Slowing Ohio's Medicaid Per Capita Spending - Progress to Date

January 2017

Since the creation of the Joint Medicaid Oversight Committee (JMOC) in May 2014, with its focus on lowering health care costs and improving health outcomes, year-over-year growth in per capita Medicaid spending has slowed. Additionally, spending at the monthly per capita or per member (PMPM) level has been significantly lower than was estimated at the introduction of the last budget. Using actual enrollment to provide an apples-to-apples comparison, these changes have produced savings of $1.6 billion across all funds in fiscal years 2015 and 2016 compared to Executive Budget PMPM estimates.

Medicaid PMPM Spending

	FY 2015	FY 2016	Growth Rate	FY 2017	Growth Rate
JMOC Limit (Oct 2014)	$628	$647	2.9%	$668	3.3%
Executive Budget	$628	$636	1.4%	$665	4.5%
Actual/*Estimate**	$606	$613	1.2%	*$620-$629*	*1.1%-2.6%*

*Actual/Estimate calculated by Optumas, December 2016

The table above shows monthly Medicaid PMPM spending for fiscal years 2015 through 2017. The table includes the PMPM limit set by JMOC in October 2014, the PMPM rate proposed by the Governor in the Executive Budget, and actual spending as calculated by JMOC's actuary.

Lowering the rate of growth in PMPM spending in the Medicaid program would not be possible without a continuing commitment from both the legislature and the administration, as achieving substantial and meaningful savings in the Medicaid Program requires a long term commitment to a consistent set of policies. The following sections identify the policies that helped to achieve the savings identified above, those that have increased spending, and additional opportunities to lower spending while improving health outcomes.

Policies That Have Lowered Medicaid Per Capita Spending Growth

Several policies have had a significant impact on slowing the rate of growth in Medicaid spending over time. While these are not new policies, they represent a clear and consistent policy direction that emphasizes value over volume, appropriate cost-containment strategies, positive health outcomes, and person-centered care.

Increased Use of Managed Care – The Ohio Department of Medicaid (ODM) began expanding its use of managed care in FY 2006 when enrollment became mandatory for recipients in the Covered Families and Children (CFC) category as well as a subset of those in the Aged, Blind, and Disabled (ABD) category. In FY 2014, Ohio expanded the use of managed care to qualifying individuals enrolled in both Medicaid and Medicare in six regions of the state with about half of Ohio's dually eligible individuals enrolled. Managed care has reduced PMPM spending in the following ways:

- Improvement in care management and care coordination;
- Reduction in inappropriate utilization of services;
- Increased use of value-based purchasing;
- Reductions in premium rates for performance and efficiency factors; and
- Shared savings with Medicare for care for dually eligible members.

Increased Use of Home and Community Based Alternatives to Institutional Care – Ohio has worked successfully to rebalance Medicaid spending toward less expensive home and community based services rather than higher cost settings like nursing facilities. More than half of all Medicaid spending on long term care services and supports is for care in home and community based alternatives to institutional care. The ultimate goal is to enable seniors and people with disabilities to live with dignity in the settings they prefer, especially their own home.

Improved Program Administration – With annual spending of $27 billion in fiscal year 2017, Ohio's Medicaid Program is the largest program in state government. While it is the largest single payer for health care in the state, it is only one payer in a much larger health care system. Managing a program of this size and complexity requires a high level of sophistication. Ohio has made a number of changes that have improved the management of the Medicaid Program, including the creation of a standalone cabinet level agency to provide the leadership and focus needed to manage a program of this size and the replacement of outdated information systems for claims processing and decision support and eligibility that have substantially improved the accuracy and efficiency of the program along with providing near-real time data for better decision making.

Policies That Have Increased Per Capita Spending Growth

While the legislature, through JMOC, has created an overarching goal of reducing Medicaid spending, some policies have increased spending, through higher rates, the addition of new covered services, or restrictions on the management of the program. Not all spending increases should be considered bad policy. Increases may be warranted to improve health outcomes, access to care, or to address systemic issues. Listed below are the more significant policy changes adopted in the last budget that have resulted in higher per capita spending this biennium.

Rate Increases – Rates have been increased for the following providers and/or services: some physician rates; ambulettes; home health services, private duty nursing, and waiver nursing services; and dental services including a 5% increase for providers in rural areas. Additionally, nursing facility prices have

been rebased to reflect more recent costs. While the experience of individual facilities may vary, rebasing resulted in increased spending.

Addition of New Services – Several services have been added to the Medicaid benefit package including: periodontal scaling and root planing; metabolic nutrition products; respite services for children with certain mental health conditions; care coordination for inmates being released from state prisons; specialized transportation through the Medicaid in Schools Program; and enhanced maternal care services.

Administrative Constraints – While not new in this biennium, regulatory provisions continue to limit program flexibility including requirements to contract with certain providers or at specified rates, enhanced rates that favor one provider, and limitations on the prior authorization of prescription drugs that raise the cost of care without corresponding improvements in quality of care or health outcomes.

It is important to note that state policymakers have limited to ability to control costs in some of the fastest growing areas in the Medicaid Program – namely prescription drugs and Medicare costs paid by Medicaid. Spending in both of these areas have increased substantially over the past two years and are expected to continue to grow quickly through the next biennium.

Additional Opportunities to Lower Medicaid Per Capita Spending

Going into the next state budget, the following policy areas offer a number of high value opportunities to both improve care and outcomes for Medicaid recipients while reducing overall spending. These areas are significant, either because they represent an area with a high level of per person spending or would affect a large number of individuals.

Behavioral Health Integration – Medicaid is the largest payer of behavioral health services, and behavioral health disorders often top the list of most expensive health conditions – mainly as a result of more care being delivered in inpatient and emergency room settings. In Ohio, many individuals with serious and persistent mental illnesses and substance use disorders are not receiving services through the community behavioral health system. Additionally, many of these individuals also have serious physical health conditions that are not well managed. The result is higher utilization rates for inpatient hospitalization and emergency room care, higher costs, and poorer health outcomes from a lack of disease management and preventive care. It will take time to see savings as consumer and provider practices change. Other states, particularly those that have good integration of physical and behavioral health, have seen substantial savings as well as improve outcomes for patients.

Improving Value in Health Care – Ohio received a State Innovation Model (SIM) grant to test multi-payer, value-based payment models. Through this grant, Ohio is implementing two initiatives – Comprehensive Primary Care and Episodic Payments. These initiatives include Medicaid, Medicare, and Ohio's major commercial insurers and have an overarching goal of covering 80% of Ohioans through a value-based payment model by 2020.

Through the use of episodic payments, the state seeks to reduce variations in cost and quality by offering rewards and penalties to providers accountable for an episode of care and to improve quality for the most common healthcare episodes. Ohio plans to roll out five to seven new episodes per year. Currently, six episodes are in the performance period where providers are able to earn bonuses or face penalties, while seven more episodes are in the initial reporting-only phase.

Through the Comprehensive Primary Care Initiative (CPCI), the state seeks to re-center primary care in the health care system to improve prevention and management of chronic disease. CPCI was launched in January 2017 among a small number of large primary care practices. Participating practices will receive a monthly per capita payment for all patients on its registry and each practice will be eligible for a shared savings payment at the end of the year based on its performance against a set of benchmarks. A broader expansion of this initiative is expected to begin in January 2018.

Improving Program Integrity – Medicaid enrollment and spending has increased substantially, which has the potential to increase the incidence of fraud, waste, and abuse. Policymakers need to ensure oversight is adequate to ensure program integrity.

One area of concern is home health care. A fast growing population and fast growing industry coupled with a low bar for provider entry and limited oversight makes this area susceptible to fraud and makes the population that relies on these services susceptible to harm. Ohio is in the process of implementing an electronic visit verification (EVV) system to help validate delivery of home health services to eligible individuals. The EVV system will significantly reduce the risk of improper claims being paid by Medicaid and reduce certain administrative burdens associated with identifying fraud, waste, and abuse.

Improving Maternal and Infant Health – In 2015, Ohio's Medicaid program paid for 51.7% of all births. Prematurity, low birth weight, and maternal addiction are among the factors that contribute to poor infant health and infant mortality. Improving maternal health prior to pregnancy can significantly impact these factors. In addition to improving Ohio's infant mortality rates, improving maternal and infant health can reduce neonatal intensive care unit (NICU) stays; reduce the length of stay in NICUs, and reduce the incidence of developmental delays – all of which can also significantly reduce Medicaid costs.

Continued Push to Improve Quality through Managed Care

Ohio continues to trail most other states on many important health outcome measures including preventive care and chronic disease management, not only in the Medicaid Program, but across all populations in the state. Medicaid managed care is an important vehicle for driving quality and improving health outcomes in the Medicaid program, but much more work needs to be done. Ohio has recently implemented a new Medicaid quality strategy that is focused on delivering better care, improving health outcomes across populations, and practicing best evidence medicine across the care continuum. To effectively increase health outcomes, the administration and legislature needs to continue to encourage and reward new, innovative strategies while maintaining focus and attention on

what is working. JMOC should increase its attention in this area by increasing its review of current initiatives, progress made, and barriers that are impeding better results.