Ohio Medicaid Overview

May 2014

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Ohio Department of Medicaid

John R. Kasich, Governor
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Medicaid Overview

- **Medicaid is Ohio's largest health payer** 83,000 active providers, hospitals, nursing homes and other providers care for 2.5 million individuals insured by Medicaid
- **Medicaid spending increased 33% in the 3 years prior to Governor Kasich taking office** – four times faster than Ohio's economy
- **Governor Kasich's first Medicaid reform budget H.B. 153 held Medicaid spending to less than 3% growth** – saving Ohioans $3 billion since 2011

Medicaid is a State/Federal Partnership

- Created by Congress in 1965 to provide health security for low-income Americans (along with Medicare for older Americans)
- Under broad federal guidelines, states establish their own standards for eligibility, benefits, and provider payment rates
- Medicaid programs vary by state
- Federal Medical Assistance Percentage (FMAP):

SOURCE: Federal financial participation in Ohio assistance expenditures for 2012, Federal Register Volume 75, Number 217 (November 10, 2010).

FMAP Formula

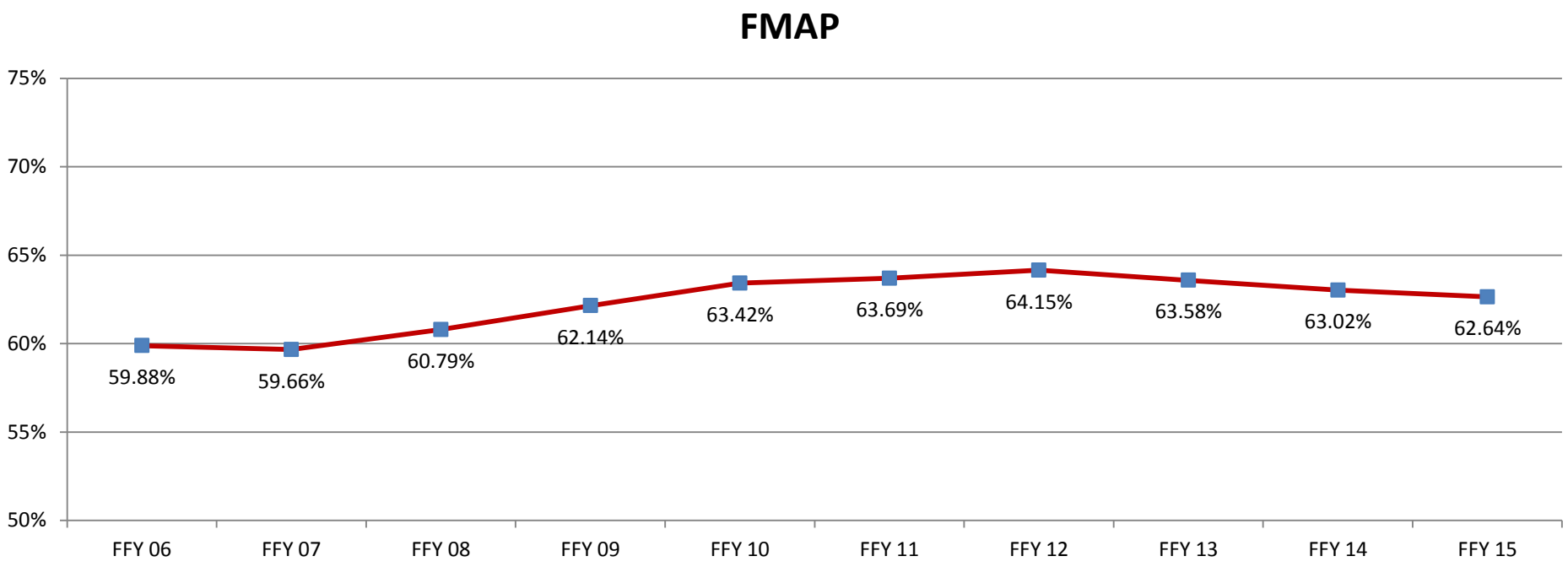
- The formula is based on a rolling three-year average per capita income data for each state and the United States, produced by the Department of Commerce's Bureau of Economic Analysis.

- The Medicaid statute sets forth how a state's and federal share of Medicaid costs is to be calculated:
  - the state share equals the square of a state's per capita income divided by the square of U.S. per capita income, multiplied by 0.45.
  - the federal share as 100 percent minus the state share.

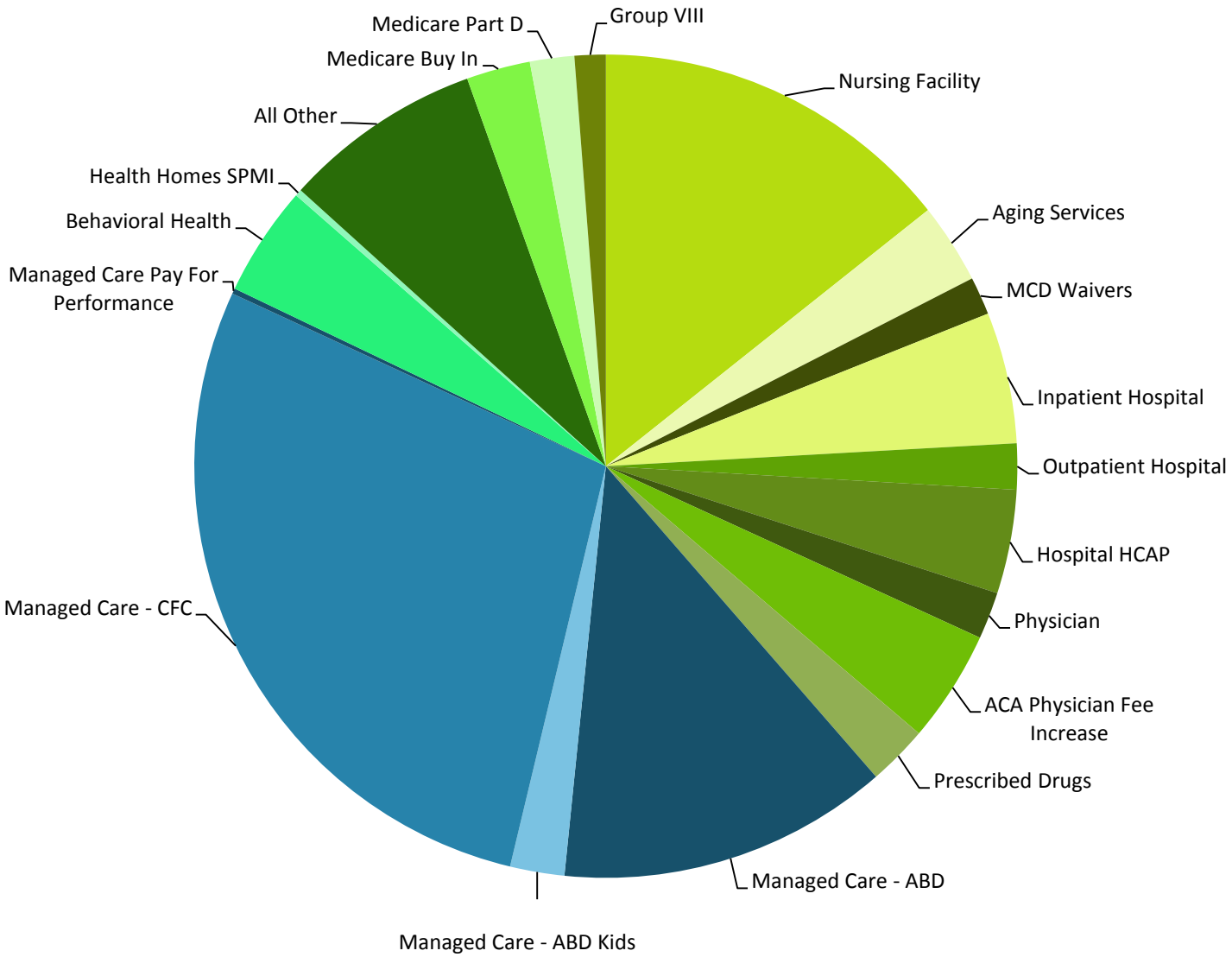
State Share = 0.45 x (State Per Capita Income/U.S. Per Capita Income)

Federal Share = 1 - 0.45 x (State Per Capita Income/U.S. Per Capita Income)

Regular FMAP Overtime



Medicaid Expenditures by Service Type - SFY 14 to Date



Medicaid State Plan

Statewide – All Medicaid services must be available on a statewide basis. States cannot limit the availability of the health care services to a specific geographic area.

Freedom of Choice – States may not restrict a Medicaid recipients' access to a qualified provider.

Amount, Duration, and Scope – For every covered service, determinations are made regarding the amount, duration, and scope of coverage provided to meet recipients' needs. States must cover each service in an amount, duration, and scope that is reasonably sufficient.

Comparability of Services – States must ensure that the medical assistance available to any recipient is not less in amount, duration, or scope than what is available to any other recipient.

Medicaid State Plan

Reasonable Promptness – States must promptly provide Medicaid to recipients without delay caused by the agency's administrative procedures.

Equal Access to Care – States must set payment rates that are adequate to assure Medicaid recipients reasonable access to services of adequate quality

Coverage of Mandatory Services – CMS requires state Medicaid programs to provide certain medically necessary services to covered populations.

Benefits

Federally Mandated Services

- Early and Periodic screening, diagnosis and treatment (EPSDT) for children
- Inpatient hospital
- Physician
- Lab and X-ray
- Outpatient, including services provided by hospitals, rural health clinics, and Federally Qualified Health Centers
- Medical and surgical vision
- Medical and surgical dental
- Transportation of Medicaid services
- Nurse midwife, certified family nurse and pediatric nurse practitioner
- Home Health
- Nursing facility
- Medicare premium assistance

Ohio's Optional Services

- Prescription drugs
- Durable medical equipment and supplies
- Vision, including eyeglasses
- Dental
- Physical Therapy
- Occupational therapy
- Speech therapy
- Podiatry
- Chiropractic services for children
- Independent psychological services for children
- Private duty nursing
- Ambulance/ambulette
- Community alcohol/drug addiction treatment
- Home and Community based alternatives to facility based care
- Intermediate care facilities for people with developmental Disabilities
- Hospice
- Community mental health services

Waivers

Section 1115 Research & Demonstration Projects – Section 1115 provides the HHS Secretary with broad authority to approve experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test merit of substantially new ideas of policy. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Some states expand eligibility to cover groups of individuals and services not otherwise eligible for federal match and to demonstrate alternative approaches to providing or extending services to recipients.

- The 1115 projects are generally approved to operate for a five-year period; states may submit renewal requests to continue the project for additional periods of time. Demonstrations must be “budget neutral” over the life of the project, meaning they cannot be expected to cost the federal government more than it would cost without the waiver.

Waivers continued

Section 1915(b) Managed Care/Freedom of Choice Waivers – Section 1915(b) provides the HHS secretary with the authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid. This section also provides waivers allowing states to skip provisions requiring comparability of services and statewideness, which together require states to offer the same coverage to all categorically needy recipients statewide.

- Prior to the 1997 Balanced Budget Act, which allowed states to implement managed care programs under their state plans, states often used these waivers to implement managed care programs by restricting recipients' choice of providers.

Waivers continued

Section 1915(c) Home and Community-Based Services Waivers – Section 1915(c) provides the HHS secretary with the authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to provide comprehensive long-term services in institutional settings. These waivers have been critical in state strategies to provide alternative settings for long-term care services.

Sections 1915(i) State Plan Home and Community-Based Services – DRA added a new section 1915(i) to the Social Security Act. Section 1915(i) provides states an opportunity to offer services and supports before individuals need institutional care, and also provides a mechanism to provide State plan home and community-based services to individuals with mental health and substance use disorders. This State Plan service package includes many similarities to options and services available through 1915(c) home and community-based services waivers, a significant difference is that 1915(i) does not require individuals to meet an institutional level of care in order to qualify for home- and community-based services. ACA made changes, which became effective October 1, 2010, to 1915(i) provisions by removing certain barriers of offering home and community-based services through the Medicaid State Plan.

Medicaid vs. Medicare

- Aid for some poor Ohioans
- Must have low income
- Children, parents, disabled, and age 65+
- Primary, acute and long-term care
- State and federal funding
- No payroll deduction

- Care for nearly all seniors
- No income limit
- Age 65+ and some people with disabilities
- Primary and acute care only
- Federal funding only
- Payroll deduction

Medicare

Part A Hospital Insurance – Most people do not pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A helps cover inpatient care in hospitals, including critical access hospitals and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice and some home health care. Beneficiaries must meet certain conditions to get these benefits.

Part B Medical Insurance – Most people pay a monthly premium for Part B. Medicare Part B helps cover doctors' services and outpatient care. It also covers some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

Medicare

Part C Advantage Plans – People with Medicare Parts A and B can choose to receive all of their health care services through Medicare Health Plans, which are referred to as Medicare Advantage Plans (MA Plans), under Part C. Medicare beneficiaries may voluntarily select this option and then choose from among a number of MA Plans contracted with the federal government to do business in the state or geographic region. Enrolling in Medicare Part C means the individual transfers their Part A and Part B health care coverage to the responsibility of their MA Plan.

Part D Prescription Drug Coverage – Medicare Part D began January 1, 2006. It has been provided through Prescription Drug Plans and MA Plans. It is optional coverage for which Medicare beneficiaries must enroll and pay a monthly insurance premium, an annual deductible, and coinsurance costs.

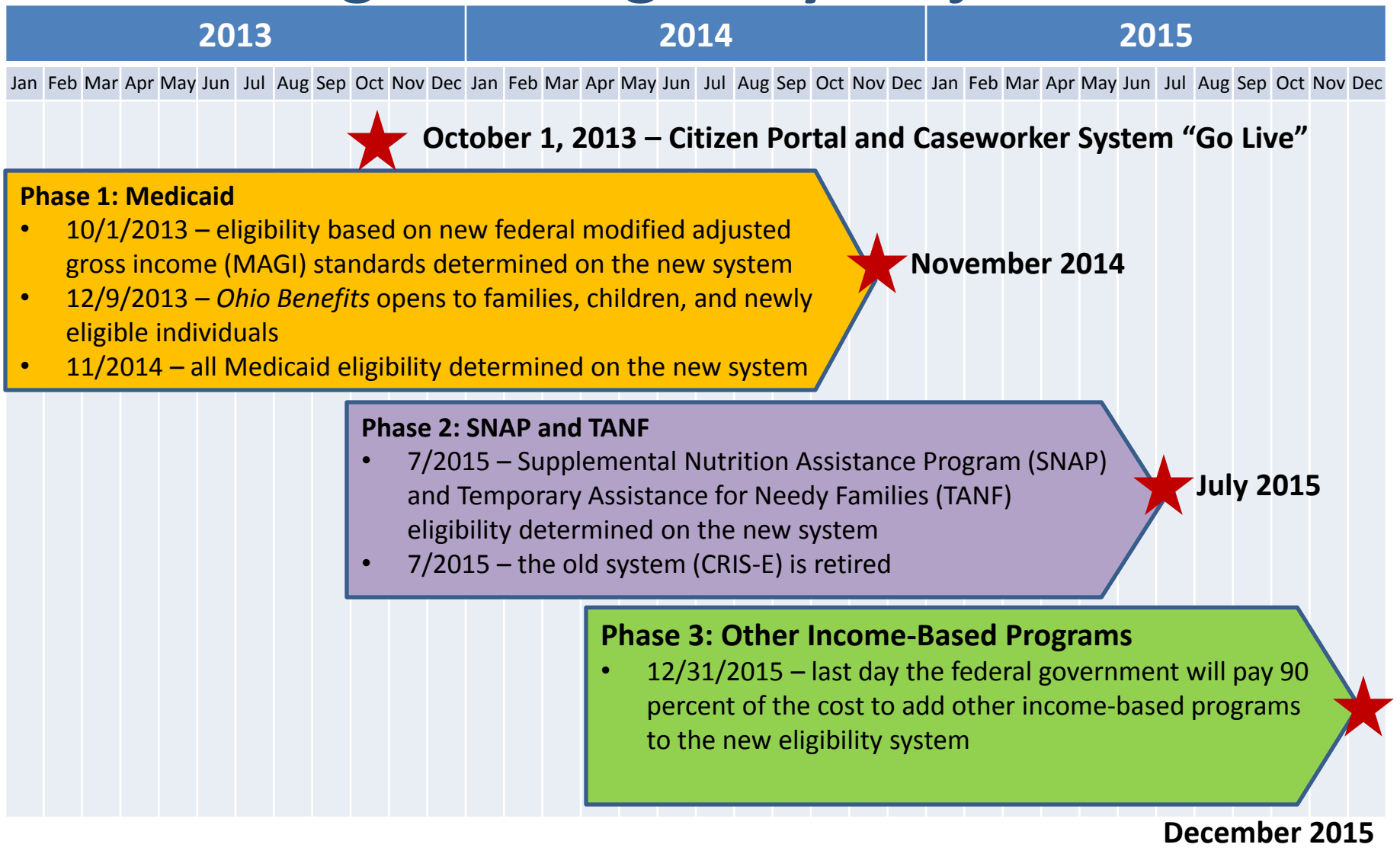
Basic Covered Groups

- Aged (over 65)
- Blind
- Disabled
- Modified Adjusted Gross Income (MAGI)
  - Children under 19, parents and caretakers, foster kids, newly eligible group

Modified Adjusted Gross Income (MAGI)

- The new standard applied to non Aged, Blind, or Disabled categories
  - Children
  - Parents
  - Childless adults (Expansion)
- IRS 1040 – bottom line modified by 5%
- The income that comprises the adjusted gross income is compared against the income threshold for different Medicaid categories.
- If your income is below a categorical income level, you qualify for Medicaid.
- If your income is above a categorical income level, you can qualify for insurance through the exchange.

Ohio Integrated Eligibility Project Timeline



Primary Payment Methods

- **Fee For Service**
  - This method pays for individual units of service, e.g. doctor office visit, single prescription, medical equipment etc.
  - Most are on a simple fee schedule
  - Nursing facility ICF/IDD payments are a “per diem” but are considered fee for service.
    - And are the only two set in legislation

Hospital Payments

- **Prospective Payment Methods**
  - Ohio Medicaid uses prospective payment methods developed in the late 1980s to pay for inpatient and outpatient hospital services provided to Medicaid consumers.

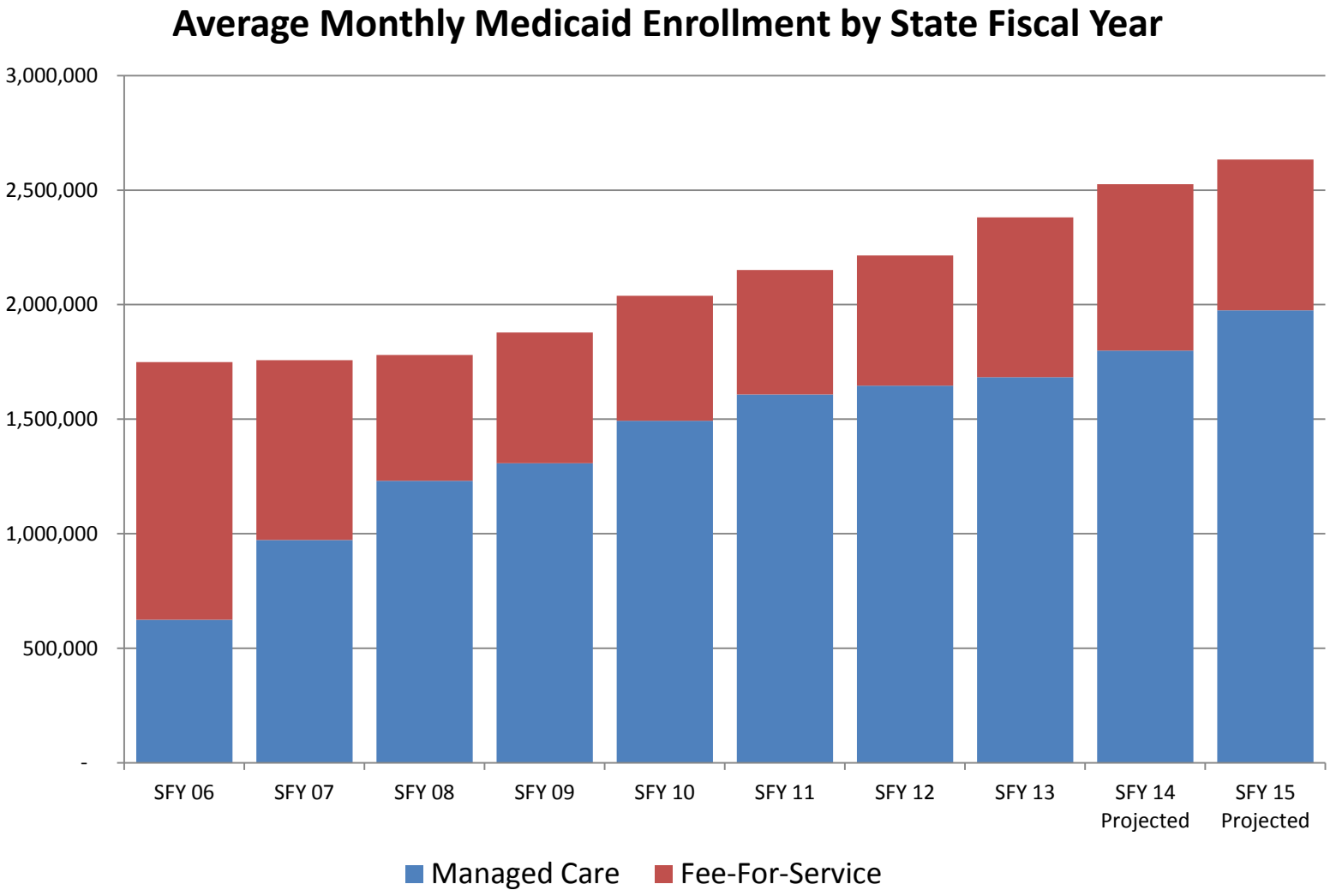
- **Diagnosis-Related Group System**
  - Ohio uses a diagnosis-related group (DRG) system to classify inpatient hospital cases into groups, which are used to determine inpatient hospital reimbursement.

- **Predetermined Fee Schedules**
  - ODM reimburses most hospitals for outpatient services using predetermined fee schedules.

Primary Payment Methods

- **Managed Care (capitation)**
  - This method involves enrolling individuals in the Medicaid program into managed care plans. The Medicaid agency makes a monthly capitation payment (similar to an insurance premium) to the managed care plan. The managed care plan is responsible for covering the cost of all services for their customer.
  - The managed care plan is "at risk" for service costs exceeding the capitation payment and thus the plan is incentivized to control costs and utilization across its entire enrollee population.
  - Not all services are covered by Medicaid managed care. Behavioral Health, institutional care, and Home and Community Based waiver services (HCBS) are "carved out".
  - My Care Ohio, is Ohio's new managed care program for Medicare/Medicaid consumers and is the first managed care to include all services.

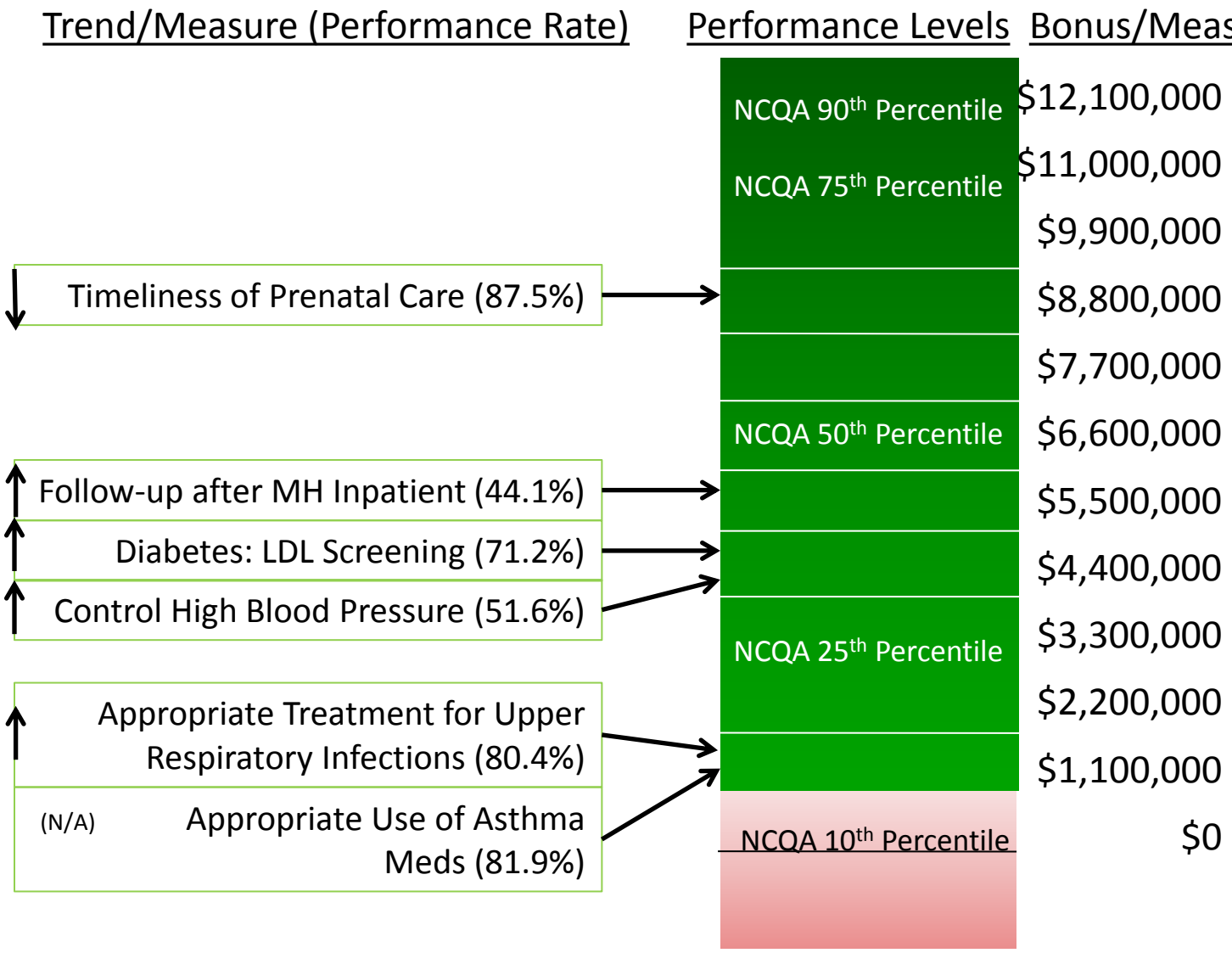
Ohio Medicaid Managed Care



Overview: 2013 Medicaid Pay-for-Performance (P4P)

- Why Pay-for-Performance?
  - Ohio Medicaid will succeed only if our managed care plans are successful in providing quality, coordinated care to Ohioans on a consistent basis.
  - Motivate partners to think outside the box in order to provide diverse and complex health care
  - Incentivize innovation and constant improvement from the plans
- Max Incentive Amount: 1% of premium = $73 million
- Method: Higher Performance = Higher Pay
- Six measures aligned with Medicaid's Quality Strategy
  - Timeliness of Prenatal Care
  - Follow-up after MH Hospitalization (7day)
  - Controlling High Blood Pressure
  - Diabetes: LDL Screening
  - Appropriate Use of Asthma Meds
  - Appropriate Treatment for Children with Upper Resp. Infections

2013 Pay for Performance (P4P)- Statewide



In Total, 5 MCPs were awarded $29 million (39%) of $73 million possible

Results: 2013 Pay-for-Performance

- In Total, 5 MCPs were awarded $29 million (39%) of $73 million possible

- Four of five measures improved from the previous year

- Plan Rank (Highest to Lowest Scoring)
  1. Paramount
  2. Buckeye
  3. CareSource
  4. Molina
  5. United HealthCare

Conclusions: 2013 Pay-for-Performance

- Although Medicaid managed care plans improved in four of five measures, this analysis shows that more work lays ahead. We are challenging each of our plans to commit their organizations to initiatives aimed at sustained improvement.

- Raise the bar for next year's P4P:
  - Elevate the minimum standards set forth for quality incentive payments

MyCareOhio

Connecting Medicare + Medicaid

MyCare Ohio is a new managed care program designed for Ohioans who receive ***both*** Medicaid ***and*** Medicare

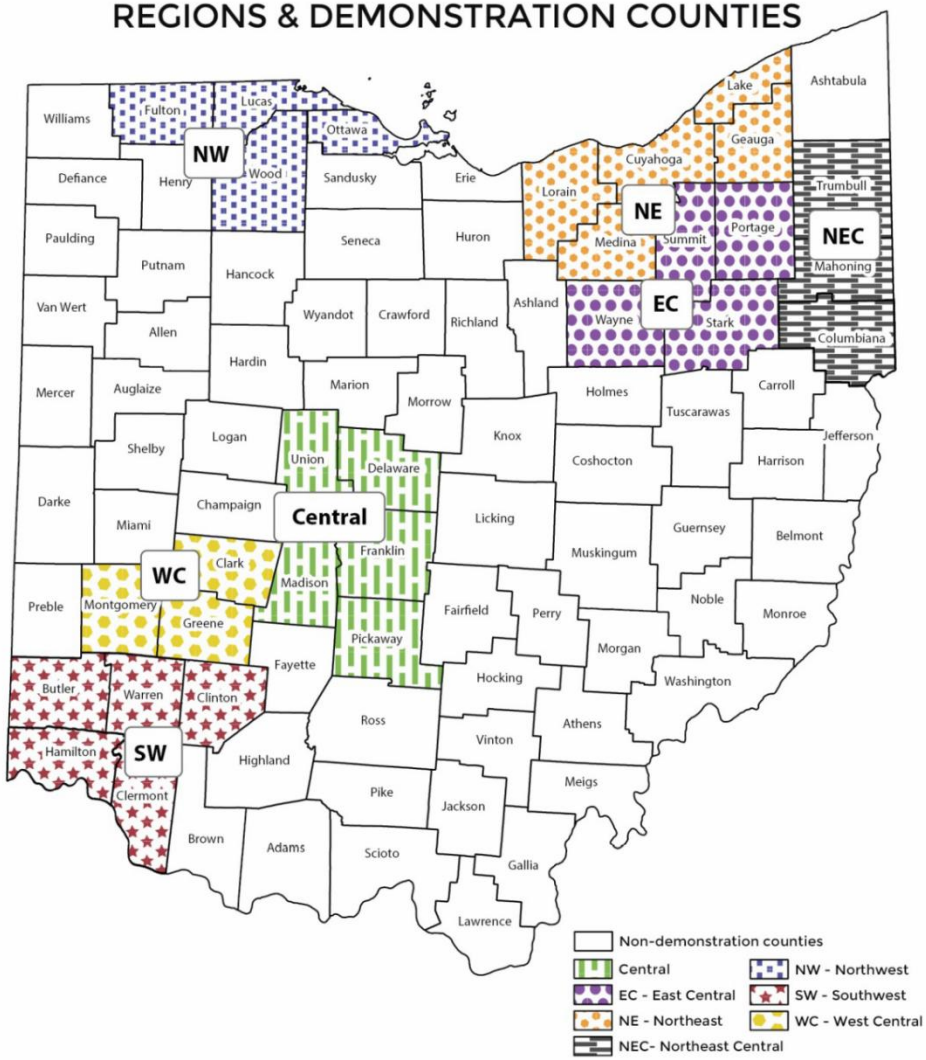
- You must enroll in a MyCare Ohio plan if you are:
  - 18 or older;
  - live in one of the 29 demonstration counties;
  - currently receive services from BOTH Medicaid and Medicare and Medicare benefits.

Ohio Department of Medicaid

MyCareOhio
Connecting Medicare + Medicaid

REGION	EFFECTIVE ENROLLMENT DATE
Northeast	5/1/2014
Northwest Northeast Central Southwest	6/1/2014
East Central Central West Central	7/1/2014

REGIONS & DEMONSTRATION COUNTIES



Why medical homes *and* episodes?

Medical homes provide the foundation for total cost/quality accountability	Episodes "nested" within total cost of care for more specific accountability
▪ **Population-based** accountability transcends delivery system ▪ **Large long-term impact:** prevention and chronic disease management ▪ Requires providers to fully **transform business model** away from FFS ▪ Requires significant provider **capabilities and commitment**	▪ **Patient-centered** design around the "patient journey" thru delivery system ▪ **Faster to impact:** clear and specific opportunities for improvement ▪ **Stages business model transition** away from FFS for specialists/hospitals ▪ **Faster to scale,** independent of market structure or capabilities

Fit with other models	**Both models being implemented agnostic of provider structure, can be "carved out" or "carved in" for ACO or capitation**

Five Year Plan: Launch PCMH & Episode Model at Scale

Goal

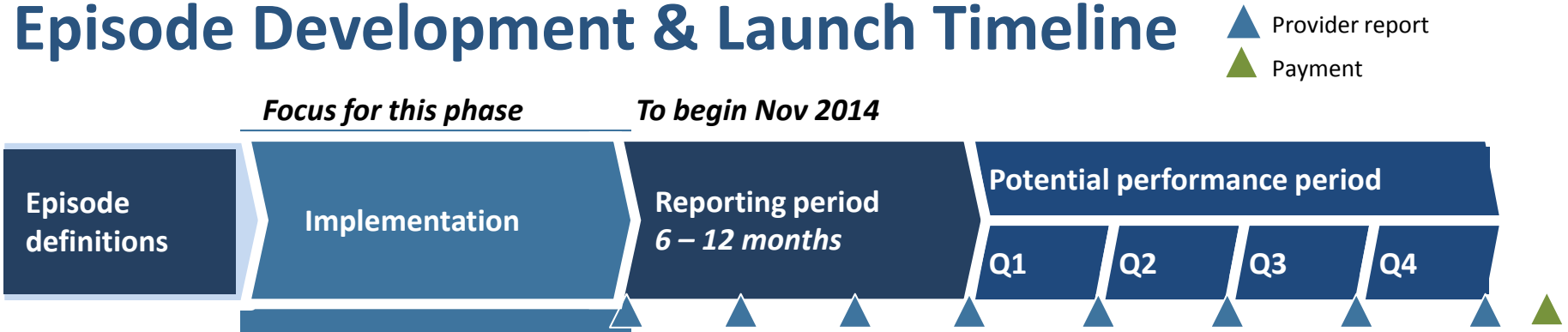
80-90% of Ohio's population in some **value-based payment model** (combination of episodes- and population-based payment) within **5 years**

State's role

- Shift rapidly to PCMH & episode model in Medicaid FFS
- Require Medicaid MCO partners to participate / implement
- Incorporate into contracts of MCOs for state employee benefit program

	Patient centered medical homes	Episode-based payments
Year 1	▪ In 2014 **focus on CPCi** ▪ Payers agree to participate in design for elements where standardization and / or alignment is critical ▪ Multi-payer group begins enrollment strategy for one additional market	▪ State leads design of **5** episodes – perinatal, asthma (acute exacerbation), COPD exacerbation, PCI, and joint replacement ▪ Payers agree to participate in design process, **launch reporting on at least 3 of 5 episodes in 2014** and tie to payment within year
Year 3	▪ Model rolled out to all major markets ▪ **50%** of patients are enrolled	▪ **20** episodes defined and launched across payers
Year 5	▪ Scale achieved state-wide ▪ **80%** of patients are enrolled	▪ **50+** episodes defined and launched across payers

Episode Development & Launch Timeline



- Focus of Clinical Advisory Group process

- Customization
- Thresholding & payment parameters
- Infrastructure development

- Reporting period prior to link to payment allows opportunity to -
  - Ensure data integrity
  - Understand practice patterns and impact on performance
  - Begin to shift practice patterns to succeed in new model

- Quarterly reporting ensures timely feedback in advance of payment reconciliation
- Payment reconciliation typically occurs one quarter beyond the end of a performance period

ODM Reports

ODM is required by the ORC to produce the following reports:

- 5162.13 – Annual Report
- 5162.131 – Semi-Annual Report on Controlling Costs
- 5162.132 – Annual report outlining efforts to minimize fraud, waste, and abuse
- 5162.133 – Annual program report; distribution; contents
- 5162.134 – Annual report of integrated care delivery system (*MyCare Ohio*).

Questions