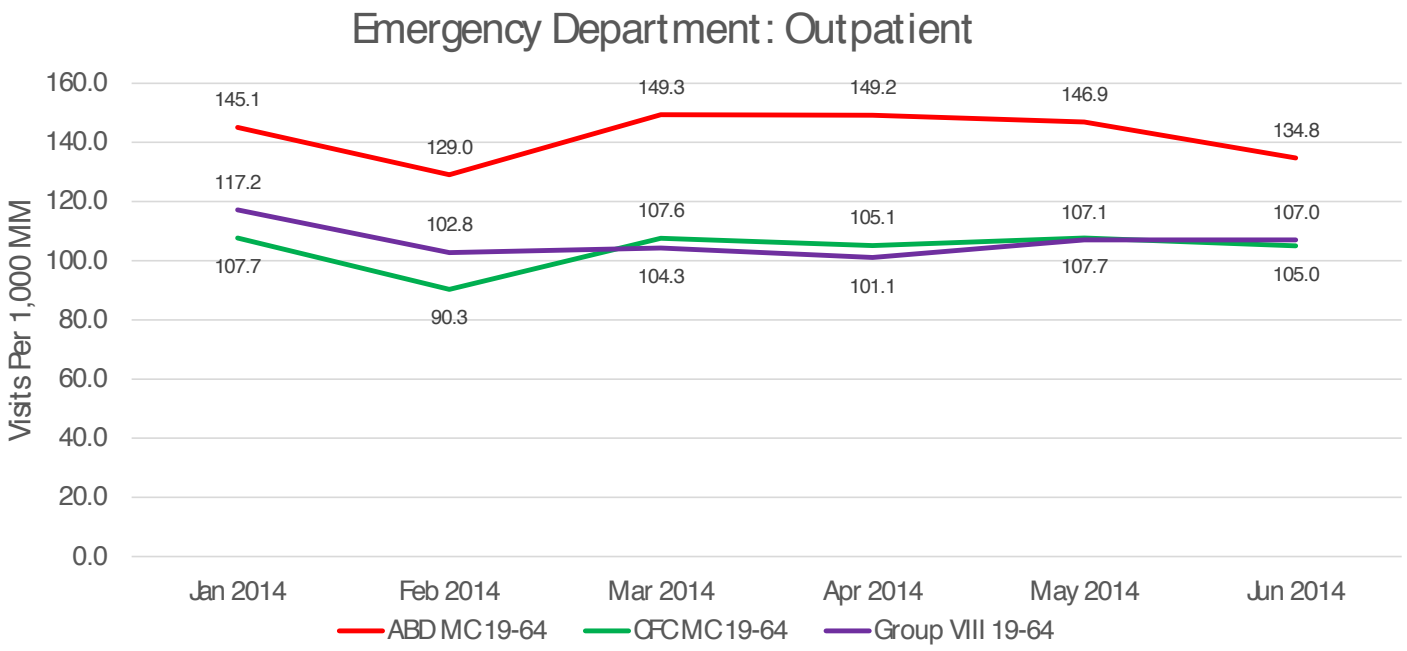

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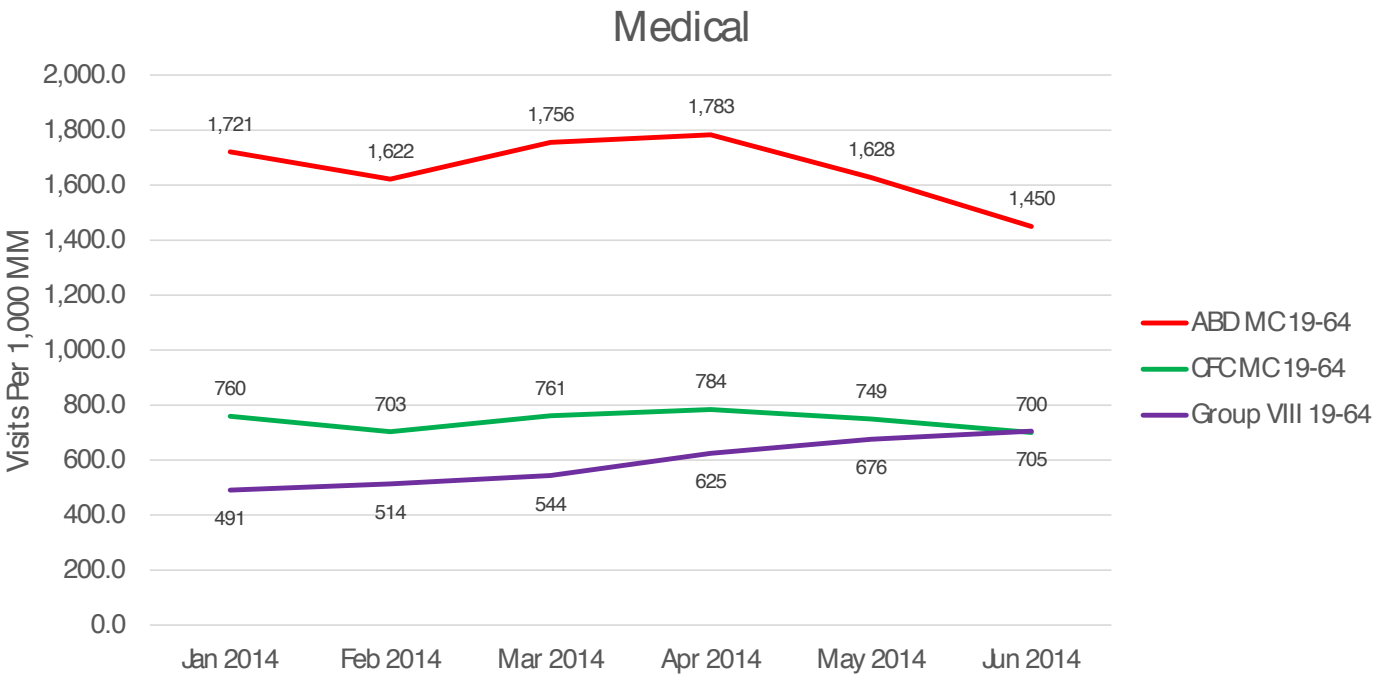

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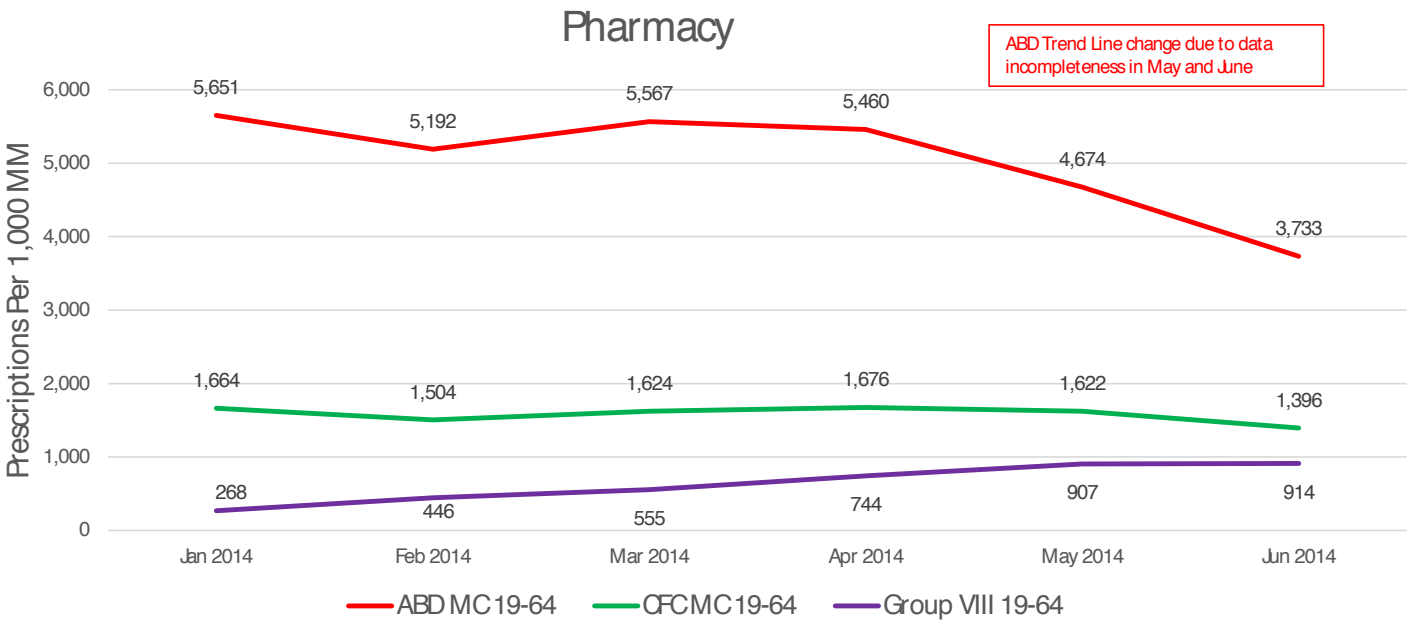

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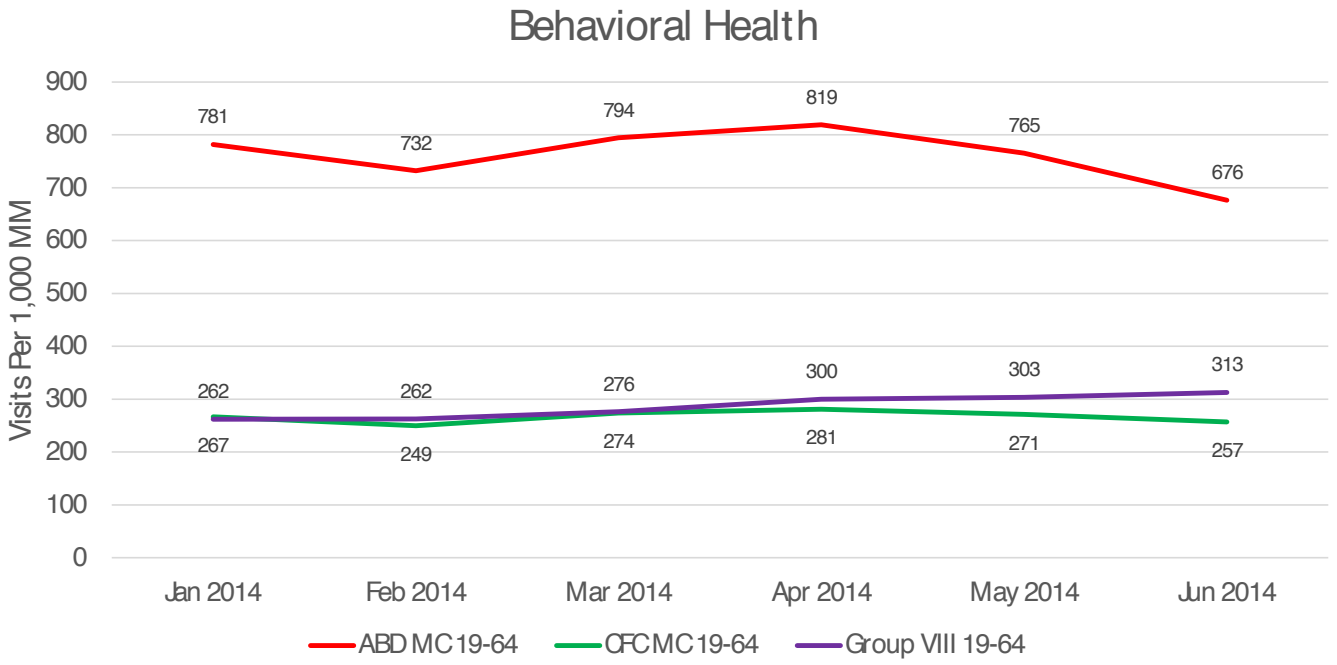
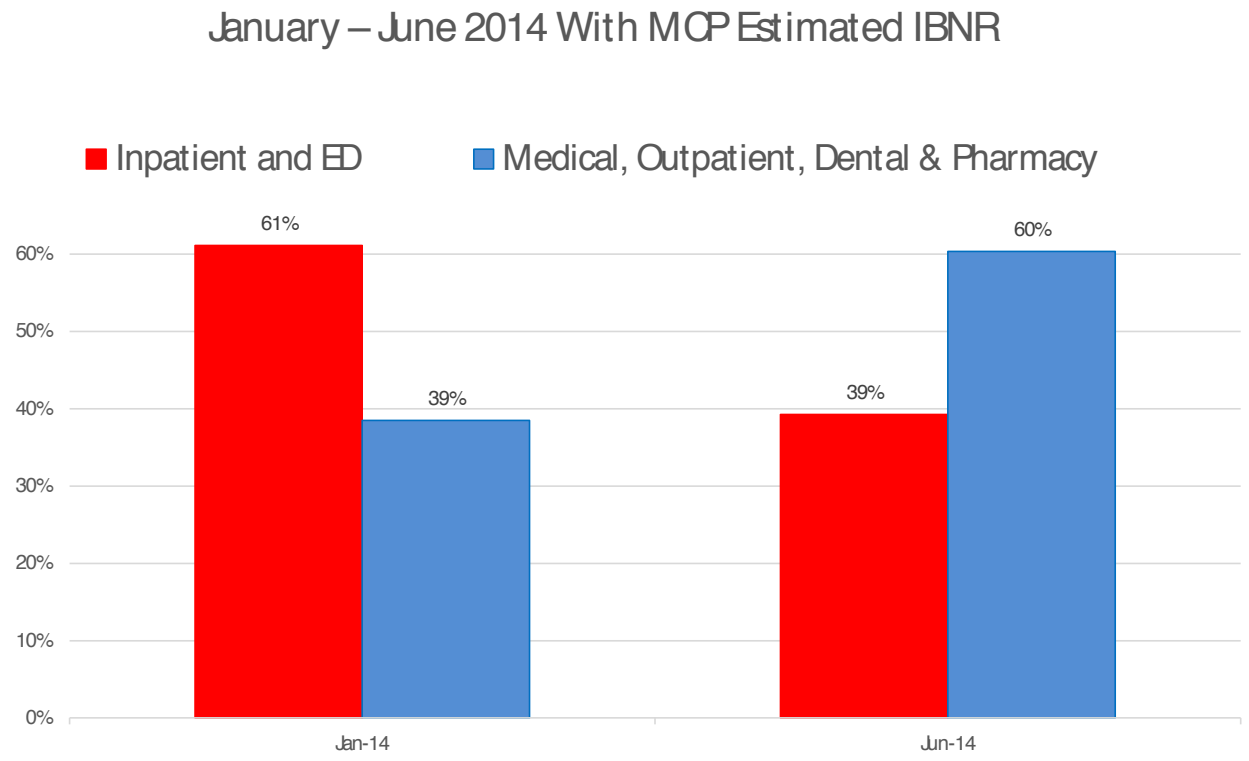


Source: Ohio Department of Medicaid
Claims data: QDSS; January-April 2014 dates of service, with claims to date in system as of January 2015.

Group VIII Comparison of PMPM (MC and FFS) Categories of Costs:

Shifting FROM Uncoordinated Care Settings (Inpatient and Emergency) TO Coordinated Care Services



Ohio Department of Medicaid

Source: Ohio Department of Medicaid
Q3 MCP Cost Report data through June 2014

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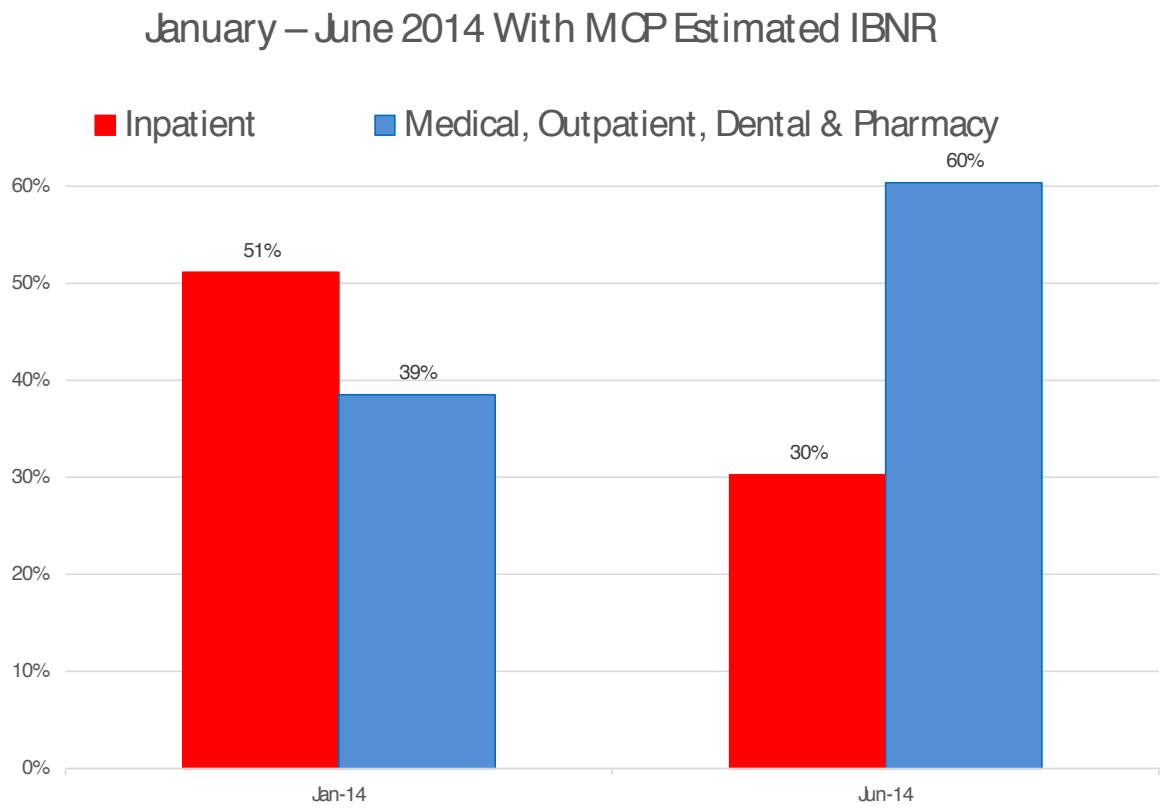

Ohio Department of Medicaid

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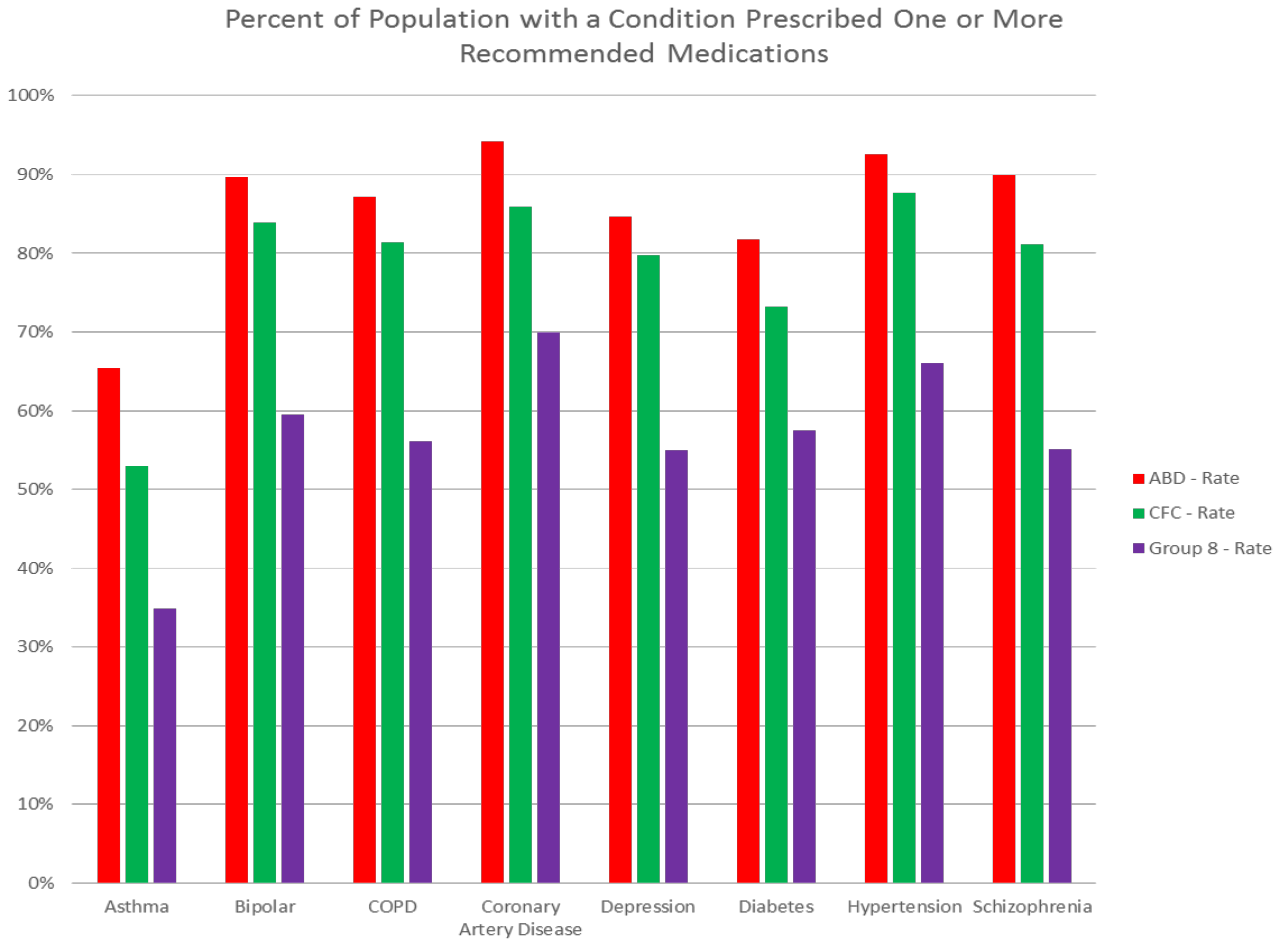
Medicaid Enrollment Overview



Group VIII Income and Health Status

Group VIII Income Level	Percent of People	Percent with either: BH procedure; DMHAS provider service; Inpatient Patient Psych claim; IP Detox; or BH Drug (including substance abuse)	Percent with either: BH procedure; DMHAS provider service; Inpatient Patient Psych claim; IP Detox; BH Drug (including substance abuse); or BH primary diagnosis	Percent with Inpatient Psych claim	Percent with Inpatient Detox Claim	Percent with a DMHAS visit
Earned Income	42%	29%	38%	0.9%	0.4%	11%
No Earned Income	50%	39%	47%	1.7%	0.9%	20%
Metro Waiver and/or Unavailable	8%	30%	37%	0.7%	0.6%	12%
Total	100%	34%	42%	1.3%	0.7%	15%

Source: Ohio Department of Medicaid

Group VIII Income and Health Status

Group VIII Income Level	Percent with Cancer	Percent with Chronic Clincal Condition (includes BH)	Percent with Chronic Clincal Condition that is not Behavioral Health	Percent with a Possible Disabling Clinical Condition	Percent with IP Stay (not delivery)	Percent with a Claim	Percent with a Preventive Visit
Earned Income	5%	72%	68%	11%	8%	80%	63%
No Earned Income	5%	77%	71%	18%	14%	83%	64%
Metro Waiver and/or Unavailable	6%	78%	74%	15%	7%	86%	76%
Total	5%	75%	70%	15%	11%	82%	65%

Ohio Department of Medicaid

Source: Ohio Department of Medicaid

Simplification and Consistency in Eligibility Policy

Disabled Ohioans Have to Prove It Twice

- Every year, about 50,000 Ohioans with a disability qualify for Medicaid coverage:
  - Includes DD, mentally ill, frail elderly and others
  - Some reside in an institution but most live in the community
  - Some have income but "spend down" to qualify for Medicaid
  - Can keep a house and car but no assets above $1500

- Today these Ohioans have to prove they are disabled twice:
  - Via county JFS offices for Medicaid and also
  - Via OOD for Social Security Income (SSI)

- Most states (33) have already eliminated this duplication and automatically enroll SSI individuals in Medicaid
  - Ohio could do this via OOD for SSI and Ohio Medicaid

What is the difference between 209(b) and 1634?

- In a 209(b) state like Ohio, individuals granted Supplemental Security Income (SSI) by the Social Security Administration (SSA) must complete a separate Medicaid application and disability determination process.

- In a 1634 state, individuals eligible for SSI are automatically enrolled in Medicaid.

- 209(b) states are required to operate a Medicaid spend down program; 1634 states are not required to do so.

What is a Spend Down Program?

- A spend down program allows individuals who have income over the eligibility threshold but otherwise meet the requirements for Medicaid under the aged, blind or disabled (ABD) categories to receive coverage.

- Individuals with income over the threshold are assigned an amount of medical expenses they must incur each month (spend down) prior to receiving Medicaid benefits.

- An individual's spend down is equal to the amount his or her income exceeds the eligibility limit after accounting for applicable income deductions.

Impact on Current Medicaid Enrollees

No change in enrollment for most current beneficiaries:

- Social Security and Ohio Medicaid use exactly the same definitions of disability
- 403,000 beneficiaries, including those in institutions or on home and community based services (HCBS) waivers, will continue to receive Medicaid benefits
- Some in this group at higher income levels will need to put their income in a trust to continue to qualify for Medicaid (currently they "spend down" income every month to qualify)

Impact on Current Medicaid Enrollees

- 7,110 Ohioans who are currently on SSI (but not yet enrolled in Medicaid) will be automatically enrolled in Medicaid

- Most of this group is eligible for Medicaid now but not enrolled – the only newly eligible enrollees will be individuals whose assets are between the Medicaid limit ($1500) and the SSI limit ($2000)

Impact on Current Medicaid Enrollees

Other coverage options:

- 4,554 disabled Ohioans would no longer qualify for Medicaid because their income is too high (>$721 monthly)
- However, Ohio Medicaid will use the 1915(i) state plan option to create a special program for the 3,660 individuals with severe and persistent mental illness with incomes that are too high
- The remaining 924 may enroll in the Exchange or may qualify through a Miller Trust

How does a Miller Trust Work?

- A Miller Trust is a legal structure that allows income in excess of the eligibility limit for Medicaid to be disregarded.
- An individual must place the portion of his or her monthly income that is greater than the current income standard into the trust.
- Individuals may apply certain deductions to these funds, and the remaining amount in the trust is paid to the institution or health care providers.
- On a monthly basis Miller trust funds pay for the cost of care, and Medicaid pays for the care not funded by the trust.
- In cases of a recipient's death, and should they be subject to a state recovery, any and all funds remaining in the Miller trust, up to the total cost of care, are paid to Medicaid.

Benefits of One System Instead of Two

- Much easier for eligible individuals with disabilities to navigate
- Eliminates the current and significant administrative burden on individuals, counties, and providers
- Advantages for those who move to the Exchange:
  - More affordable to pay premiums and copays on the Exchange but otherwise preserve income that would have been spent down to qualify for Medicaid
  - Continuous coverage without interruption instead of month-to-month Medicaid eligibility based on spend down

Summary of Policy Changes

Policy	Federal SSI	Ohio Medicaid	Proposed
Disability Test	• Defined in federal law	• Same	• Same
Income Limit	• 75% of poverty ($721 monthly)	• 64% of poverty ($632 monthly) • However, no effective limit because federal law requires non-SSI states to allow individuals of any income to "spend down" income to qualify for Medicaid	• 75% of poverty ($721 monthly) • Option to establish a Miller Trust to disregard income
Asset Limit	• $2,000	• $1,500	• $2,000

Eligibility Changes

- Align upper threshold of non-ABD adult eligibility with the federal exchange at 138% of the federal poverty level:
  - Pregnant women
  - BCCP
  - Family planning services eligibility group (not the benefit)
- Change the Temporary Medical Assistance (TMA) policy back to the pre-recession policy:
  - Quarterly reporting required
  - Six months of additional Medicaid enrollment with two additional quarters possible if quarterly reported income remains below 185% FPL
- Premiums for non-ABD adults with incomes over 100% FPL

Changes in Long Term Care Benefits

Improve Quality in Home Care

- Ensuring effective, quality home care oversight has posed significant challenges among state Medicaid programs.
- Particularly, the oversight of independent providers has proven difficult within the high-risk arena of home care.

During Calendar Years 2010-2014:

- Medicaid Fraud Control Unit of the Ohio Attorney General's Office (MFCU) received 1,473 referrals for home health-related Medicaid fraud. Of those 1,473 fraud referrals, 634 (~43%) were tied to independent providers.
- MFCU indicted 535 home health providers. Of those 535 fraud indictments, 335 (~63%) were for independent providers.
- 479 home health providers were criminally convicted, and independent providers accounted for 306 (~64%) of those convictions.

Improve Quality in Home Care

- 90,000+ Ohioans rely on direct care workers. Most are employed by agencies, but roughly 13,000 are independent providers.
- A majority of states and Medicare only do business with agencies.
- The Budget transitions to an agency-only model over three years:
  - Prohibition on new independent provider enrollment beginning July 2016
  - Prohibition on provider agreement revalidations beginning July 2016
  - Provider revalidations are to be done every three years
- Independent providers will continue to be permitted under 'self-directed' waivers/services.

Modernize Nursing Benefit

- There is currently a proposed rule with an effective date of July 1, 2015 to implement new rationalized rates
- Continue to reform Private Duty Nursing (PDN) by changing the benefit from a state plan long-term benefit to a short-term benefit by July 1, 2016.
- Add nursing to all waivers for individuals that need long-term nursing services:
  - Improves care management through the waiver service coordinator
- Add the same delegated nursing services available in the DODD waivers to ODM and ODA waivers.

Changes in School-Based Services Benefits

Medicaid in Schools Program

- Ohio Medicaid reimburses schools through the Medicaid in Schools Program (MSP) for services provided to children with an Individualized Education Plan (IEP).

- Reimbursable services are limited to:
  - behavioral health
  - nursing
  - occupational therapy
  - targeted case management
  - specialized transportation

- The school is responsible for providing these services, but can draw federal funds through the MSP program to reimburse 63 percent of the cost.

- Currently 580 school systems enrolled in the MSP program serving 61,000 Medicaid-eligible students with an IEP.

Medicaid in Schools Program

- Proposed expansion of the services that are Medicaid reimbursable include:
  - Intensive behavioral services provided by a Certified Ohio Behavioral Analyst (COBA)
  - Services provided by an aide under the direction of a registered nurse or COBA
  - Specialized transportation from a child's home to school
- This provision will allow schools to claim additional federal funds of $46.4 million that the school districts otherwise would have been required to provide with their own funds.
- There will be no impact on the state general revenue fund because the school districts provide the local match, through expenditures tied to eligible IEP services, to draw federal Medicaid funds.

Reform Hospital Payments

Reform Hospital Payments

- Reforms the payment methodology for drugs given in a hospital outpatient setting by paying the FFS fee schedule rates instead of 60% of cost
- Consolidates outpatient charges within 72 hours before and after an inpatient stay
- Eliminates the 5% outpatient rate add-on for non-children's hospitals

Reform Hospital Payments

- Assumes a 1% reduction in potentially preventable readmissions (PPR) because PPR rates are posted to the ODM website:
  - http://www.medicaid.ohio.gov/RESOURCES/ReportsandResearch/ModernizeHospitalPayments.aspx
- New penalties and incentives for PPR rates starting in SFY 17
- Implements National Correct Coding Initiative (NCCI) standards for outpatient hospital claims
- Converts direct medical education subsidy into primary care rate increase
- Increases the hospital franchise fee from 2.75 to 3.0 percent
  - Returns a portion of fees paid via the upper payment limit program

Source: Office of Health Transformation, Reform Hospital Payments (February 2015).

Reform Hospital Payments: Franchise Fee

All funds in millions	SFY 2014 actual	SFY 2015 estimated	SFY 2016 proposed	SFY 2017 proposed
Hospital Baseline (FFS + MCO)	$ 4,302	$ 5,434	$ 5,722	$ 6,105
- Current Hospital Franchise Fee	$ 514	$ 554	$ 554	$ 554
- Proposed increase from 2.75 to 3.0 percent			$ 107	$ 142
Hospital Baseline (FFS + MCO) minus Franchise Fee	$ 3,788	$ 4,880	$ 5,061	$ 5,410
Supplemental Payments Supported by the Franchise Fee				
- Managed Care Incentive	$ 162	$ 162	$ 162	$ 162
- Current Upper Payment Limit Program	$ 492	$ 582	$ 582	$ 582
- Proposed UPL gain from increasing the franchise fee			$ 30	$ 62
Subtotal	$ 654	$ 744	$ 774	$ 806
Baseline Plus Supplemental Payments	$ 4,442	$ 5,624	$ 5,835	$ 6,216

Source: Office of Health Transformation, Reform Hospital Payments (February 2015).

Reform Hospital Payments: Other Reforms

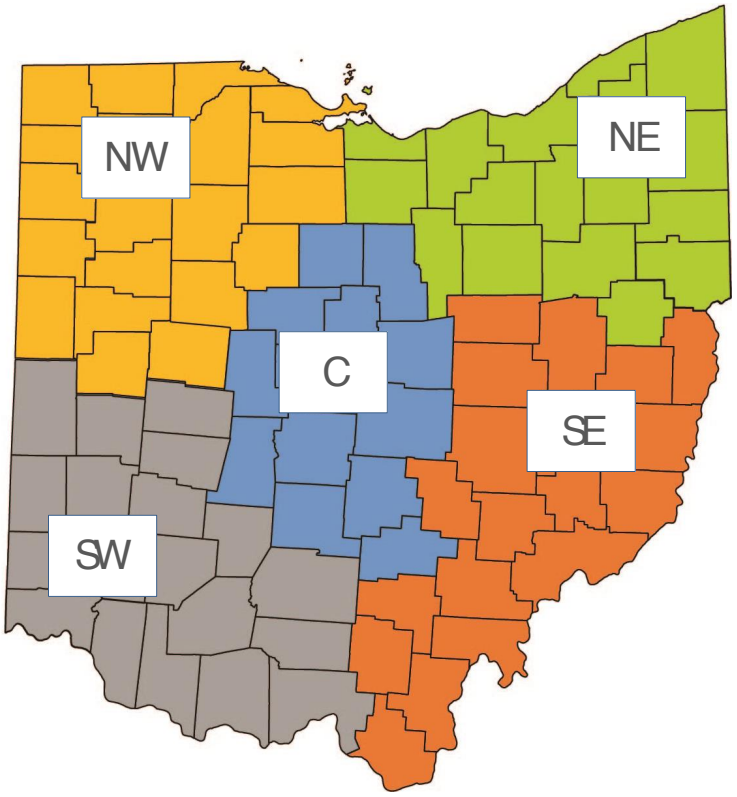
All funds in millions	SFY 2014 actual	SFY 2015 estimated	SFY 2016 proposed	SFY 2017 proposed
Baseline Plus Supplemental Payments	$ 4,442	$ 5,624	$ 5,835	$ 6,216
Hospital Payment Reforms (All Funds)				
- Reform payment method for detail-coded drugs			$ 22	$ 44
- Consolidate outpatient charges			$ 6	$ 11
- Eliminate 5 percent rate add-on for outpatient services			$ 50	$ 107
- Reduce potentially preventable hospital readmissions			$ 14	$ 32
- Implement correct coding standards			$ 5	$ 10
- Convert medical education subsidies into a primary care rate increase[3]			$ -	$ 25
Subtotal			$ 97	$ 229
Ohio Medicaid Hospital Spending	$ 4,442	$ 5,624	$ 5,738	$ 5,987
Percent Change		26.6%	2.0%	4.3%

Ohio | Governor's Office of Health Transformation

Source: Office of Health Transformation, Reform Hospital Payments (February 2015).

Total Amount of Uncompensated Care - 2013

Northwest:
$170.7 million



Northeast:
$489.2 million

Southwest:
$512.9 million

Southeast:
$100.9 million

Central
$352.7 million

Estimated Uncompensated Care w/ Group VIII - 2014

Northwest:

Total w/o Expansion:
$152.5m

Actual total w/ Expansion:
$57.3m

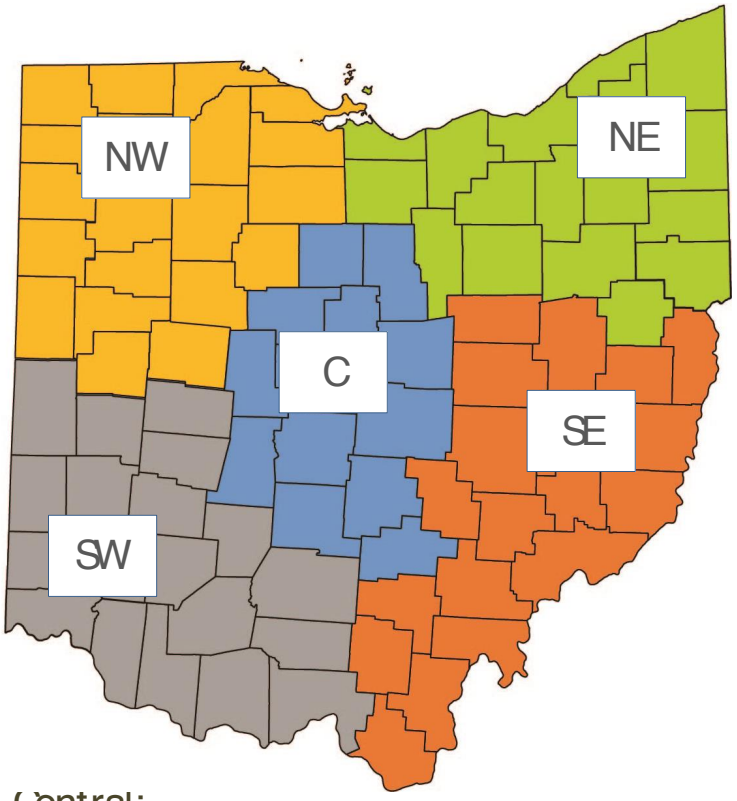
2013-14 Change:
-66.42%

Southwest:

Total w/o Expansion:
$464.6

Actual total w/ Expansion:
$252.1m

2013-14 Change:
-50.86%



Northeast:

Total w/o Expansion:
$512.8m

Actual total w/ Expansion:
$185.2m

2013-14 Change:
-62.75%

Southeast:

Total w/o Expansion:
$95.4m

Actual total w/ Expansion:
$65.9m

2013-14 Change:
-34.66%

Central:

Total w/o Expansion:
$349.4m

Actual total w/ Expansion:
$176.5m

2013-14 Change:
-49.95%

Reform Nursing Facility Reimbursement

Reform Nursing Facility Reimbursement

- Increases NF reimbursement $84 million in 2017 by rebasing the formula (+$154 million) and updating the "grouper" (-$70 million)

- Implements RUGS IV same as Medicare:
  - Ohio uses nationally recognized acuity measurement software that utilizes clinical data collected by CMS.
  - In 2010 CMS updated the data collection tool (to MDS 3.0) and offered states the option of using an updated grouper (RUGS IV).
  - Ohio continued using the older grouper because it aligned with the rate components in effect.
  - The new grouper that reflects current clinical practice will be implemented as the new rate components are calculated.
  - In addition, Ohio will move from 45 acuity groups to 66 acuity groups so that facility payments are more reflective of the differences in the needs of the individuals served.

Reform Nursing Facility Reimbursement

- Links 100 percent of the increase to quality performance
  - Staffing levels above current minimums (recommended by the Consumer Voice, a national advocacy group representing nursing facility residents and their families)
  - Consistent assignment of nurse aides
  - Rate of pressure ulcers across the facility census (both long-stay and short-stay measures)
  - Rate of atypical antipsychotic use for both long-stay and short-stay residents
  - Rate of avoidable inpatient admissions from nursing facilities

Reform Nursing Facility Reimbursement

- Reduces reimbursement for low acuity individuals (-$24 million)
  - Current budget implemented a reduced rate for low acuity individuals.
  - The rate per day paid for the lowest acuity individuals in Ohio's nursing facilities will be reduced from $130 per resident day to $91.70 per resident day.
  - The Medicaid rate will better align with the needs of the individual while recognizing necessary costs related to room and board and the regulatory requirements related to a licensed setting.
- Removes the nursing facility reimbursement formula from statute

Reform Managed Care Payments

Reform Managed Care Payments

- Sets managed care rates at the bottom actuarial boundary for the third budget in a row
- Uses one-time unearned pay-for-performance (P4P) funds to offset the cost of moving additional populations into managed care and support for health plan activities to reduce infant mortality
- Budgets P4P funds at 63% instead of 100%

Additional Populations

- Additional populations will be served through private insurance companies instead of government run fee-for-service:
  - Adopted and foster children
  - Immediate enrollment into a plan instead of, on average, a 45 day waiting period in FFS
  - Individuals with intellectual and developmental disabilities (optional with an assumed 5% take up rate)

Additional Benefits

Behavioral Health

- Behavioral health benefits will be provided through managed care
  - Behavioral-Health Health Home payment methodology phased out
- ODM, ODMHAS, and OHT will work with stakeholders through a process to decide best delivery model during SFY15

Care Coordination

- Use community health workers from the communities where infant mortality is the highest in order to engaged in culturally connected care coordination and education

Reform Non-Institutional Provider Reimbursement

Reform Non-Institutional Provider Reimbursement

Primary Care Rates are Increased:

- Increases Medicaid primary care rates $151 million over two years

- Applies to:
  - Physicians
  - Optometrists
  - Physician Assistants
  - Advanced Practice Registered Nurses

- Estimated increases in rates:
  - Non-facility – 19% (as a % of Medicare 53.6% to 65.4%)
  - Facility – 30% (as a % of Medicare 45.6% to 60.2%)

- Increases Medicaid dental provider rates $5 million over two years

Reform Non-Institutional Provider Reimbursement

From Rationalization of Reimbursement Policy:

- Applies Medicaid maximum payment to Medicare crossover claims (saves $129 million over two years)

- Normalizes payments that are made to only one health system from 140% of FFS to 100% of FFS to align the health system with other providers in the same geographic area (saves $1.5 million)

Fight Fraud, Waste, and Abuse

Fight Fraud, Waste and Abuse

Electronic Visit Verification:

- The Executive Budget calls for Electronic Visit Verification (EVV) technology to assist with ensuring the proper delivery and reporting of home care services.

- Several states have already adopted state-of-the-art systems that ensure that necessary services are being rendered in accordance with the proper time, manner, and scope designated in the service plan.

- EVV systems may incorporate various forms of technology such as, GPS, biometrics, tablets, and smartphones.

Fight Fraud, Waste and Abuse

- Releasing an RFP to procure a vendor to use advanced analytics to mine existing data for fraud
- Recoup related physician payments when a hospital claim has denials after it is reviewed by our utilization review vendor

Payment Innovation

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5-Year Goal for Payment Innovation

Goal

80-90 percent of Ohio's population in some value-based payment model (combination of episodes- and population-based payment) within five years

State's Role

- Shift rapidly to PCMH and episode model in Medicaid fee-for-service
- Require Medicaid MCO partners to participate and implement
- Incorporate into contracts of MCOs for state employee benefit program

	Patient-centered medical homes	Episode-based payments
Year 1	▪ In 2014 focus on Comprehensive Primary Care Initiative (CPCI) ▪ Payers agree to participate in design for elements where standardization and/or alignment is critical ▪ Multi-payer group begins enrollment strategy for one additional market	▪ State leads design of five episodes: asthma acute exacerbation, perinatal, COPD exacerbation, PCI, and joint replacement ▪ Payers agree to participate in design process, launch reporting on at least 3 of 5 episodes in 2014 and tie to payment within year
Year 3	▪ Model rolled out to all major markets ▪ 50% of patients are enrolled	▪ 20 episodes defined and launched across payers
Year 5	▪ Scale achieved state-wide ▪ 80% of patients are enrolled	▪ 50+ episodes defined and launched across payers

Retrospective Episode Model Mechanics

Patients and providers continue to deliver care as they do today

1

Patients seek care and select providers as they do today

2

Providers submit claims as they do today

3

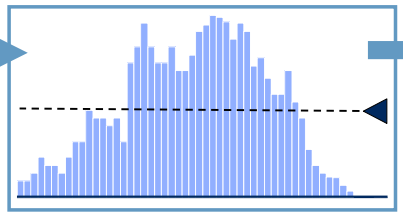
Payers reimburse for all services as they do today

Calculate incentive payments based on outcomes after close of 12 month performance period

4

Review claims from the performance period to identify a 'Principal Accountable Provider' (PAP) for each episode

5 Payers calculate average cost per episode for each PAP



Compare average costs to predetermined "commendable" and "acceptable" levels

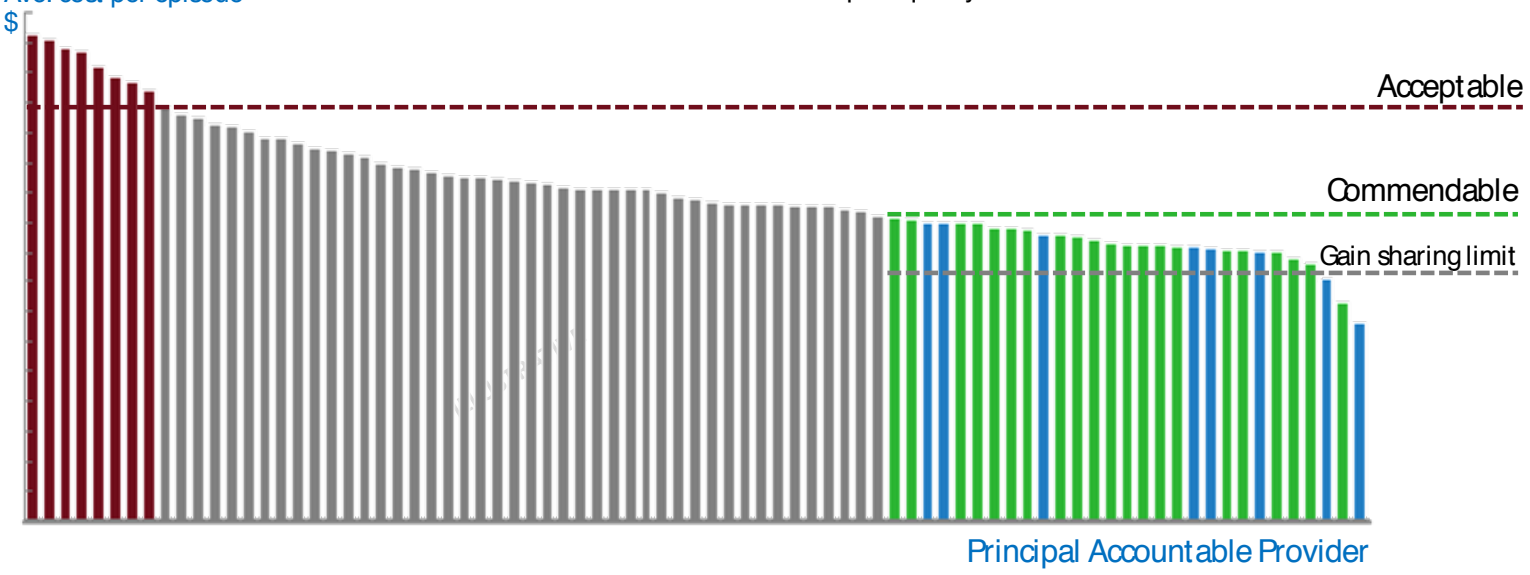
6 Providers may:

- Share savings: if average costs below commendable levels and quality targets are met
- Pay part of excess cost: if average costs are above acceptable level
- See no change in pay: if average costs are between commendable and acceptable levels

Retrospective thresholds reward cost-efficient, high-quality care

Provider cost distribution (average episode cost per provider)

- **Risk sharing** — Pay portion of excess costs
- **No change** — Payment unchanged
- **No Change** Eligible for gain sharing based on cost, but did not pass quality metrics
- **Gain sharing** — Eligible for incentive payment



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NOTE: Each vertical bar represents the average cost for a provider, sorted from highest to lowest average cost

Questions