January 22, 2015

Dear Colleagues:

The attached report provides a brief overview of the activities of the Joint Medicaid Oversight Committee (JMOC) during the first eight months of operation. Even within this short time period, we have seen a relationship develop between the Administration and the General Assembly that has led to a better understanding of the Medicaid Program and increased accountability. This will enable us to have more meaningful conversations about health care quality, cost, and value than we have been able to in the past.

This report includes a description of issues discussed to date as well as a list of regulatory provisions that have been identified as potentially limiting the program's ability to control costs and improve health outcomes. These provisions will be studied in more depth in the year ahead.

Through JMOC, we look forward to continuing to improve the depth and quality of policy discussions about Ohio's Medicaid program.

Sincerely,

Senator Dave Burke
Outgoing Chair
Joint Medicaid Oversight Committee

Representative Barbara Sears
Incoming Chair
Joint Medicaid Oversight Committee

Joint Medicaid Oversight Committee

2014: Year in Review

The Joint Medicaid Oversight Committee (JMOC), created by SB 206 of the 130th General Assembly, first met in May 2014. The JMOC Committee is charged with providing continuing legislative oversight of all facets of the state's Medicaid program. In 2014, Senator Dave Burke (R- Marysville) served as Chair, Barbara Sears (R-Monrovia) served as Vice Chair, and Nickie Antonio (D- Lakewood) served as Ranking Member. Other members appointed to JMOC included Senators Chris Widener (R-Springfield), Bill Coley (R-Liberty Township), Charleta B. Tavares (D-Columbus), and Capri Cafaro (D-Hubbard) and Representatives Ryan Smith (R-Bidwell), Robert Sprague (R-Findlay), and Vernon Sykes (D-Akron).

In its first partial year of existence, the committee has hired an executive director and policy aide to provide research and administrative support to the committee. The Committee, with the help of a contracted actuary, set the projected medical inflation rate for the Medicaid Program for the FY 2016-2017 biennium. The Medicaid director must submit a final budget that grows, on a per member per month basis, no more than the rate projected by the JMOC actuary (2.9% in FY 2016 and 3.3% in FY 2017), while meeting the program goals set in Sections 5162.70 and 5162.71 of the Revised Code.

Topics Discussed in 2014

During calendar year 2014, the committee met a total of eight times and heard testimony from various administration officials including the directors of the Departments of Medicaid (ODM), Health Transformation (OHT), and Mental Health and Addiction Services (OMAS). The Committee also heard testimony from the Executive Director of JMOC and the Committee's contracted actuary, Optumas. The following topics were discussed in 2014:

- Medicaid Program Overview (John McCarthy/ODM);
- Medicaid Managed Care Rate Setting (John McCarthy/ODM);
- MyCare Ohio (John McCarthy/ODM);
- State's Payment Innovation Project (SIM) (Greg Moody/OHT);
- FY 2014-2015 Medicaid Budget Update (Susan Ackerman/JMOC);
- Medicaid Medical Inflation Rate for FY 2016-2017 (Optumas/JMOC);
- Medicaid Program Integrity (John McCarthy/ODM);
- Overview of Behavioral Health Transformation (Tracy Plouck/OMAS); and
- Overview of Medicaid Hospital Payments (John McCarthy/ODM).

In the hearings, the Committee heard about the administration's longer term vision for the Medicaid program and more detailed descriptions of how many of the components of the program work. The committee heard repeatedly that Ohio's public and private health care systems are in the midst of a period of systemic change that has the potential to substantially improve health outcomes and reduce costs by changing the way we pay for health care. There are a number of initiatives with a variety of public and private partners in progress across the state to test new models of care, and the Medicaid Program is using its leverage, as the state's largest single payer, to help push the health care system towards greater value.

As the Medicaid system moves from paying for volume to paying for value, the committee heard that the state's underlying rule-based regulatory structure, which was necessary for a fee for service system, can work against efforts to improve care and health outcomes while lowering costs.

Regulatory Barriers to Medicaid Efficiency

As required in Section 6 of SB 206, listed below are the provisions in Ohio's current regulatory framework that have been raised during the past eight months as potential barriers to the Medicaid program's flexibility and ability to control costs and improve health outcomes. Over the next year, the Committee will be gathering more information about why these provisions were initially added by prior General Assemblies and how the health care market has changed as a result. The Committee will also assess how these provisions and any changes would affect health care costs, care, and health outcomes.

Payment System

To benefit from the larger systemic reform in progress across all payers, the Medicaid payment system needs to be flexible enough to accommodate new payment models and to allow the Medicaid program to effectively manage delivery system changes.

- Rates for nursing facilities (5165.15) and ICF/DDs (5124.15) are set in statute, which creates an obstacle to effective program management.
- Unbundling initiatives (5165.01) create barriers to the alignment of fiscal incentives and incentives for effective care management.
- Non-contracting urban hospitals (5167.20(B)) – Because managed care rates must be actuarially sound, the state must account for the prices that plans pay for services across the state. In some regions, plans are paying rates in urban areas substantially over fee for service rates for inpatient care irrespective of health outcomes or quality of care.
- Rate differences for the same services provided to different populations (Sections 323.53 and 323.263 of HB 59) – Paying different rates for the same service creates disparities between programs and increases the administrative complexity of the program.
- Payment outliers (OAC 5160-1-60.1) – Enhanced rates that favor a single provider create a competitive advantage for that provider that impedes competition and consumer choice and increases the overall cost of care.

Infrastructure

Health care costs across all payers have been rising at an unsustainable rate. Public investment policies in the health care infrastructure should be reviewed to ensure that public projects prioritize areas of critical need and lower the total cost of care.

- Issuance of Public Debt for Health Care Capital Projects (various including 140.06, Chapters 339 and 3377) – Debt financing is available for health care projects through a number of public entities, yet investment favors bricks and mortar projects in institutions such as hospitals and nursing facilities, and these projects often raise the total cost of care. Opportunities that use debt financing for projects that lower the overall cost of health care are needed. Examples include supporting new models of care in areas of critical need, such as integrated care in community behavioral health settings and information technology projects that support data sharing to improve care across the health care system.
- Excess capacity in nursing facilities – Even with a moratorium on the addition of new nursing home beds, Ohio continues to have excess capacity in nursing facilities, which adds administrative overhead and can drive inappropriate utilization.
    - Currently, Ohio allows nursing home beds to move between counties using a bed need formula that maintains the status quo rather than reflecting true need across the state (3702.593).
    - Because of certificate of need, bed licenses have value. In instances where facilities have been closed due to poor quality, bed licenses have been sold rather than forfeited, which would help reduce excess capacity.

Provider Quality

Not only is poor care potentially dangerous for consumers, but poor care by one provider often results in the need for additional health care services. The inability to remove poor quality providers from the Medicaid program limits the effective administration of the program and increases overall costs.

- Ability to quickly sanction low quality providers (5164.38) – Except in certain circumstances, the Department of Medicaid may not terminate a provider agreement or implement an audit finding without months of administrative procedure and subsequent litigation. Due process could be provided more efficiently through an administrative reconsideration process.
- Quality metrics and incentives to improve care should be implemented throughout the Medicaid program.

Delivery System

To benefit from systemic reform and to improve patient care across all providers, the delivery system should be flexible enough to encourage new models of care and to facilitate collaboration between non-traditional partners.

- Current law exempts community behavioral health services from being provided via Ohio's managed care system (5167.03 (B)(3)) to the consumers enrolled in these plans.

- The success of payment reform relies on the availability of real time data to enable providers to make optimal decisions regarding care for their patients.
    - There is a need for the ability to share information in a universal format among those providing and coordinating care to achieve healthier outcomes.
- Current law prohibits the Department from allowing managed care plans to require prior authorization of antidepressants and antipsychotic medications (5167.12).
    - A number of Medicaid consumers are taking four or more behavioral health drugs. Prior authorization would provide an opportunity to question polypharmacy, which is not only a growth area in cost, but it can also negatively impact patient health.
    - One of the top selling drugs in the nation, Abilify, will go generic in April 2015.
- Realignment of legacy programs and institutions that were been created to address the health care needs of uninsured populations, including:
    - State psychiatric hospitals; and
    - Legacy health care programs at the Department of Health.

Enable Better Coordination Across Systems

Better collaboration between agencies and programs is critical to improving not just health but life outcomes for low income families and individuals.

- A lack of stable and affordable housing often increases health care costs for high need Medicaid recipients. There is increasing collaboration between the two programs, but the overall mission of Ohio's Housing Finance Authority (175.02) could be more closely aligned with the needs of the Medicaid program.
- Transportation can be a barrier to access and can lead to higher health care costs, yet services are funded by multiple public entities using different methodologies, which limits collaboration and increases complexity. Some of the unmet needs in this area include same day transit, transportation for urgent care, and family transportation.

State Staffing Constraints

Due to restrictive state human resource policies and a very competitive job market, the Department of Medicaid reports having difficulty attracting and retaining talented staff to manage the state's largest program.

Regulatory Cost

Out-of-date and cumbersome rules can increase costs; however, the five year rule review (119.032) and Common Sense Initiatives (107.52) processes provide additional "bites at the apple" for providers that can also increase costs.

Data Collection/Sharing

There are increasing opportunities to increase health system productivity and lower the cost of care through use of "Big Data." Ohio can to lead the charge by increasing the availability and transparency of state data for research, innovation, and industry.

The Year Ahead

Over the next year, JMOC will continue the work begun in 2014. JMOC anticipates additional discussion on the issues listed above. In the upcoming year, the Committee will also hear more about the system transformation underway in the Developmental Disability system and about cost drivers and quality with a focus on the Medicaid program's largest categories of service: long term care, managed care, and inpatient and outpatient hospitalization. JMOC will continue to work with its actuary, Optumas, to better understand per capita costs and cost drivers by Medicaid population.