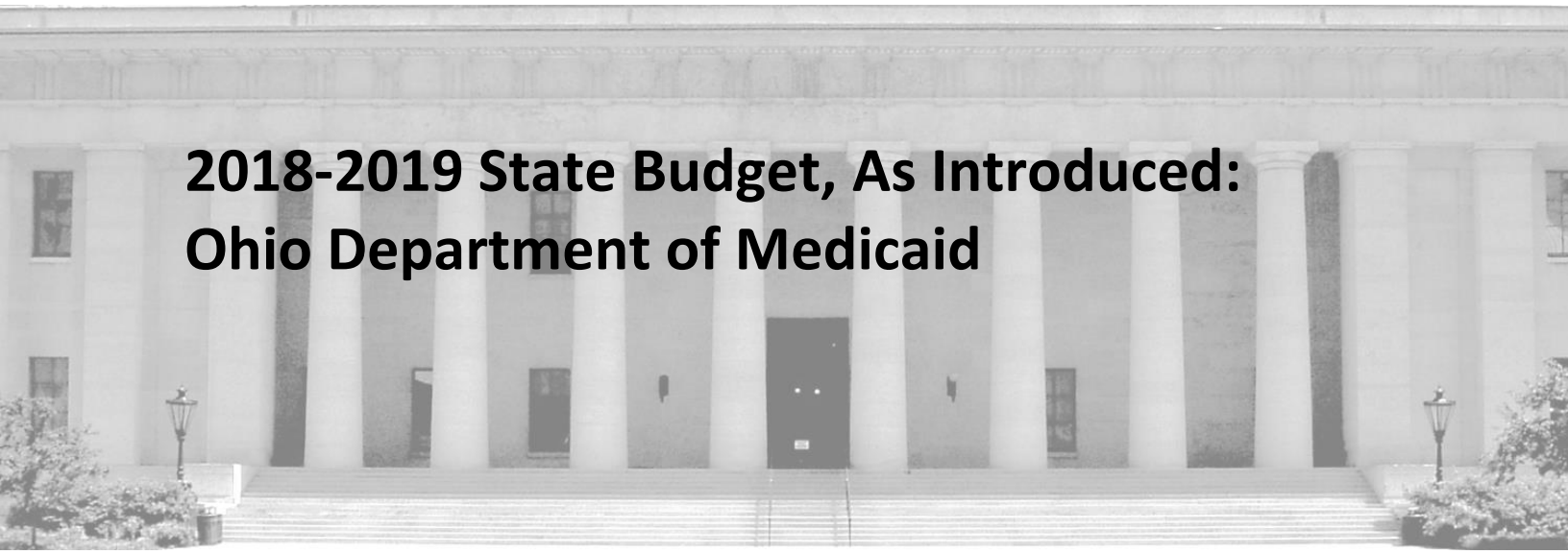
THE CENTER FOR COMMUNITY SOLUTIONS
EST. 1913
RESEARCH • ANALYSIS • ACTION



2018-2019 State Budget, As Introduced: Ohio Department of Medicaid

Loren Anthes, Public Policy Fellow, Center for Medicaid Policy

State Budgeting Matters
Volume 13, Number 2
March, 2017

2018-2019 State Budget, As Introduced: The Ohio Department of Medicaid

Loren Anthes, Public Policy Fellow, Center for Medicaid Policy

March, 2017

Introduction

In the last biennial budget of the Kasich administration, the Ohio Department of Medicaid (ODM) continues many of the reforms sought over the course of the last six years, this time with a new Medicaid director, former legislator Barbara Sears, at the helm. Initiatives put forward include additional utilization of managed care, greater expansion and transparency of value-based payment methodologies through the State Innovation Model (SIM), and additional investments in home and community-based alternatives to facility-based care. The state has also completed its work with the State Health Improvement Plan (SHIP) which has incorporated survey-based public health goals as a foundation for long-term reimbursement and policy planning in Medicaid.

ODM's budget submission, however, contains a number of pieces that are receiving scrutiny by the General Assembly and stakeholders interested in the program, generally. Moreover, while it does not directly affect this biennial budget submission, movement on the federal level provides additional complexity to the long-term planning associated with Medicaid expenditures and the eligibility, benefits, and program design associated with those dollars.

To sort through what is being proposed, this edition of *State Budgeting Matters* details proposals in the Ohio Department of Medicaid, as introduced.

Overall Funding Picture

Pursuant to Ohio Revised Code, the Medicaid director is required to submit a budget request that limits the growth of the Medicaid program based on a target established by the Joint Medicaid Oversight Committee (JMOC).[1] In the fall of 2016, the JMOC target was established at 3.3 percent. Upon submission of the budget, the administration proposed a case-mixed growth rate that exceeded this target.

A case-mixed approach involves costs that are calculated separately by population and aggregated using the same number over the course of the biennium. The executive budget proposed to move all populations into managed care, including those in long-term care, except the developmentally disabled (DD). When constructing the initial target in JMOC, this policy shift was not contemplated and, as a result, the average rates for the aged, blind and disabled (ABD) group increased, resulting in a higher growth rate. When these populations are disaggregated--separating out the DD population--the overall growth rate goes down. Here's the result of that analysis:

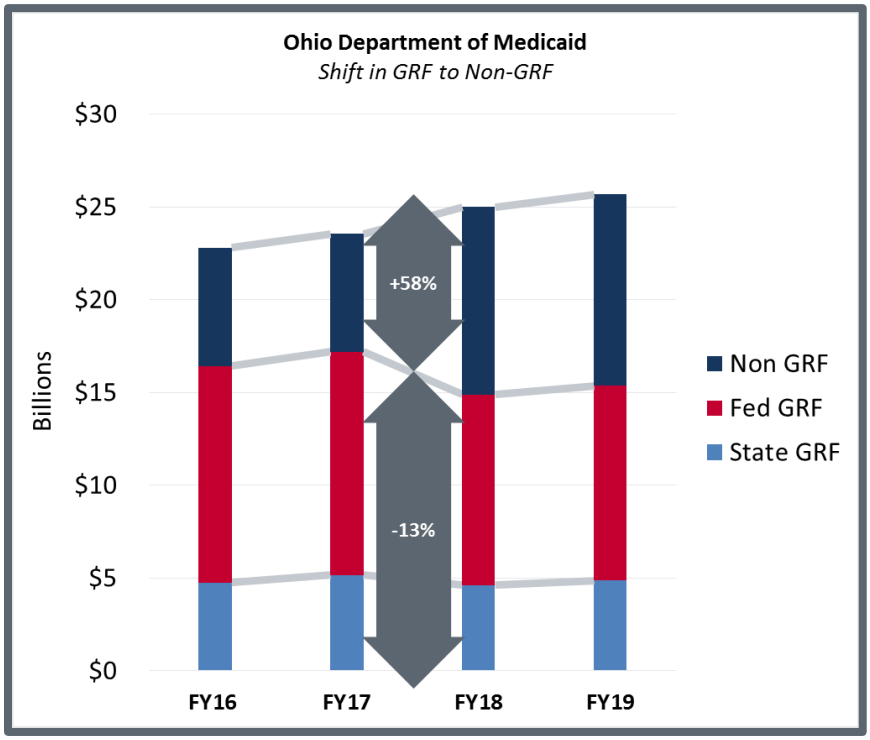
Table 1: Medicaid Growth Rate Comparison

Growth Rates	FY 2018	FY 2019	Biennial Average
JMOC Limit	3.30%	3.30%	3.30%
Exec. Budget (Case Mixed)	2.24%	6.38%	4.29%
Disaggregated Exec Budget (Case Mixed)	1.90%	1.54%	1.72%

Source: Joint Medicaid Oversight Committee

It remains to be seen if the budget as submitted violates Ohio Revised Code, given the higher case-mixed growth rate. With that said, the General Assembly still has the ability to appropriate beyond what JMOC has outlined as the statutory mandate only applies to the governor and his agent, the Medicaid director. Regardless of the outcome of this funding, it is worthwhile to highlight the difficulty that comes in tying Medicaid spending to a specific growth rate in law, which is one of the complicating factors that will be explored in this report's examination of the alternative financing proposal being debated by Congress.

Overall, the ODM budget reflects a similar maneuver seen across state agencies in regard to shifting more resources from General Revenue Funds (GRF) to non-General Revenue Funds (non-GRF). Most of this is due to the transition of the managed care (MCO) tax from one based on sales to that of a provider tax, with most of the revenue generated, including the federal draw down, being deposited into a non-GRF line item:[2]



Because the MCO tax is being transitioned, local governments lose their ability to collect revenues from Medicaid health insurance companies via a sales tax. That said, the more dramatic and long-term structural problem for ODM may be in the provider tax longevity itself.

The new provider tax creates $789 million in FY 2018 and $888 million in FY 2019, leading to federal draw down amounts of $1.3 billion and $1.5 billion, respectively. While Ohio did receive approval for this replacement tax from the Centers for Medicare and Medicaid Services (CMS), it still does not conform to federal standards of uniformity. As such, if the waiver is not continued, or another policy is not developed, ODM could lose 8.9 percent of the funding for the Medicaid program.[3]

Changes Proposed in the Budget

Hospitals

The as-introduced budget contains a number of policies that affect hospitals, including a rate cut, the creation of a new peer group of hospitals within Medicaid, and language regarding the process of contracting with managed care. First, ODM has stated that the change to a new system of billing, which is built on a coding set known as ICD-10, resulted in an artificial inflation of rates to hospitals through spending. To correct this, ODM is proposing to cut reimbursement rates by $75 million per fiscal year. ODM also proposed to reduce rates, generally, though it will protect hospitals who have a disproportionately higher volume of Medicaid patients as a part of their caseloads. This creation of a new, high Medicaid peer group is not unique to Ohio, however, and is supported by the Medicaid and Chip Payment and Access Commission (MACPAC) as a best practice to implement value-based reforms in Medicaid.[4] This provision is a one-time reduction of $175 million in FY 2019. Lastly, ODM is also proposing that any hospitals which refuse to contract with Managed Care Companies have their rates default to Fee For Service (FFS) rates. This is not a new suggestion in the state budget process, though, and is seen as a strategy to provide insurance companies with more leverage in the contract negotiation process. Often, hospitals are paid well above FFS rates.

Long-term Care

Significantly, ODM has proposed to privatize the benefits for individuals in the Long-Term Services and Supports (LTSS) system. This continues the orientation of the Kasich administration in relying on privatization as an element of reform given managed care organizations' ability to coordinate care, implement utilization controls such as prior authorization, and respond to the contracting needs of the state in regard to quality and outcomes. While developmentally disabled individuals on waivers will be exempted from the carve-in, they will have the option to enroll in a plan for acute care services. It should be noted that recent regulatory guidance from CMS has specifically spelled out processes for the state in regard to carving LTSS into managed care, though the state has not yet outlined how it will conform to those standards of public input and quality assurance.[5]

Beyond managed care, the LTSS system is also seeing a number of changes to rates. First, assisted living rates have been increased, leading to an increase of $34.9 million in FY 2019. This complements other efforts in promoting alternatives to nursing facilities such as increases in home-delivered meals ($3.1 million) and additional investments in waivers and rates for personal care aid services. Funding for "Money Follows the Person" (MFP), a federal grant which promotes transitions to community-based alternatives, is also continued ($19.7 million). MFP, though, is ending on December 31, 2018, so the state may need to backfill any gaps with state funds. On the other hand, nursing facility rates, which are currently the only provider rates defined in Ohio Revised Code, will be revised, including a reduction in the per diem rates and rates for lower-acuity residents, resulting in a cut of $98.6 million in FY 2018 and $138.5 million in FY 2019.

Value

The movement to value-based design, largely built on the State Innovation Model (SIM), continues in Medicaid with a greater number of episodes being introduced, a roll-out of the Comprehensive Primary Care "Plus" (CPC+) initiative, greater transparency in clinical and cost performance, as well as an increase in the contractual expectations of Managed Care Organizations (MCOs) in Ohio. With episodes, the state plans on increasing the number of episodes from 13 to 43 in 2017. This will mean a significant share of Medicaid reimbursement will be in an episodic model. With CPC+, Ohio will invest over $124 million to reward primary care practices that keep costs down and improve patient outcomes. Notably, for the first time, the reporting process associated with the two activities of SIM will be made more transparent between providers participating in this work as well as patients and insurance plans in Medicaid and the private market. The financial incentives associated with this work, then, will follow the performance as reported and will try to capture some of the public health principles outlined in the State Health Improvement Plan.[6]

Value is not just being implemented through SIM, however. The state is also continuing to increase its efforts in quality by increasing the

Table 2: Ohio's P4P Program

OHIO'S PAY FOR PERFORMANCE PROGRAM 2013-2015

Standards	2013	2014	2015	2016 (proj.)	TREND
Number of Measures	6	6	6	7	
Amount of Premium	1%	1%	1.25%	1.50%	
Minimum Percentile	10	25	25	25	
Maximum Percentile	75	90	75	75	
Total Performance	94%	75%	81%		

Award Achieved (millions)	2013	2014	2015	TREND
Buckeye	$3.4	$1.6	$2.1	
CareSource	$17.0	$7.4	$13.4	
Molina	$4.9	$4.0	$9.8	
Paramount	$2.1	$1.8	$3.1	
United HealthCare	$1.8	$0.6	$1.7	

Award Achieved (% of Possible Award)	2013	2014	2015	TREND
Buckeye	42%	22%	16%	
CareSource	39%	18%	22%	
Molina	36%	32%	53%	
Paramount	62%	45%	33%	
United HealthCare	30%	10%	13%	

Source: Ohio Department of Medicaid

amount set aside in its payments to managed care from 2 percent to 5 percent.[7] Current law permits ODM to hold some of the payments made to MCOs to incent quality performance. This amount can be as high as 10 percent. If the MCOs do not meet the standards defined in law, then ODM does not award them the associated dollars. Historically, MCOs have not achieved the majority of the incentive payment. Moreover, a 2016 longitudinal study of MCOs clinical performance relative to national averages in the Healthcare Effectiveness Data and Information Set (HEDIS), shows that MCOs only performed at or above the 50th percentile 29.4 percent of the time, with zero achieving above the 75th percentile.[8]

Infant Mortality

The state is continuing its efforts to improve Ohio's infant mortality rate which, while the United States' rate improves, still lags other states in terms of progress.[9] Efforts include an additional $26.8 million over the biennium to incent managed care organizations (MCOs) to work directly with consumers, especially in at-risk areas, to ensure that women have successful pregnancies. The state is also tying strategies outlined in the State Health Improvement Plan (SHIP) into these efforts, developing a "toolkit" for communities to address infant mortality, and utilizing the State Innovation Model to leverage those principles in the context of reimbursement to hospitals and primary care physicians.

Federal Impact

With the election of Donald Trump to the office of the Presidency, as well as a Republican majority in both houses of Congress, Medicaid policy has been the subject of intense scrutiny on the federal level, leading to potential short-term and long-term consequences for Ohio's Medicaid budget. First, as described in a recent communication by Secretary of Health and Human Services (HHS) Dr. Tom Price and Director of CMS Seema Verma, the orientation of the new administration will be more receptive to experimentation in Medicaid programs.[10] This means that the state's proposed waiver that seeks to impose cost-sharing requirements on Medicaid recipients is more likely to be approved than its predecessor, "Healthy Ohio."

In a departure from "Healthy Ohio," the Kasich administration has also indicated that the cost-sharing requirements will be limited to the Medicaid expansion population (Group VIII) and will only apply to individuals above 100 percent of the federal poverty level. This represents about 150,000 of the 700,000 individuals who receive coverage through the expansion and the state estimates that the proposal will save Ohio Medicaid $52.6 million in FY 2018 and $184.7 million in FY 2019, mostly from disenrollment. Currently, there are no exemptions being discussed for the medically frail, which, in other states with similar policies, include victims of domestic violence, victims of human trafficking, cancer patients, those living with HIV/AIDS, and persons with serious and persistent mental illness.

Beyond the administrative effects associated with a new Congress, there is also a proposal to fundamentally change the financing structure of Medicaid and eliminate the entitlement. This proposal, which Community Solutions has written about at length, will lead to a decrease in

Ohio's Medicaid funding between $19 billion and $26 billion by 2025.[11] The Ohio Department of Medicaid also released estimates on the impact of the federal legislation and forecasts a loss of $37 billion through the termination of the expansion, which our analysis does not assume in its entirety, including the elimination of coverage for 750,000 Ohioans.[12]

Conclusion

As the budget moves through the House Finance Subcommittee and back over to the House Finance Committee, many stakeholders will weigh into the process. The House version of the budget will include many changes compared to the governor's as-introduced budget. Future editions of *State Budgeting Matters* will examine these changes and the potential impact they will have on Medicaid.

[1] Reforms to medicaid program., § 5162.70 (2014).
[2] GOVERNOR KASICH'S EXECUTIVE BUDGET RECOMMENDATIONS FOR FISCAL YEARS 2018 AND 2019, 132nd General Assembly. (2017) (testimony of Tim Keen, Director of the Ohio Office of Budget and Management).
[3] United States. The Legislative Service Commission of Ohio. LSC Analysis of Executive Budget. By Ivy Chen and Nicholas J. Blaine. March 2017. Accessed March 2017. http://www.lsc.ohio.gov/fiscal/redbooks132/mcd.pdf.
[4] "The Challenges Of Rewarding Value Over Volume Without Penalizing Safety-Net Hospitals." Health Affairs. Accessed March 23, 2017. http://healthaffairs.org/blog/2016/03/30/the-challenges-of-rewarding-value-over-volume-without-penalizing-safety-net-hospitals/
[5] "Medicaid final rule defines the future of LTSS." Deloitte Center for Health Solutions. August 30, 2016. Accessed March 23, 2017. http://blogs.deloitte.com/centerforhealthsolutions/medicaid-final-rule-defines-the-future-of-ltss/.
[6] "Make Health Care Price and Quality Transparent." January 30, 2017. Accessed March 2017. http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=dL8YM_EZPco%3d&tabid=254.
[7] "Department of Medicaid: Agency Analysis." March 2017. Accessed March 2017. http://www.lsc.ohio.gov/budget/agencyanalyses132/introduced/mcd.pdf.
[8] United States. Ohio Department of Medicaid. October 2016. Accessed March 2017. http://www.medicaid.ohio.gov/Portals/0/Medicaid%20101/QualityStrategy/Measures/OH-SFY2016_HEDIS_Aggregate_Report_F1.pdf.
[9] Zeltner, Brie. "U.S. infant mortality rate hits historic low, Ohio lags other states in progress." Cleveland.com. March 21, 2017. Accessed March 24, 2017. http://www.cleveland.com/healthfit/index.ssf/2017/03/us_infant_mortality_rate_hits.html.
[10] Thomas E. Price, M.D. and Seema Verma, MPH to Governors of States. March 15, 2017. Accessed March 2017. https://www.hhs.gov/sites/default/files/sec-price-cms-admin-verma-ltr.pdf.
[11] Anthes, Loren, MBA. "Per Capita Cuts: Proposed American Health Care Act Costs Ohio $19-26 Billion." March 13, 2017. Accessed March 2017. https://ccs.memberclicks.net/assets/docs/Health_Policy/2017_2019/issue%20brief%20per%20capita%20cuts%20update%204_lanthes_03092017.pdf.
[12] "HEALTH INSURANCE MARKET REFORMS." March 2017. Accessed March 2017. http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=R6ZfxgeoWvI%3d&tabid=160.

State Budgeting Matters is published by The Center for Community Solutions.

Comments and questions about this edition may be sent to lanthes@communitysolutions.com.
1501 Euclid Ave., Ste. 310, Cleveland, OH 44115
101 E. Town St., Ste. 520, Columbus, OH 43215
P: 216-781-2944 // F: 216-781-2988 // www.communitysolutions.com