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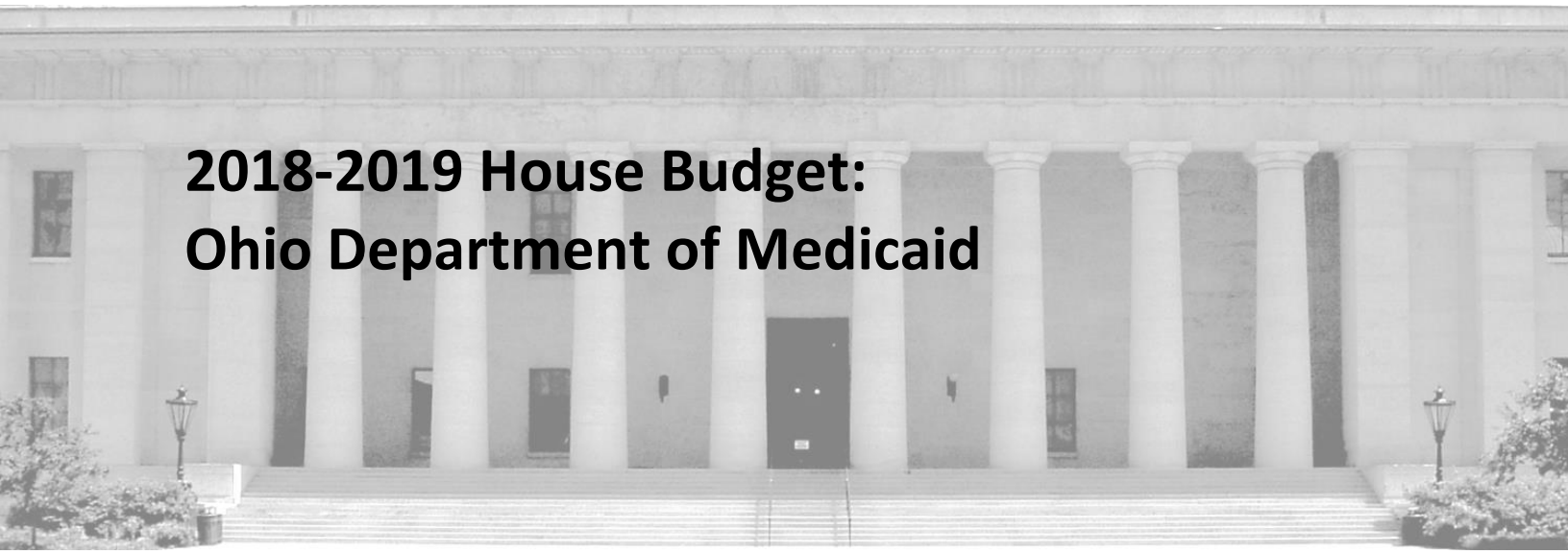

2018-2019 House Budget: Ohio Department of Medicaid

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Introduction

The House has deliberated the Kasich administration's budget proposal and has made a number of changes that affect Medicaid. These changes, some of which are documented in a previous blog post, trend in the direction of greater control over the Medicaid program by the General Assembly. This push for supervision included efforts to delay managed care models of delivery, the elimination of some efforts in value-based payment, and a reduction of departmental authority.[1] This push for control also included a complex and potentially conflicting set of policies, which involve the combination of program funding with the pursuit of new waivers built on work requirements, inpatient behavioral health, and experimentation. The House also made significant alterations to how Medicaid reimburses some of its largest cost centers in hospitals and nursing facilities (NFs), retreating from some of the proposed cuts and, in the case of NFs, actually increased funding for the only provider group with its reimbursement established in law. Underlying this debate with Medicaid is the broader structural challenge in the budget with tax revenues falling significantly below projections, creating fertile ground for future debate as the General Assembly seeks to backfill the gap in financing its policy priorities.[2]

Changes Proposed in the Budget

Managed Care & Value

The House has taken formal steps to push against the administration's efforts to privatize the program through managed care and move in the direction of value-based reimbursement. In regards to managed care, the House delays the Behavioral Health Redesign by six months. This not only includes the coding redesign (moving from July 2017 to January 2018) but the carving-in of the benefit (moving from January 2018 to July 2018). There is also an effort to prohibit the carving-in of the long-term services and supports system (LTSS) into managed care (MLTSS) until January 1, 2021. The MLTSS delay is coupled with a newly created study committee that is charged with reviewing the policy concept and issuing a report (due June 2020) on the merits of such an endeavor. It is worth noting that the Executive Director of the Joint Medicaid Oversight Committee (JMOC) has previously referred to managed care expansions as a practice of other states to hold down costs.[3] Additionally, Ohio recently issued a report on its recent efforts in its managed care demonstration project, MyCare Ohio, which often deals with the same population in need of long-term supports. This report has been a staple for the administration's argument in expanding managed care given the reported success in controlling costs and increasing quality for one of the highest cost populations in Medicaid, the dually-eligible.[4]

The House also eliminated one of Ohio's most significant efforts in value-based reform, the Comprehensive Primary Care Initiative (CPC). CPC is part of Ohio's State Innovation Model (SIM) grant from the federal government to make data more transparent in primary care settings for the purposes of increasing quality, improving outcomes, and decreasing cost. The elimination of CPC is a somewhat surprising and confusing move from the legislature, especially given the fact the House did not eliminate the administration's complimentary policy efforts in episodic-based payments. The removal of this program may be an effort by the House to find additional general revenue dollars needed to ensure the budget was balanced in the midst of a revenue crunch, with the Legislative Service Commission highlighting about $32 million in savings from the elimination.[5] According to the Office of Health Transformation, however, there are a number of unintended consequences associated with elimination, including significant reductions in payments to primary care doctors, a potential a claw back of the federal funds associated with the project and, notably, an annual increase of costs of $370 million starting in 2020.[6]

Increasing the General Assembly's Power

In an effort to increase the influence of the General Assembly on the general management of Medicaid, the House proposed policies, which require statutory authority for covered groups, JMOC approval for provider rate changes, and Controlling Board control for limited funding associated with the program. By making eligibility and rates subject to legislative authority and guidance, the Ohio Department of Medicaid loses control of some of its basic tools in managing its costs. Some have highlighted how these changes would open reimbursement to special interest influence and could make the program more inflexible and bureaucratic to economic conditions, especially during recessionary periods when spending tends to increase.[7] Beyond these elemental management pieces, there is the effort to have the ODM seek Controlling Board approval for expenditures every six months. These dollars include not only general revenue, but monies from dedicated purpose funds stemming from recoveries (like drug rebates) and the new managed care tax proposal. All told, the funding is about $611.3 million over the biennium, which is a little over 1.5 percent of the total funding associated with Medicaid at roughly $40 billion for the Department:

Funding Source	FY18	FY19
GRF	$58.7M	$68.6M
5DL0 (recoveries)	$26.3M	$34.7M
5TN0 (HIC Fee)	$196.2M	$226.8M
Total	**$281.2M**	**$330.1M**

Table 1: Ohio LSC Comparison Document

Administratively, the Controlling Board maneuver creates a number of questions that may make it difficult to achieve the goals of the program, including in cost containment. First, all categories of individuals served on the program, including children, the elderly, those with addiction, and the disabled, would be affected by this provision. Beyond the challenges this

may present in ensuring people have access to care, this may also affect the State's ability to enter into long term agreements with providers and contractors, likely leading to price increases for those vendors that rely on the guarantee of the appropriation. Additionally, this provision seems to conflict with another piece of language embedded in the House version, which would restrict an agency's Controlling Board approval limit to the lesser of $10 million, or 10 percent of an agency's budget, much lower than the $600 million withhold being proposed for ODM. Importantly, the state also gave the Controlling Board the approval to deny funding to the Department unless it is "satisfied" with a number of variables including Congressional action, obtaining a 1332 waiver, an 1115 waiver, and an IMD waiver. All of these pieces, in terms of timing and scope, rely on federal approval and are very different from one another.

With a 1332 waiver, states have the ability to change a number of elements associated with the Marketplace plans via the Affordable Care Act, including changes in the premium credits provided to plans and the mandates for employer and individual insurance.[8] The 1115 waiver is essentially the same as what was proposed by the General Assembly last budget, though the Kasich administration has indicated making the application more limited in terms of who it affects by only including those above 100 percent of the federal poverty level. The House also included language that added workforce participation language, though it is a bit vague and problematic. As currently constructed, the work requirement's lack of definition may have some negative consequences in terms of desired outcome. For example, in the context of Temporary Assistance for Needy Families (TANF), work requirements without the appropriate connection to training and placement opportunities actually decreased workforce participation.[9] What's more, as we have recently examined, those Ohio counties which rely most on Medicaid in terms of coverage and employment through the medical industry, often have the highest unemployment rates, meaning there may be very few options for individuals in terms of finding work, generally.[10] As such, this proposal may have the dual effect of not only decreasing coverage, but increasing unemployment in Ohio's rural counties. Finally, the state is directed to pursue an Institutions for Mental Disease (IMD) waiver, though it is unclear how this would be designed. While the state has expanded access to inpatient behavioral health services as an extension of federal regulation with managed care, waivers must be budget neutral and the costs associated with such an exemption are likely going to be significant.[11] Moreover, it is unclear what protections would need to be in place to ensure that reinstitutionalization does not occur.

Changes to Provider Payments

Hospitals saw a few changes that affect how they operate. First, the proposed rate cuts are eliminated and a new $6.9 billion ceiling on expenditures in each fiscal year is created. Once this ceiling is hit, the rate cuts would then be implemented. This ceiling was at $7 billion, but the House lowered the ceiling in an effort to capture more dollars after revenue estimates continued to come in under projections. Additionally, the "non-contracting" language was eliminated. Non-contracting, a policy proposed by the Kasich administration in previous budgets, would require a hospital to contract with a managed care plan at fee-for-service rates if there is not an established contract between a hospital and plan. Often, hospitals contract at much higher rates than fee-for-service, particularly children's hospitals, so this would provide more leverage to

insurance companies when negotiating rates. An unintended consequence of this language, then could be a constriction of available providers if they see the fee-for-service rates as being untenable.

In recent months, Ohio nursing facilities have come under greater public scrutiny as reports citing nationally-indicated lower quality have come out.[12] While the industry has pointed to the lag in the data, the Kasich administration has used this information as a case statement for reforming how payments are made to the nursing facility industry. The administration's proposed budget not only included the managed care carve-in of long term services and supports (MLTSS) as one element of reform, but also proposed the elimination of the reimbursement for NFs in law and a number of spending reductions. In the House, not only was MLTSS delayed, but NFs saw a $307M increase and the state's authority around overpayment collection reduced from five years to three.

Conclusion

The Senate will face the same pressures as the House in responding to the revenue uncertainty stemming from Ohio's structural tax problems. This will place greater pressure on Medicaid as a financier of programs and services, especially as a first responder to some of Ohio's most pressing public health issues like the opiate epidemic and high infant mortality rates. Federal uncertainty and an emboldened House have only complicated the policy legacy of the Kasich administration's efforts in value and coverage expansion. This has included the ambiguous aggregation of disparate waiver proposals and an authority annexation of Medicaid that may open up the reimbursement strategies of the program to greater special interest influence.

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