

Medicaid  
**Modernize Hospital Payments**

**Budget Impact**

FY 2012	FY 2013	Biennial Total
(\$179,879,200)	(\$297,920,400)	(\$477,799,600)

**Background:**

Ohio Medicaid is using 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-driven and do not reward providers for improved outcomes. They need to be revised to support Medicaid modernization and movement to improve outcomes.

**Executive Budget Proposal and Impact:**

The Executive Budget proposes the following changes to modernize Medicaid hospital reimbursement:

- **The DRG System.** Ohio uses a diagnosis-related group (DRG) system to classify inpatient hospital cases into one of approximately 500 groups, which are used to determine inpatient hospital reimbursement. Ohio is using DRG version 15, Medicare is using Grouper version 28, and more modern versions can assign up to two and a half times as many DRGs, which allows for more accurate and efficient reimbursement (For example, the current outdated Grouper has limited ODJFS’ ability to enforce non-payment for health care acquired conditions.) A new DRG Grouper will be identified and implemented by January 1, 2013. This change is expected to be budget neutral.
- **Outpatient Services.** ODJFS reimburses most hospitals for outpatient services using predetermined fee schedules. Although the majority of services have a set reimbursement rate, there are a few services reimbursed using a percentage of billed charges. Depending on the service, the percentage can vary from 50 to 70 percent of charges, a result that does not comply with Ohio’s current Medicaid State Plan Amendment. Effective January 1, 2012, the Budget will change the percentage-based reimbursement to each hospital’s specific outpatient cost-to-charge ratio. This will limit reimbursement to cost for these services and save \$66.2 million over the biennium.

- **Outlier Payments.** ODJFS pays hospitals for outlier cases as part of the inpatient hospital reimbursement methodology. One form of outlier payment is based on a predetermined charge threshold for each DRG. These charge thresholds are inflated annually based on cost growth as opposed to growth in charges. Hospital charge inflation is nearly three times the cost of inflation. As a result, the percent of all fee-for-service (FFS) claims which qualify as cost outliers increased by 35 percent since 2007. Effective October 1, 2011, the Executive Budget will require that future cost outlier inflation factors be based on the most recent three-year average increase in charges per discharges. This will align the inflationary factor with the methodology for determining which claims qualify for cost outliers. This change saves \$157.4 million over the biennium.
- **Crossover Payments.** Currently Medicaid is not maximizing its cost avoidance opportunities for outpatient Medicare Part B crossover claims. Currently, Medicaid is overpaying providers when a person is enrolled in both Medicare and Medicaid and Medicaid has a lower reimbursement rate than Medicare. Effective January 1, 2012, the Executive Budget will change the payment methodology for crossover claims to pay no more than the Medicaid maximum as the cost sharing obligation under Medicare Part B. This change saves \$94.5 million over the biennium.
- **Hospital Acquired Conditions.** Ohio's current Medicaid payment systems do not allow enforcement of payment prohibitions for services related to provider-preventable conditions. ODJFS will update its payment systems to improve enforcement and, consistent with Section 2702 of the federal Affordable Care Act, implement policies to prohibit Medicaid payment for provider-preventable conditions. The goal is to prompt providers to develop quality programs to reduce medical errors and avoid related costs. This change saves \$308,000 over the biennium.
- **Children's Hospital Line Item.** Since SFY 2006, the Ohio General Assembly required ODJFS to make supplemental payments to Ohio's children's hospitals. Funding of \$6 million per year state funds plus federal matching funds was designated in temporary law. In SFY 2009 the General Assembly created a designated line item for these payments and created an earmark of \$4.4 million in SFY 2010 and \$4.0 million in SFY 2011 from the hospital franchise fee to provide additional payments to children's hospitals. Effective July 1, 2011, the Executive Budget will eliminate GRF funding for the children's hospital line item (600-537). This change saves \$33.4 million over the biennium.
- **Inpatient Capital Rates.** Historically, Medicaid managed care plans have reimbursed hospitals using the same capital rate as calculated for FFS inpatient capital costs. With Medicaid managed care fully implemented, the remaining FFS population consumes more capital resources (\$772 per discharge on average) compared to the managed care population (\$427 per discharge on average). Instead of using FFS inpatient capital rates for managed care, the Executive Budget proposes to set specific Medicaid managed care

capital rates for hospitals beginning January 1, 2012 and updating those rates annually thereafter. This change saves \$126 million over the biennium.

The current budget is supported by health care-related provider fees that generate matching funds to be used for Medicaid program spending. The Executive Budget proposes the following changes related to self-funded hospital franchise fee programs (these programs are self-funded and not included in the state “Budget Impact” at the top of this page):

- **Five Percent Rate Increase.** The Ohio Hospital Association (OHA) has proposed to continue the existing franchise fee, which otherwise will sunset June 30, 2011, and apply the proceeds and related federal matching funds to extend a temporary five percent hospital rate increase that without a source of funding would expire June 30, 2011. The Executive Budget incorporates the OHA franchise fee methodology, which results in a net gain of \$554 million for hospitals and \$434 million in general revenue funds (state share) for the state over the biennium. This change expends \$371 million over the biennium funded by the continuation of the hospital franchise fee.
- **HCAP Program.** The 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 Budget reauthorizes HCAP until October 2013, which allows Ohio hospitals to receive \$560 million in DSH payments annually. This change expends approximately (depending on federal allotments) \$1.1 billion over the biennium.

Medicaid  
**Reform Nursing Facility Payments**

**Budget Impact**

FY 2012	FY 2013	Biennial Total
(\$212,118,246)	(\$214,902,241)	(\$427,020,487)

**Background:**

Nursing facilities are a critically important service in the continuum of long-term services and supports reimbursed by Medicaid. However, Ohioans spend more per capita on nursing homes than citizens in all but five states. Nursing facility rates are approximately \$4.75 higher than the national average, and the current reimbursement methodology does not reflect individual preferences for personalized care. The current high level of spending on nursing homes limits Ohio Medicaid’s investment in home and community based services, and amplifies the current institutional bias in the Medicaid long-term care delivery system.

**Executive Budget Proposal and Impact:**

The Executive Budget proposes the following changes in nursing facility reimbursement:

- **Rate Methodology.** Since 2006, the Ohio Medicaid program has been transitioning from a cost-based to price-based reimbursement methodology for nursing facilities. The Executive Budget will complete that process, establishing a price for most services at the 25<sup>th</sup> percentile of historical peer group cost experience, including for direct care, ancillary and support services, and capital. A semi-annual adjustment for direct care related to resident acuity will be retained. The consolidated services per diem (services that were “bundled” into the nursing facility rate in the previous budget) will be incorporated into the direct care price so that facilities serving higher acuity individuals will receive more of the funds. The existing process-oriented quality incentive payment program will be replaced with a patient-oriented quality program, and the current quality incentive payment (1.7 percent of the rate) will be increased (to 8.75 percent of the rate) by redirecting per diem payments related to the franchise permit fee and workforce development. This change saves \$399,862,517 over the biennium.
- **Crossover Claims.** When an individual eligible for both Medicare and Medicaid receives nursing facility services, Medicaid is responsible for any cost-sharing obligation the individual might have under Medicare coverage policies. The Executive Budget will require ODJFS to compare the payment Medicare made for the nursing facility service to the payment Medicaid would have made for the service as the primary payer (defined as

100 percent of the Medicaid per diem for the facility). If the Medicare payment is equal to or exceeds the payment Medicaid would have made, then the nursing facility is considered paid in full and no further payment is made. If the Medicare payment is less than Medicaid would have paid, then Medicaid pays the lesser of the consumer's cost sharing amount or the difference between the Medicare and Medicaid rates. This change saves \$8,473,478 over the biennium.

- **Leave Days.** A "leave day" is a day when the individual is not in the nursing facility, for example, during a hospital admission or weekend with family. Leave days are intended to hold the individual's room for a temporary absence from the facility. Today, Medicaid will pay 50 percent of the facility's rate for up to 30 leave days per resident per calendar year. The current leave day policy reflects a time when Ohio's nursing homes operated at high occupancy levels and holding a bed represented missed opportunities for income. As the role of nursing facilities in the delivery system has changed, the opportunity cost to the nursing facility of holding a bed during a temporary absence has declined. In response, the Executive Budget will reduce the number of covered leave days to 15 per calendar year and reduce the payment for those leave days to 25 percent of the facility's rate. This change saves \$16,243,342 over the biennium.

The current budget is supported by health care-related provider fees that generate matching funds to be used for Medicaid program spending. The Executive Budget proposes the following changes related to the nursing facility franchise fee program, which is self-funded and not included in the state "Budget Impact" at the top of this page:

- **Franchise Fee.** The nursing facility franchise fee is assessed on licensed nursing home beds in Ohio. The per bed per day assessment rate will decrease from \$11.95 in SFY2011 to \$11.38 in SFY2012 and then increase to \$11.60 in SFY2013. In SFY 2012 collections from the franchise fee will be approximately \$392.1 million and in SFY 2013 collections from the franchise fee will be approximately \$392.9 million. These funds are used, in part, to support the increased quality incentive payment included in nursing facility rates.

Medicaid  
**Reform Managed Care Plan Payments**

**Budget Impact**

FY 2012	FY 2013	Biennial Total
\$37,680,300	(\$196,344,300)	(\$158,664,000)

**Background:**

Currently, over 1.6 million individuals enrolled in the Medicaid program receive care through a managed care plan. In SFY 2011, the estimated cost to serve those individuals is approximately \$5.1 billion in capitation payments. Capitation rates are set annually using a combination of actual cost data and medical cost inflation data to establish the cost of medical services and the cost of administrative services. As the Medicaid managed care delivery system continues to mature in Ohio, the managed care plans should become better managers of care and be able to reduce the trend in medical cost inflation and become more efficient at running their operations.

**Executive Budget Proposal and Impact:**

The Executive Budget will reform Medicaid managed care plan reimbursement to improve care coordination for beneficiaries and achieve cost savings through greater efficiency in managed care plan administration. These changes will apply not only to services for populations currently in Medicaid managed care, but also to services for children with disabilities who are currently enrolled in the fee-for-service system but the Executive Budget proposes to enroll in managed care (this initiative and the budget savings associated with are described under “Improve Care Coordination: Promote Accountable Care for Children”). The Executive Budget proposes the following changes in managed care plan reimbursement:

- **Capitation Rates.** A review of the administrative portion of the capitation rate and medical inflation trend used to determine the medical services component of the rate by the actuary indicates that there are opportunities to achieve savings in these components due to the maturity of the Ohio Medicaid managed care program. For example, the actuary has recommended that ODJFS use the lower boundary of the medical cost inflation trend, reduce the administrative components of the capitation rate to reflect reductions in administrative requirements placed on the plans by the Ohio Medicaid program, and reduce the administrative component based on actual managed care plan experience and national trends. Also, the expansion of managed care to include children with disabilities will allow the plans to more efficiently spread their administrative costs across more lives. The Executive Budget proposes to make these changes in capitation rates, which will save \$144 million over the biennium.

- **Pharmacy Benefit.** In February 2010, the pharmacy benefit was “carved out” of the managed care capitation rate to allow ODJFS to collect rebates on pharmaceuticals, which at the time could only be collected by the state in the FFS program, and provide for a single drug list and prior authorization process. In March 2010, the federal Affordable Care Act created the same access to drug rebates in managed care. In support of better care coordination, the pharmacy benefit will be carved back into the managed care program effective October 1, 2011. In addition, ODJFS will work with the plans, providers, and advocacy groups to develop a more standardized set of prior authorization criteria than what was used previously. This change expends \$114 million all funds over the biennium.
- **Hospital Non-Contracting.** Medicaid managed care plans on average pay hospitals more than 104 percent above Medicaid FFS rates. The Executive Budget will require Medicaid reimbursement to default to FFS rates for hospitals that will not contract with a Medicaid managed care plan. This change will allow hospitals and managed care plans to compete based on the quality and availability of services instead of leveraging the need to meet access standards. This change saves \$119.6 million over the biennium.
- **Eliminate the Children’s Buy-In Program.** The Children’s Buy-In Program was implemented in April 2008 to provide families with income between 300 and 500 percent of the federal poverty level with a subsidy to purchase a commercial-like health insurance benefit from a Medicaid managed care plan for children otherwise uninsurable. Despite early estimates that 5,000 uninsured Ohio children would obtain coverage, as of March 2011 there were only five children enrolled in the Program. The Executive Budget allows children who are currently enrolled in the program to keep their coverage but otherwise eliminates the program. This change saves \$9 million over the biennium.

In addition to the changes above, the budget is supported by a sales and use tax on managed care plan premiums. As premiums go up, so does the revenue generated by the tax. The reverse is also true – as premiums decrease, the revenue generated by the sales tax decrease. Each of the policy changes described above has an impact on sales tax revenue. Sales tax revenue will increase \$152.6 million over the biennium as a result of moving the pharmacy benefit back into managed care and decrease \$17.2 million over the biennium as a result of reducing administrative payments, changing how hospitals are reimbursed if they do not sign a managed care contract, and enrolling fewer people if the economy improves. The net impact of these changes on sales tax revenue is an increase of \$135.4 million over the biennium. In summary, the Medicaid payment reforms described above result in Medicaid savings totaling \$158.7 million over the biennium and sales tax revenue gains of \$135.4 million over the biennium, or \$294.1 million in total benefit for the State of Ohio over the biennium.

Medicaid**Reform Other Benefits and Payments****Executive Budget Proposal and Impact:**

- Nursing and Home Health Services.** Ohio Medicaid currently pays nurses \$54.95 whether the nurse delivers 15 minutes of service or 60 minutes of service (this is called the “base rate”). After the first hour, Medicaid pays \$5.69 for each additional 15 minutes of service (this is called the “unit rate”). Similarly, Ohio Medicaid pays home health aides a \$23.98 base rate and \$3.00 unit rate. The base rate is paid each time the nurse or home health aide sees a different patient and can result in excessive payment. For example, if a nurse sees four patients in the same building within one hour, the nurse can charge Medicaid \$54.95 four times or \$219.80 for a single hour of services. Between February 2010 and January 2011, 59 independent nurses (2.5 percent of total) were paid \$100,000 or more and three were paid between \$200,000 and \$250,000. Beginning in October 2011, ODJFS will reduce the base rate it pays for Medicaid community-based nursing services from \$54.95 to \$48.93 and reduce the base rate for home health aide and personal care from \$23.98 to \$22.50. Also, by July 1, 2012, ODJFS will develop new payment methods for community-based nursing services for home health aide and personal care. The new method will take into account labor market data, education and licensure status, home health agency and independent provider status, and length of service visit. This change saves \$35.0 million over the biennium.
- Waiver Services.** From the time it was created, the PASSPORT/Choices waiver has not been subject to the same utilization and pricing restrictions imposed on most other Medicaid services and providers. The Executive Budget will reduce PASSPORT/Choices, assisted living, and PACE provider rates 3.0 percent, an amount that is relatively less than reductions in other areas. The budget will reduce PASSPORT/Choices emergency response provider rates 30 percent and implement a group rate for transportation. State support for Area Agencies on Aging will be reduced 15 percent and PASSPORT per member per month costs will be reduced by eight percent for consumers through utilization protocols. These changes achieve greater efficiencies to avoid waiting lists for services and save \$176.4 million over the biennium.
- Physician Payment Codes.** The 2011 Medicaid price exceeds the Medicare price for a number of physician services. Effective July 1, 2011, ODJFS will reduce the Medicaid price to 100 percent of the Medicare price for all codes. This change saves \$3.1 million over the biennium.
- Non-Emergency Transportation.** Non-emergency transportation is a statewide program of transportation assistance designed to facilitate access to Medicaid providers. The

program is administered by the 88 County Departments of Job and Family Services, which function as a local broker to consumers for whom transportation cannot be arranged through other resources. ODJFS will assist at least one group of CDJFS to form a regional brokerage on a voluntary basis. The goal of the initiative is to reduce direct program costs by a minimum of five percent while assuring continued access to services. This change saves approximately \$200,000 over the biennium.

- **Nutrition Products.** Ohio Medicaid pays for enteral nutritional products based on the average wholesale price, and the amount Medicaid pays varies widely as manufacturers offer different additives or flavoring at a higher cost. As a result, Medicaid pays more for these products than basic, lower cost, nutritionally equivalent products in the same therapeutic category. These "extras" are not always medically necessary and are not required by Medicaid coverage criteria. Beginning January 1, 2012, ODFJS will reform the coverage and authorization of enteral nutritional products by establishing a maximum payment rate based on lower-cost but nutritionally equivalent products, and instituting more rigorous prior authorization review criteria for medical necessity. This change saves \$5.1 million over the biennium.
- **DME and Diabetic Supplies.** ODJFS currently reimburses suppliers of durable medical equipment based on a fixed fee schedule and, as a result, pays at least 20 percent more for select items than if market forces were used to determine reimbursement amounts. The Centers for Medicaid and Medicare Services began selective contracting for durable medical equipment in 10 Ohio metro counties this past January. The payment amounts based on bids submitted averaged 32 percent less than Medicare's fee schedule payment amounts. ODJFS will implement a selective contracting program for diabetic test strips and incontinence garments in July 2012, and eventually expand to include some or all of the items for which CMS received bid prices in the 10 Ohio metro counties. This change saves \$13.5 million over the biennium.

The Executive budget also includes authorization and funding to implement program requirements and benefit expansions mandated by the federal Affordable Care Act (ACA):

- **National Correct Coding Initiative.** ACA Section 6507 requires each state Medicaid program to implement compatible methodologies of the National Correct Coding Initiative (NCCI) to promote correct coding and control improper coding leading to inappropriate payment. Ohio will integrate the NCCI payment methodology into its claims payment systems. This change saves \$1.3 million over the biennium.
- **Face-to-Face DME.** ACA Section 6407(d) requires a face-to-face encounter with a patient during the 6 months prior to the prescribing physician certifying the medical necessity of a patient's need for durable medical equipment (DME). ODJFS will increase

the frequency of the required encounter from the current 12 months to every 6 months. This change expends \$1.4 million over the biennium.

- **Freestanding Birthing Centers.** ACA Section 2301 requires Medicaid to cover the services provided by freestanding birthing centers. ODJFS covers the services provided by a physician or a midwife in any setting but does not currently reimburse birthing centers for the facility costs incurred. Currently there are 4 known freestanding birthing centers operating in Ohio, 3 of which serve an exclusively religious (Amish) clientele. None of these have provider agreements with Medicaid. In the future, ODJFS may receive requests for freestanding birthing centers to enroll as Medicaid providers and will develop a reimbursement methodology for this provider type. This change expends \$400,000 over the biennium.
- **Preventive Services.** ACA Section 4106 requires Medicaid coverage for a limited set of preventive services currently not covered by Ohio Medicaid, including obesity screening, medical nutrition therapy, and the herpes zoster vaccine. ODJFS will develop rules to include coverage of these services as part of the Medicaid benefit package. This change expends \$15.6 million over the biennium.
- **Smoking Cessation for Pregnant Women.** ACA Section 4107 requires the provision of counseling and pharmaceuticals for tobacco cessation for pregnant women. ODJFS will develop OAC rules to include coverage as part of the benefit package. This change expends \$219,044 over the biennium.
- **Family Planning.** Prior to enactment of the ACA, for a state to obtain a 90 percent federal match rate for certain family planning services, a complicated approval method from the Centers of Medicare and Medicaid Services (CMS) was required. The ACA streamlined this process and now a state has the option to simply submit a Medicaid State Plan Amendment (SPA) to obtain a 90 percent federal matching rate for all family planning services. Family planning services are cost effective and improve health outcomes by reducing the number of unintended pregnancies and reducing complications during pregnancy and child birth due to venereal diseases. In 2010, ODJFS submitted a SPA to allow Medicaid to claim the 90 percent federal match rate in SFY 2012, and to claim 90 percent federal match for individuals not previously eligible for this service. This change expends \$15.6 million over the biennium.