

Improve Care Coordination

Coordinate care to achieve better health and cost savings through improvement.

1. Create a Single Point of Care Coordination
2. Promote Health Homes
3. Provide Accountable Care for Children

Integrate Behavioral and Physical Health Care

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

4. Integrate Behavioral and Physical Health Benefits
5. Elevate Behavioral Health Financing to the State
6. Manage Behavioral Health Service Utilization
7. Consolidate Housing Programs

Rebalance Long-Term Care

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

8. Create a Unified Long-Term Care System
9. Evaluate PACE
10. Link Nursing Home Payments to Person-Centered Outcomes
11. Align Programs for People with Developmental Disabilities

Modernize Reimbursement

Reset Medicaid payment rules to reward value instead of volume.

12. Modernize Hospital Payments
13. Reform Managed Care Plan Payments
14. Reform Nursing Facility Payments
15. Reform Other Benefits and Payments

Balance the Budget

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

16. Overall Impact of Transformation

Medicaid

Create a Single Point of Care Coordination

Budget Impact

FY 2012	FY 2013	Biennial Total
\$0	\$0	\$0

Background:

Ohio's Medicaid program serves approximately 173,000 individuals with long-term care needs each year. For most of these individuals, long-term care services, behavioral health services, and physical health services are provided through separate delivery systems with little or no coordination. While only seven percent of the Medicaid population uses long-term care services, 41 percent of annual Medicaid expenditures are for services to this population.

Many individuals receiving long-term care services are covered by both Medicare and Medicaid. These "dual eligibles" consume 46 percent of Medicaid long-term care service spending and 16 percent of behavioral health service spending. Because Medicare and Medicaid are designed and managed with little or no connection to each other, the system is unnecessarily complex for individuals and providers to navigate.

In addition to dual eligibles, Ohio serves many "dual-like" individuals who are on Medicaid only but have similar long-term care needs, often as a result of severe mental illness. These individuals receive services through separate physical and behavioral health systems. This fragmented system does not support coordination among providers, results in both unmet needs and over-utilization, and is building toward a financial crisis. Since 2000, public funding for behavioral health services has not kept pace with demand and service costs.

Executive Budget Proposal and Impact:

The Executive Budget builds on a February 2011 [proposal](#) submitted by the Governor's Office of Health Transformation to the federal Center for Medicare and Medicaid Innovation for a planning grant to improve care coordination. The vision is to create a person-centered care management approach – not a provider, program, or payer approach – that reflects the following core values:

- Individuals receive person-centered care through a delivery system designed to address all of the individual's physical health, behavioral health, long-term care, and social needs;
- Individuals have access to the services they need in the setting they choose;
- The delivery system is easy to navigate for both the individuals receiving services and the providers delivering the services;
- Individuals transition seamlessly among settings and programs as needs change; and

- Incentives in the system focus on performance outcomes related to better health, better care, and cost savings through improvement.

To achieve this vision, the planning grant outlines an implementation strategy for a new Individual-Centered Integrated Care Delivery System (ICDS) that will:

- Focus first on Ohio's 113,000 dually eligible individuals who are residents of nursing facilities, enrollees in Ohio's home and community based services waivers who require a nursing facility level of care, and individuals with severe persistent mental illness;
- Explore alternative models for implementation, including managed care plans, accountable care organizations, health homes, and/or other integrated care models;
- Require providers to have ONE point of contact for an individual receiving services;
- Require providers to pursue the triple quality aim of improving the experience of care, enhancing the health of populations, and reducing costs through improvement; and
- Develop innovative rate-setting methods, including outcome-based performance incentives and focused care coordination.

The ICDS program will be implemented in September 2012. One of the first steps toward implementation will be to seek federal waivers to allow Ohio Medicaid to provide a limited room and board option, share in federal Medicare savings that result from state Medicaid reforms, and establish different level of care requirements for nursing facility and home and community based services to reduce the institutional bias. The Executive Budget will allow Medicaid to contract with ICDS providers and enroll dual eligibles in managed care.

ICDS is designed to provide person-centered care addressing all of an individual's physical health, behavioral health, long-term care and social needs. It will be the cornerstone of Ohio's efforts to achieve a balanced delivery system that enables the aged and people with disabilities to live with dignity in the settings they prefer.

Medicaid
Promote Health Homes

Budget Impact

FY 2012	FY 2013	Biennial Total
\$900,000	\$46,350,000	\$47,250,000

Background:

Medicaid consumers with chronic conditions are costly. For Medicaid enrollees living in the community, 34 percent have at least one chronic condition and account for 70 percent of costs, about \$7.2 billion annually (11 percent have two or more chronic conditions and cost Medicaid \$4.0 billion annually). The current uncoordinated, disjointed, provider-centered health system has low value to the state as a health care purchaser. There is growing evidence that primary care is vital to a high performance health system and that care management, care coordination, and transition services at the point of care can reduce other avoidable and costly services.

Creating health homes in Medicaid has the potential to improve the value of health care purchased for individuals with severe and/or multiple chronic conditions. Research demonstrates that a health system built on a solid foundation of primary care delivers more effective, efficient, and equitable care than systems that fail to invest adequately in primary care. States that rely more on primary care have lower resource inputs, lower utilization rates, and better quality of care. Numerous studies demonstrate seeing a regular doctor is associated with fewer preventable emergency room visits and fewer hospital admissions.

Executive Budget Proposal and Impact:

The Executive Budget includes a Health Home initiative to expand on the traditional medical home model by enhancing coordination of medical and behavioral health care consistent with the needs of individuals with severe and/or multiple chronic illnesses. Health Homes are an intense form of care management that includes a comprehensive set of services and meaningful use of health information technology. For each chronically ill person in the Medicaid program, a Health Home will be required to:

- Provide quality-driven, cost-effective, culturally appropriate, person-centered services;
- Coordinate or provide access to high-quality and evidence-based preventive/health promotion services, mental health and substance use/dependence services, comprehensive care management across settings, individual and family supports, and long-term care services;

- Build linkages to other community and social supports to aid the patient in complying with their care treatment plan;
- Develop a person-centered care plan that integrates clinical and non-clinical health care needs and/or services;
- Establish a continuous quality improvement program; and
- Use electronic health records, link services with health information technology, and communicate across teams and with individual and family caregivers.

The Health Home initiative will build on the medical home initiatives already underway throughout Ohio. It will add to these efforts by taking advantage of the federal Affordable Care Act provision that allows states to claim a 90 percent federal match for eight quarters (two years) for a defined set of care coordination services for individuals who are severely chronically ill or have multiple chronic conditions. All qualifying Medicaid patients under the care of a Health Home will receive these additional services, including those who are dually eligible for Medicaid and Medicare. The state will work with CMS to design payment methods that work for Ohio, and phase the program in by condition and/or geography.

The Health Home model is independent of delivery systems. For example, the single point of care coordination proposed in the Executive Budget for dual eligible and “dual-like” individuals will provide a Health Home for this subset of individuals enrolled in Medicaid. A Health Home can operate within fee-for-service, managed care, or other service delivery systems.

Medicaid

Provide Accountable Care for Children

Budget Impact

FY 2012	FY 2013	Biennial Total
\$0	\$87,100,000	\$87,100,000

Background:

Currently, 37,544 disabled children are served through Ohio’s fee-for-service program at a cost of \$313 million per year. These children often have complicated and long-term medical conditions, but receive little assistance in accessing and coordinating care. Without some form of care coordination, these children will continue to experience difficulties in managing complicated medical conditions, and have less than desirable health outcomes at a significant cost to the Medicaid program.

Several of Ohio’s children’s hospitals are working to develop a new model of care – called a Pediatric Accountable Care Organization (ACO) – to provide the additional support required to meet the complex medical and behavioral health needs of disabled children. These efforts are encouraging, but many of the potential ACO sites are not ready to accept the risk and responsibilities of a free-standing ACO.

Executive Budget Proposal and Impact:

The Executive Budget will improve care coordination for disabled children and encourage the development of pediatric ACOs. As shown in the chart below, the process begins by enrolling disabled children who do not reside in an institution or receive home and community based waiver services in Medicaid managed care beginning July 1, 2012 (Phase I). Managed care plans will be encouraged to form new contract relationships with developing ACOs where the ACO assumes responsibility for care coordination and a portion of the risk for children enrolled in the ACO (Phase II). This allows potential ACO sites to develop and eventually decide whether or not to take on the full risk and responsibilities of a free-standing ACO (Phase III).

Responsibility	Current	Phase I	Phase II	Phase III
Medicaid Contract	Fee-for-Service	Health Plan	Health Plan	ACO
Care Coordination	None	Health Plan	ACO	ACO
Financial Risk	Medicaid	Health Plan	Health Plan	ACO
Savings	None	Medicaid	Health Plan/ACO	ACO/Medicaid

Pediatric ACOs will be expected to provide additional attention and care to the unique needs of disabled children. Such attention will assist in delivering the proper care in the proper setting resulting in improved health care outcomes and reduced cost. Until the pediatric ACOs can be fully developed, Ohio's managed care program will provide access to specialized care management services to improve outcomes while decreasing costs in the Medicaid program. Eventually, Medicaid children will have another avenue of specialized care available to them directly through the pediatric ACO.

This change will cost \$87 million over the biennium as a result of \$288 million in savings expected to result from better utilization control, and \$375 million in costs associated with moving from a retrospective to prospective payment system.

Medicaid

Integrate Behavioral and Physical Health Benefits

Budget Impact

FY 2012	FY 2013	Biennial Total
\$0	\$0	\$0

Background:

In the past, Ohio has viewed the Medicaid budget and policy for individuals with severe mental illness (SMI) as two separate systems: (1) physical health benefits managed by the ODJFS and (2) behavioral health benefits “carved out” of ODJFS Medicaid and administered by the mental health (ODMH) and alcohol and other drug (ODADAS) systems. These separate systems do not support coordination among providers or services at the local level. As a result, people often are served in “silos” without the benefit of shared information between providers or meaningful referrals between the physical and behavioral health systems.

Adults with serious mental illness represent 10 percent of Ohio’s Medicaid population but account for 26 percent of total Medicaid expenditures. The level of spending is significant and growing but, because of the lack of coordination between service providers, health outcomes are not improving. The drain on financial resources to support uncoordinated care between Ohio’s physical and behavioral health systems is not sustainable. According to a recent [study](#):

- The incidence of chronic physical health conditions is higher among individuals with severe mental illness (SMI) than among Ohio’s general Medicaid population;
- Individuals with SMI have twice the rate of hospitalization and emergency department visits for diabetes, COPD, pneumonia, and asthma;
- Approximately 29 percent of individuals with SMI do not receive services in a specialty behavioral health system, and often have multiple providers assessing and treating their mental health condition;
- Major cost drivers for individuals with SMI include admissions to nursing facilities and hospitals, utilization of prescription drugs, and services provided by the developmental disabilities waivers; and
- Concurrent alcohol and substance use disorder was identified in 22 to 46 percent of individuals with SMI, depending on the SMI diagnosis.

Executive Budget Proposal and Impact:

The Executive Budget will integrate Medicaid behavioral health care and physical health care benefits. “Integrated care” means treating both physical health conditions and mental health

conditions in a comprehensive, coordinated way so the patient's physical and mental health practitioners work together and actively communicate about all the patient's conditions.

Integration will require changes to financing and policy. During the SFY 2012-2013 biennium, the Governor's Office of Health Transformation will integrate the Medicaid alcohol and other drug treatment and mental health carve-out benefits (currently administered by ODADAS and ODMH) into the overall Medicaid program administered by ODJFS. This will be done in a phased-in "elevation" approach beginning in SFY 2012 with the financial responsibility for the non-federal share of Medicaid matching funds moving from the local boards to the state. A Medicaid-specific allocation may occur to the boards in SFY 2012, and boards may continue to perform administrative functions on behalf of the state. In SFY 2013, full integration of behavioral health services into the ODJFS-administered Medicaid program will occur.

In addition to those changes, the Kasich Administration has applied for a federal planning grant (via the federal Center for Medicare and Medicaid Innovation) to obtain permission to design and implement care coordination strategies to improve health outcomes for 113,000 residents of nursing facilities, recipients of home and community based services who have a nursing home level of care, and consumers with severe and persistent mental illness. The Governor's Office of Health Transformation will explore opportunities to utilize care coordination through managed care, accountable care organizations (ACOs), and other Health Home models to implement integrated care management. The goal of this effort is to improve care coordination, reduce system complexity for consumers and providers, decrease overall costs, and achieve long-term benefits both for consumers and taxpayers.

Medicaid

Elevate Behavioral Health Financing to the State

Budget Impact

FY 2012	FY 2013	Biennial Total
\$0	\$0	\$0

Background:

The Mental Health Act of 1988 purposefully created a funding tension within Ohio’s public behavioral health care community. State funding for state-operated psychiatric institutions was, with the closure of many of these facilities, redirected to fund community-based services. The past two decades of ODMH hospital closures, consolidations, and efficiencies have decreased hospital capacity to a minimum – one of the lowest in the nation – with those state resources being redirected to build and maintain community services.

However, the tension achieved under the current funding structure is now out of balance – sufficient savings to offset the rising costs of community based services can no longer be achieved merely from hospital downsizing. Additionally, revenue from the closure of ODMH hospitals over the past three years has gone toward balancing state budget deficits and was not reinvested in community-based programs. A growing number of county boards are unable to meet their community behavioral health Medicaid match responsibilities without additional state assistance. (This risk is increasing as Medicaid costs grow faster than local levy and state subsidy support.) The tension of the Mental Health Act of 1988 is no longer sustainable and will not on its own maintain the investment in community based services.

Executive Budget Proposal and Impact:

The Executive Budget “elevates” to the state the financial responsibility for community behavioral health. This will be phased in with the financial responsibility for Medicaid matching funds moving from local boards to the state in SFY 2012. A Medicaid-specific allocation may occur to the boards in SFY 2012, and boards may continue to perform administrative functions on behalf of the state as the state prepares to take over administration in SFY 2013. In SFY 2013, appropriation authority for community behavioral health Medicaid services will be included in ODJFS’ Medicaid 600-525 line item.

These changes allow a better alignment of responsibility, with ODJFS administering Medicaid community behavioral health services, ODMH providing hospital level services and treatment for civil and forensic patients, and community behavioral health boards focused on developing and managing critical local community services and supports.

Medicaid

Manage Behavioral Health Service Utilization

Budget Impact

FY 2012	FY 2013	Biennial Total
(\$146,724,700)	(\$95,954,342)	(\$242,679,042)

Background:

The community mental health Medicaid benefit currently is operated in a different manner than the rest of Ohio Medicaid. Unlike community-based services such as dental or physician care, the community mental health benefit contains few limits on the amount, frequency, and duration of services. Without utilization management controls and cost containment measures, funding for community mental health services will not be sustainable and increased pressure will be placed on state and local financing structures.

Executive Budget Proposal and Impact:

Using Ohio-specific data and information related to approaches employed in other states, the Executive Budget proposes the following policy changes to support individuals' recovery and at the same time manage service costs:

- **Tiered Rates.** Much of the administrative expense of delivering a unit of service is contained in the initial unit of service and diminishes as additional units are provided. The Executive Budget allows the initial unit of certain services to be reimbursed at a higher rate than subsequent units provided on the same date of service. At first, only community psychiatric supportive treatment (CPST) will be subject to this new policy. The first hour of CPST during the day will be paid at the full rate and subsequent units will be reimbursed at 50 percent. This change will save \$60,277,077 over the biennium.
- **V-Codes.** ODMH will limit the use of certain V-codes to crisis intervention and diagnostic assessment. The following V-codes will be accepted when associated with claims for mental health assessment only: parent child relationship problems (V61.20); neglect, physical abuse, or sexual abuse of child (V61.21); and bereavement (V62.82). Edits will be established in the mental health claims payment system (MACSIS) to disallow any other billings to occur with the exception of crisis intervention. This change will save \$8,134,999 over the biennium.
- **Defined Benefit Package.** ODMH will establish basic benefit limits that specify the amount, frequency, and duration of services as required by federal Medicaid regulations. A workgroup established in 2009 and comprised of constituents representing all aspects

of the community behavioral health system developed recommendations on the Medicaid package. The workgroup recommendations are shown in the table below next to the service limits proposed in the Executive Budget. These changes will save \$135,156,454 over the biennium.

Service	Workgroup	Proposed	% of clients not impacted by limits
Community psychiatric supportive treatment	130 hours	104 hours	96%+
Pharmacy management	24 hours	24 hours	98%+
Counseling	100 hours	52 hours	97%
Diagnostic assessment by an MD	4 hours	2 hours	95%
Diagnostic assessment	10 hours	4 hours	90%+
Partial hospitalization	90 days	30 days	50%
*Percentages use SFY 2008 claims to show the distribution of service utilization data. For example, 97percent of clients who received counseling services in SFY 2008 received 52 hours or fewer. Analysis of SFY 2005- 2010 claims data indicates that on an annual basis there has been very little change in the units of service per client.			

- Nursing Facility Reimbursement.** ODMH will clarify reimbursement policy to eliminate duplicate payments for mental health services provided to long-term residents of nursing facilities. The only mental health services that will be reimbursed separately through the community mental health benefit will be those associated with admission and discharge planning and to assure continuity of care. Community mental health providers will be able to provide other mental health services to residents of nursing facilities by contracting with the nursing home for the provision of those services. This change will save \$39,110,512 over the biennium.

These strategies address the immediate need to manage the Medicaid benefit in the existing environment where community mental health services are authorized in the Medicaid State Plan, and are available to any eligible Medicaid recipient with a medical need for these services. Establishing basic benefit limits will mitigate the effects of service utilization changes, define parameters to support utilization review activities, and provide information about the population served to support future system reform.

Medicaid

Consolidate Housing Programs

Budget Impact

FY 2012	FY 2013	Biennial Total
\$0	\$0	\$0

Background:

The Residential State Supplement (RSS) program provides housing subsidy funding for people with a variety of disabilities and needs. 80 percent of the more than 1,800 Ohioans who receive RSS have behavioral health needs. Currently RSS is managed and financed by ODA with payments to eligible consumers made by ODJFS with money transferred from ODA. ODMH-licensed residential treatment facilities and some housing certified by Area Agencies on Aging are eligible but not typically claimed for RSS housing reimbursement.

Most RSS recipients use their subsidy to stay in adult care facilities (three to five bed family homes and six to 16 bed group homes) and residential care facilities (typically 17 or more bed facilities). Ohio has 650 adult care and 560 residential care facilities. All are licensed by ODH and required to provide personal care services to at least three individuals. Residential care facilities also provide skilled nursing services. Ohio's current RSS policies are confusing, uncoordinated, and in need of reform.

Executive Budget Proposal and Impact:

The Executive Budget consolidates the administration of the Residential State Supplement Housing Program and Adult Care Facilities Program in ODMH. Consolidating the administration of these programs will result in a more streamlined and efficient administrative structure.

Medicaid

Create a Unified Long-Term Care System

Budget Impact

FY 2012	FY 2013	Biennial Total
\$0	\$0	\$0

Background:

The delivery system for long term services and supports in Ohio is complicated and fragmented. Today a Medicaid-eligible consumer who needs long term services must navigate through a system that includes the following major programs:

- **PASSPORT**—a home and community based services (HCBS) waiver for individuals age 65 and over or age 60 and over with a disability;
- **Ohio Home Care** – HCBS waiver for individuals with physical disabilities who are age 59 or younger;
- **Ohio Home Care/Transitions Aging Carve-out** – HCBS waiver for individuals 60 or older who were enrolled in Ohio Home Care and who have service needs that cannot be met with the PASSPORT service package;
- **CHOICES** – HCBS waiver for individuals age 65 and over or age 60 and over with a disability with a self-direction component available in selected regions of the state;
- **Assisted Living** – HCBS waiver for the aged and individuals with disabilities age 21 and over who live in assisted living facilities;
- **Program of All-Inclusive Care for Elders (PACE)** – a capitated program with an all-inclusive service package that serves individuals age 55 and over in Cleveland and Cincinnati;
- **Nursing Facility** – an institutional delivery model for long term services;
- **Hospice** – a program that is focused on care at the end of life that can be used alone or in combination with other options for long term services; and
- **State Plan Home Health and Private Duty Nursing** – services that can be used alone or in combination with other options for long term services.

Individuals are asked to choose among as many as five different waivers and four Medicaid state plan delivery models with different enrollment requirements and processes and different service packages for each. Some options (PACE, CHOICES) are available only in selected parts of Ohio. Other options (nursing facility, PASSPORT) are administered by separate agencies, which create barriers for individuals who are eligible and want to move from one service to the other, and limited waiver slots can force individuals into institutional settings.

The complexity inherent in the current delivery system magnifies the institutional bias created by a federal preference for nursing facilities. Individuals seeking long-term services are often making decisions under significant time pressures and emotional stress. The number of programs with different requirements and service packages makes it difficult for an individual seeking service to identify his or her choices and to understand what those choices are. Discharge planners in hospitals and nursing homes, staff in physician offices and others who are charged with assisting these individuals are challenged by the number of programs, different service packages, and different points of access and care coordination for programs (e.g., Area Agencies on Aging, County Departments of Job and Family Services, managed care plans). As a result, the “easy” default often is into a nursing home.

Executive Budget Proposal and Impact:

The Executive Budget proposes a unified long term care system so that individuals who need long-term services can easily understand their choices and how to access services. It acts on recent experience such as Home Choice (Ohio’s Money Follows the Person program), transition and diversion activities of Area Agencies on Aging, Ohio’s Centers for Independent Living, and federal initiatives to support transition and diversion activities as follows:

- **Unified Budget.** Effective July 1, 2011, Medicaid funding for long term services and supports will be combined in ODJFS line item 600-525. This creates a unified long-term care budget for people with physical disabilities and seniors. Spending will be driven by the settings and services individuals choose rather than line item appropriations in the state budget process. This fundamental change is an essential first step toward establishing a person-centered delivery system.
- **Accessing Services.** A clear “front door” into the delivery system for long-term services and supports is essential for individuals to understand their options and achieve balance among various settings. The Office of Health Transformation will work to align access points so individuals can obtain needed services and supports in a seamless, timely and cost-effective manner in settings they choose. This effort will build on work already underway through the Money Follows the Person program and the Unified Long-Term Care Systems Stakeholder Workgroup.
- **Single Waiver.** Currently there are five HCBS waivers (PASSPORT, Ohio Home Care, Ohio Home Care/Transitions Aging Carve-out, Choices, and Assisted Living) that serve individuals with a nursing facility level of care. These five waivers will be replaced with a single waiver, creating a seamless delivery system for individuals needing long-term services and supports. (This proposal has no impact on waivers in the DODD system.) The new waiver will incorporate self-direction, a single set of provider and enrollment requirements, a service package to meet the needs of the aged and individuals with physical disabilities, and consistent care management across populations. Program

design and utilization of current state plan services (home health and private duty nursing) will be considered in conjunction with waiver design. ODJFS will seek authority to establish waiver enrollment priorities to reduce hospital and nursing facility utilization. Where possible, incentives for person-centered care and quality will be considered. Enrollment in the new waiver is intended to begin on or about July 1, 2012.

By implementing a unified delivery system for unified long-term services, the barriers to a balanced delivery system are removed. These policy changes are important steps toward providing consistent opportunities for choice to individuals needing long-term services and supports to live in and receive services in the settings they prefer and provide opportunities for improved care coordination. In addition, Ohio will also achieve greater transparency in price and quality by combining funds and programs for individuals needing long term services. The “Unified Long-Term Services System” also is an important element in the implementation of the Integrated Care Delivery System (ICDS), Ohio’s proposed demonstration to integrate services for dually eligible individuals and other individuals with long term care needs.

Medicaid
Evaluate PACE

Budget Impact

FY 2012	FY 2013	Biennial Total
\$200,000	\$0	\$200,000

Background:

The Program of All-Inclusive Care for the Elderly (PACE) is a capitated service delivery model that addresses physical health, behavioral health, long term care, and social needs for enrolled individuals. Services are provided in acute, sub-acute, institutional and community settings. Ohio currently has PACE sites in Cleveland and Cincinnati serving approximately 750 people.

PACE is the most expensive community-based option for seniors. With an average Medicaid per member per month (PMPM) cost of \$2,890, PACE participants are almost twice as expensive as those enrolled in PASSPORT. However, on average, individuals enrolled in PACE have a lower acuity than individuals using other long-term care models. Under the current model, PACE sites seem not to be serving the individuals with acuity needs who will most benefit from the service options, and the Medicaid rates paid are not appropriately aligned with the needs of the individuals being served.

Approximately 83 percent of individuals enrolled in PACE are dually eligible for the Medicare and Medicaid programs. Care coordination across payers is integral to the program design, but savings generally accrue to Medicare rather than to Medicaid. As a result, Medicaid realizes only a fraction of the savings that result from reduced health care expenditures over time.

Executive Budget Proposal and Impact:

The Executive Budget proposes that Miami University's Scripps Gerontology Center complete a comprehensive evaluation of the cost-effectiveness of current PACE sites. This work will inform efforts to modernize the PACE program so that the rate paid for services aligns with the needs of individuals. In addition, Ohio will pursue an initiative to share savings with Medicare for dually eligible individuals enrolled in PACE. No additional PACE sites will be considered until the evaluation is complete and a shared savings program with Medicare is in place.

Medicaid

Link Nursing Home Payments to Person-Centered Outcomes

Budget Impact

FY 2012	FY 2013	Biennial Total
\$0	\$0	\$0

Background:

The Medicaid rate for nursing facilities currently includes a small quality incentive payment that averages \$3.03 per day (approximately 1.7 percent of the rate). Measures used to drive the current quality incentive payment are focused on business performance rather than the quality of care and quality of life for people receiving services in nursing facilities. While occupancy levels and Medicaid utilization may indicate strong business performance, they are not focused on the way care is provided in a facility or on the outcomes the facility produces. The current sole focus on business measures creates a disconnect between financial performance incentives and the state’s expectation that every individual in a nursing facility receive person-centered services. In addition, many of the current measures are structured so that only about half of the nursing homes in the state can earn the related reimbursement.

Executive Budget Proposal and Impact:

The Executive Budget proposes to modify the quality incentive payment included in the Medicaid rate for nursing facility services by replacing current measures with measures focused on person-centered care and increasing the value placed on good outcomes for individuals.

- **Person-Centered Performance Measures.** The current quality measures will be replaced by measures focused on person centered care and individualized outcomes. The new measures will align with federal requirements for nursing homes and focus on areas shown to improve the individual experience of people living in nursing homes (and often to reduce facility costs over time). The final measures will be developed through a collaborative stakeholder process that includes representatives of individuals receiving nursing facility services and individuals providing nursing facility services. Examples of possible measures include a dining program where individuals can choose the foods they eat and the times they eat, rooms that are personalized to respond to individual needs, practices that allow individuals to wake up and go to bed when they please, and active support and assistance for individuals who want to transition to a community setting.
- **Person-Centered Quality Incentive Payment.** Current funding for nursing facility services will be repurposed so that instead of the 1.7 percent quality component in effect

today approximately 8.75 percent of the total nursing facility rate will be directly connected to the quality of care and quality of life for residents. Unlike the current model, which results in winners and losers, the quality measures will be designed so that every nursing home in the state will have the opportunity to earn the related reimbursement and, thus, the full price Medicaid establishes for nursing home care.

By shifting the focus of the quality incentive payment from a business focus to the care provided to individuals receiving nursing facility services, the performance incentives are aligned with expectations for Ohio's nursing homes. When considered in conjunction with the ability of all facilities to achieve the quality standards established, the increased value placed on quality of care and quality of life transforms the current quality incentive payment into a "pay for performance" initiative that is designed to truly impact the way services are provided and the outcomes for individuals. This will help ensure that nursing homes are a valuable component of an overall system of long-term services and supports.

Medicaid

Align Programs for People with Developmental Disabilities

Budget Impact

FY 2012	FY 2013	Biennial Total
(\$22,058,680)	(\$39,988,565)	(\$62,047,245)

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 framework that enabled thousands more people to live and work in the community, instead of institutions. There were federal funds available to support the effort, but only if Ohio could modernize funding, regulations, roles and responsibilities and how services were delivered. House Bill 94 was the mechanism for this transformation. It leveraged local levy dollars for use as Medicaid match, enabling an incredible growth in services with little additional state funding. As a result, thousands more Ohioans with developmental disabilities live and work in the community, instead of institutions.

Today, nearly 30,000 individuals with developmental disabilities receive home and community based services, with federal funds supporting two-thirds of the costs. Soon, *fewer than one thousand people* will 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. While there are still too many people waiting for services, Ohio is working on a new flexible, cost effective waiver program to help meet these needs. Every day, more and more individuals with developmental disabilities are working in competitive employment – enriching the quality of their communities, as well as their own lives.

Despite significant progress, there remain inefficiencies in the system of services for people with developmental disabilities. There are still too many people waiting for services. In addition, individuals with developmental disabilities, their families, and caregivers must navigate a system of services that includes some programs administered by DODD (state-operated institutions and two HCBS waiver programs) and others administered by ODJFS (private intermediate care facilities and the HCBS “transitions” waiver). The current structure makes it difficult to align policies and set priorities across these programs, and can result in confusion and barriers for individuals who want to move from one service to another.

Executive Budget Proposal and Impact:

The Executive Budget consolidates Medicaid programs for people with disabilities in DODD. It completes the system transformation that began in 2001, and creates new opportunities for DODD to set priorities across programs and eliminate barriers that keep people with developmental disabilities from accessing the services they need. The budget proposals include:

- **Move the ICF/DD program to DODD.** The administration of the intermediate care facility for people with developmental disabilities (ICF/DD) program will be moved from ODJFS to DODD. ICF/DD facilities provide 24-hour personal care, habilitation, developmental, and supportive health services to individuals with developmental disabilities whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.
- **Move the Transitions/DD program to DODD.** The administration of the Transitions Developmental Disabilities HCBS waiver program will be moved from ODFJS to DODD. The Transitions/DD program includes nursing services, personal care assistance services, skilled therapy services, and waiver-specific services such as home modifications, home-delivered meals, adult day health care, respite care, supplemental transportation, and emergency response systems.
- **Modernize the Individual Options benefit package.** DODD has requested federal CMS approval to implement additional cost-effective services under the Individual Options HCBS waiver program, including adult family care, adult foster living, respite and remote monitoring. DODD has also requested CMS approval to create a new participant-directed Self-Empowered Life Funding (SELF) waiver. The proposed budget includes a three percent service utilization reduction.
- **Consolidate Funding.** Historically, DODD has had four different line items for Medicaid funded programs. DODD will put all of its Medicaid funding into one line item to facilitate the movement of residents of state-operated institutions to HCBS waiver programs, and to better absorb fluctuations in individual waiver programs.

The combined impact of these initiatives will give DODD more authority and control to design programs that allow people with disabilities to move seamlessly from one setting of care to another. This is important as DODD continues to downsize state-operated institutions, with a goal of reducing the average daily census from 1,258 residents currently to 1,078 residents by the end of SFY 2013. This process will result in a reduction of 10.2 percent in GRF spending, with half of those savings used to support the community waiver program. DODD will also support downsizing in the ICF/DD program by transitioning 200 individuals from ICF/DD to waivers over the biennium.

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 25th 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.

Medicaid

Overall Impact of Transformation

Budget Impact

FY 2012	FY 2013	Biennial Total
(497,267,206)	(941,847,823)	(\$1,439,115,029)

Background:

Medicaid represents a large and growing share of budgets in six Ohio departments. In past budgets, Medicaid spending was shown by agency but not rolled up into a statewide total. As a result, most estimates of Medicaid spending (e.g., \$8.4 billion in ODJFS line item 600-525 in 2010) understate the full impact of the program. Ohio Medicaid actually spent \$15.8 billion across all agencies in SFY 2010, accounting for 30 percent of total state government spending and 4 percent of the Ohio economy. If we do nothing, Medicaid spending will increase 28 percent over the next three years to \$20.3 billion in SFY 2013. The current rate of growth is unsustainable and threatens to crowd out other state budget and policy priorities.

On January 13, 2011, Governor John Kasich created the Office of Health Transformation to immediately address Medicaid spending issues, plan for the long-term efficient administration of the Ohio Medicaid program, and act to improve overall health system performance (Executive Order [2011-02K](#)). The new Office quickly organized existing staff in all of the Medicaid-related agencies to advance the Administration's Medicaid modernization and cost-containment priorities in the operating budget. The goal is not incremental but transformational change – aiming higher to achieve better health, better care, and cost savings through improvement.

Executive Budget Proposal and Impact:

The Executive Budget includes an aggressive package of Medicaid reforms developed by the Governor's Office of Health Transformation. It aligns policy and funding priorities across all Medicaid-related agencies to: (1) improve care coordination, (2) integrate behavioral and physical health care, (3) rebalance long-term care, and (4) modernize reimbursement. These priorities leverage Medicaid to act on opportunities to keep people as healthy as possible instead of reacting only after they get sick, prevent chronic disease whenever possible and, when it occurs, coordinate care to improve quality of life and reduce costs. These changes shake loose the status quo and create win-win opportunities for Medicaid enrollees (better services) and Ohio taxpayers (better value).

The Executive Budget achieves an unprecedented level of Medicaid savings – \$4.3 billion over the biennium. It maximizes savings in the state general revenue fund (GRF), resulting in a

remarkable 83 percent of net savings (\$1.2 billion) accruing to the state. This outcome was critically important to avoid a one-time 42.8 percent (\$1.6 billion) increase in state GRF that otherwise would have occurred as a result of Ohio needing to backfill enhanced federal match that is due to expire June 30, 2011. The impact of the expiring federal funds is still significant, but manageable as a result of decisions made in the Executive Budget.

All Funds	SFY 2011	SFY2012	%	SFY 2013	%	SFY 2012-2013
Initial Trend	\$18,020,279,696	\$19,342,184,313	7.3%	\$20,796,914,822	7.5%	\$40,139,099,135
<i>Revised Baseline</i>	\$ (157,440,366)	\$ (379,813,566)		\$ (454,545,028)		\$ (834,358,593)
<i>Additional Costs</i>		\$ 959,811,555		\$ 1,849,269,574		\$ 2,809,081,129
<i>Franchise Fee Revenue</i>		\$ 449,395,358		\$ 438,657,744		\$ 888,053,102
<i>Savings and Cost Avoidance</i>		\$ (1,526,660,553)		\$ (2,775,230,114)		\$ (4,301,890,667)
<i>Subtotal</i>		\$ (497,267,206)		\$ (941,847,823)		\$ (1,439,115,029)
Budget	\$17,862,839,330	\$18,844,917,107	5.5%	\$19,855,066,999	5.4%	\$38,699,984,106

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

GRF State	SFY 2011	SFY2012	%	SFY 2013	%	SFY 2012-2013
Initial Trend	\$ 3,737,265,147	\$ 5,335,729,055	42.8%	\$ 5,680,339,444	6.5%	\$11,016,068,499
<i>Revised Baseline</i>	\$ 18,240,342	\$ (82,727,222)		\$ (103,091,587)		\$ (185,818,809)
<i>Additional Costs</i>		\$ 343,728,971		\$ 649,428,780		\$ 993,157,751
<i>Franchise Fee Revenue</i>		\$ 161,602,571		\$ 157,258,801		\$ 318,861,372
<i>Savings and Cost Avoidance</i>		\$ (944,873,117)		\$ (1,376,702,881)		\$ (2,321,575,998)
<i>Subtotal</i>		\$ (522,268,797)		\$ (673,106,887)		\$ (1,195,375,684)
Budget	\$ 3,755,505,489	\$ 4,813,460,258	28.2%	\$ 5,007,232,557	4.0%	\$ 9,820,692,815

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

This Medicaid budget is challenging but fair. It establishes a vision for overall health system performance that is based on better health, better care, and cost savings through improvement. It includes new strategies and tools in Medicaid to move in that direction. And most important, it fulfills the state's responsibility to provide health coverage for vulnerable citizens while also working to ensure taxpayers get the best possible value for their money.