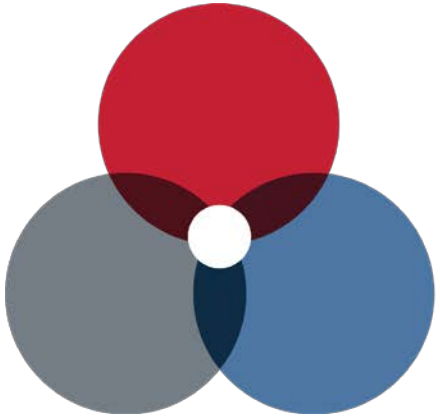

THE CENTER FOR COMMUNITY SOLUTIONS
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Strategic Review of the Ohio Department of Medicaid

Part I: Profile

August 20, 2018

Loren Anthes, Policy Fellow

Center for Medicaid Policy

Why a Strategic Profile

In-depth, strategic review of Medicaid policy during Kasich administration divided into three parts:

1. **PROFILE (August 20):** This is a summary of key characteristics of the department as defined by the department, including major decisions, general organizational structure, strategic direction, financing and approaches to policy by eligibility type. Many aspects may be described but not fully implemented.
2. **ASSESSMENT (August 27):** Beneficiary and environmental trends, health value relative to other states and a review of the current capacity to address policy challenges. This includes the major strategic issue faced by the state moving forward and status/success of efforts.
3. **RECOMMENDATIONS (September 4):** This will include large, broad recommendations for future strategic focus by the next administration.

This review is intended to be high-level and conceptual.

The three parts will be released in consecutive weeks, with accompanying blogs found at https://www.communitysolutions.com/blog/

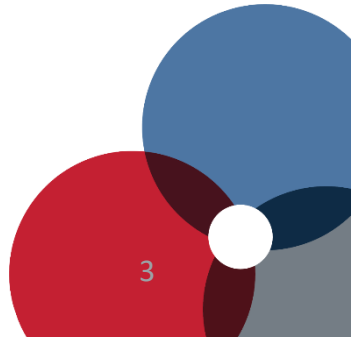
There will be a **WEBINAR (September 6)** to review the entire report. Register for the webinar here.

August into September

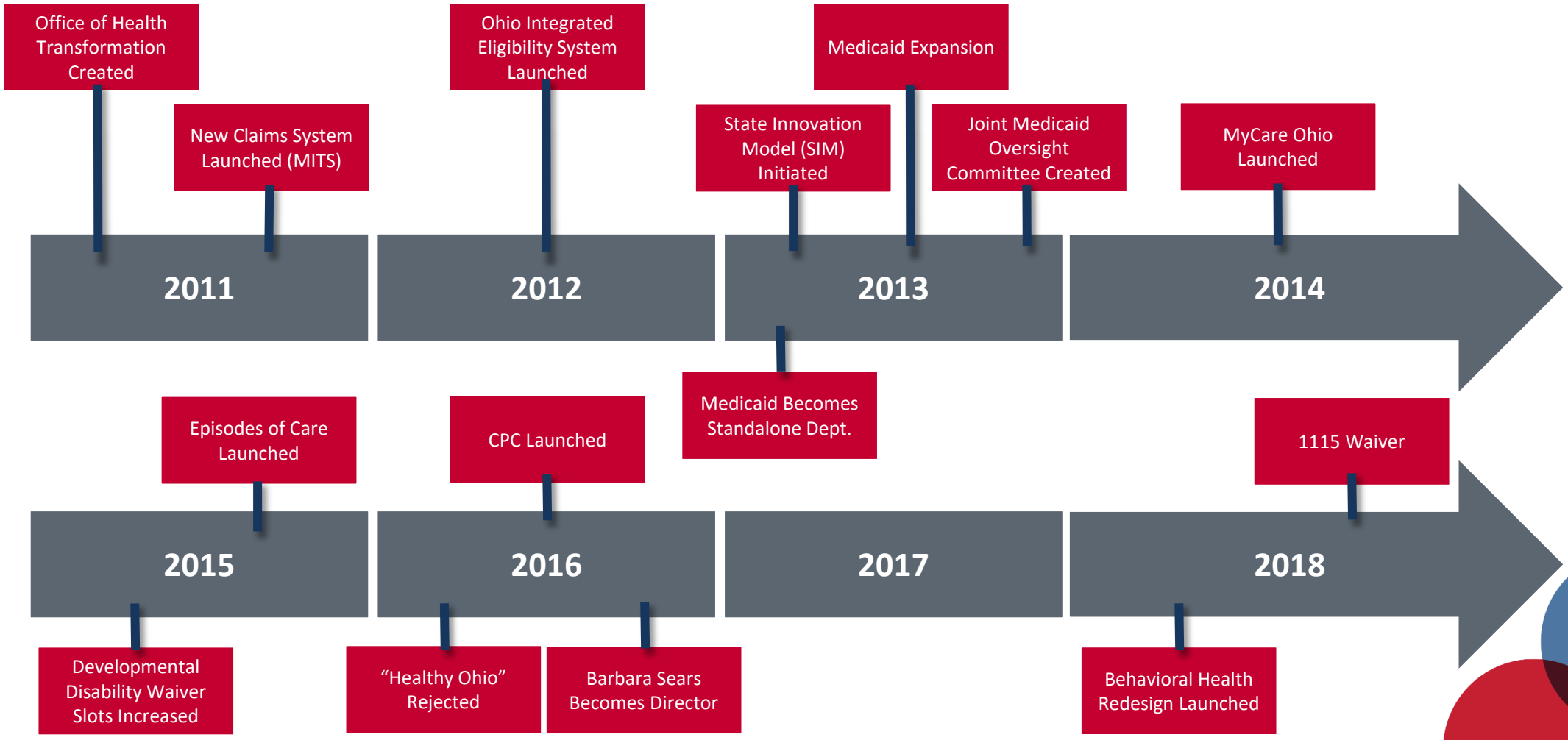
Su	M	Tu	W	Th	F	Sa
19	20 Part 1	21	22	23	24	25
26	27 Part 2	28	29	30	31	1
2	3	4 Part 3	5	6 Web	7	8

Strategic Profile

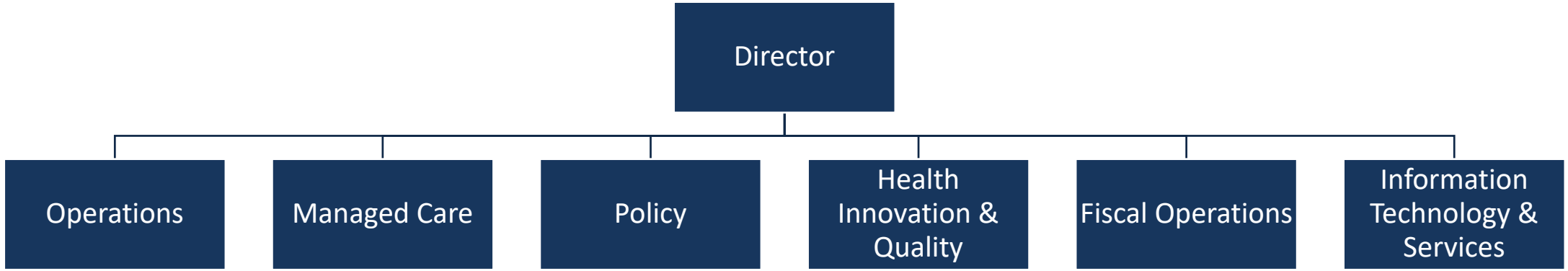
- Historical Milestones
- Structure of the Department
- Eligibility & Benefits
- Financing
- Delivery Model
- Value Drivers
- Strategic Intent
- Policy Strategy



Historical Milestones



Structure of the Department



- Department is bureaucratic and functionally grouped
- Dominant structural design is centralized and mechanistic, with focus on
  - Controls
  - Efficiency
  - Reliability
- Core processes center around state plan agreement and law
- Department functions for benefit administration are largely privatized
- Leadership staff are highly qualified and educated
- Customization in benefit administration comes largely through regulation and managed care contracting
- Managerial organizational life-cycle tied to electoral cycle
- Efforts to move to value-based design indicate evidence-based management transition

Beneficiary Profile: Enrollment & Spending

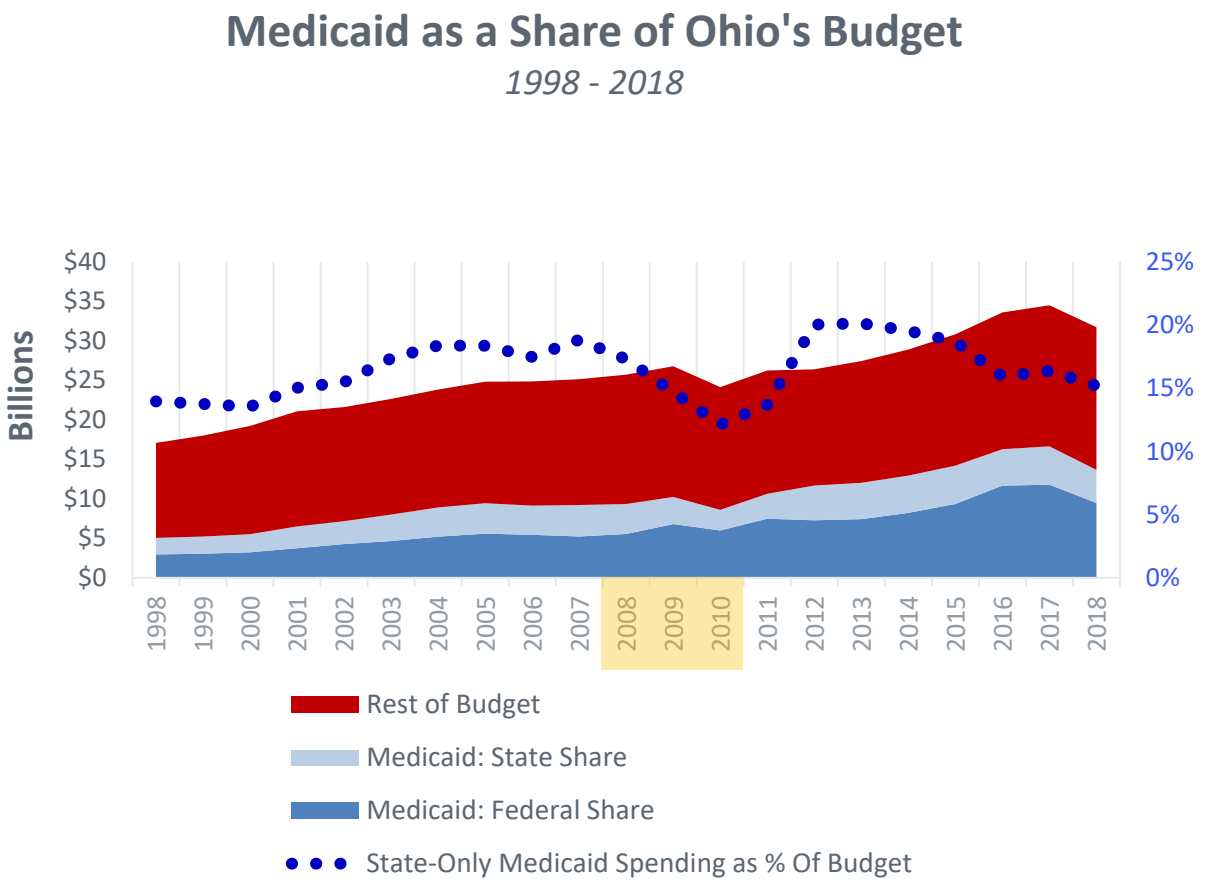
State Fiscal Year 2017

		Covered Families and Children	Aged, Blind and Disabled	Expansion	Other
Volume*	2,976,239	1,791,797	425,378	721,316	97,527
% Volume		59.0 %	14.0%	23.8%	3.2%
Spending	$23.17 B	$6.78 B	$11.88 B	$5.19 B	$.29 B
% Spending		28.1%	49.1%	21.5%	1.2%
Predominant Delivery Model		Managed Care	Mostly FFS, Some Managed Care	Managed Care	Varies
Value Success Factors		Prevention, Access, Medical Adherence	Case Management, Complex Medical Needs	Prevention, Access, Medical Adherence	Access

*State Fiscal Year 2017 Average, Source: http://medicaid.ohio.gov/Portals/0/Resources/Reports/Caseload/2018/06-Caseload.pdf

**Annualized from December 2017, Source: http://medicaid.ohio.gov/Portals/0/Resources/Research/MedicaidEligExpReports/2018/Med-5.pdf

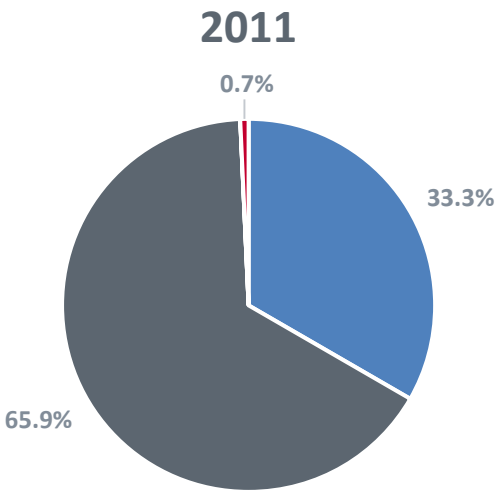
Financing



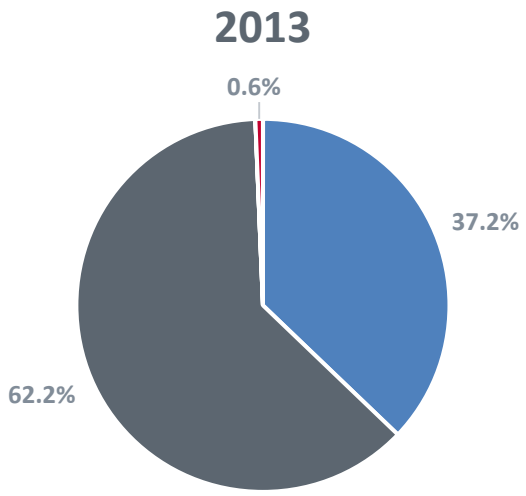
- Dip in state share between 2008-2012 tied to **enhanced stimulus funding**
- Average state-share spending 16.2% since 1998 (currently 15.2%)
- State share has decreased 25% since 2010

Legislative Service Commission, Historical Revenues and Expenditures, Source: https://www.lsc.ohio.gov/pages/reference/current/historicalrevandexpenditure.aspx

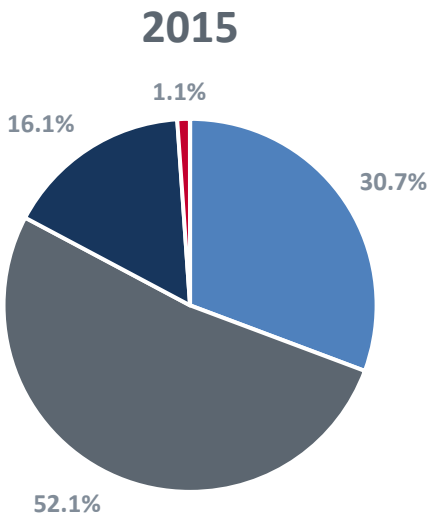
Financial Performance by Beneficiary Group



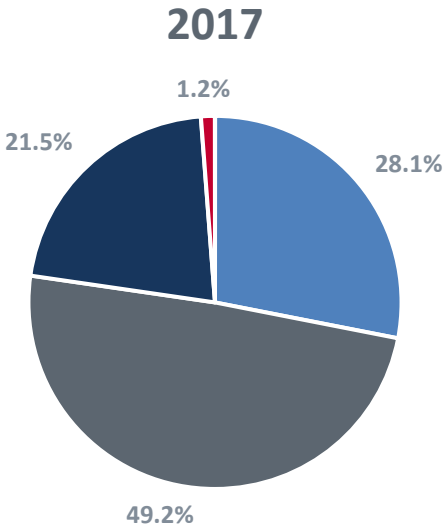
Total Expenditure
$16,115,768,136



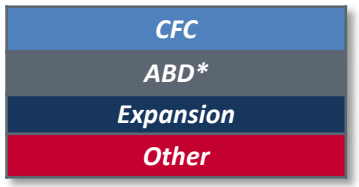
Total Expenditure
$16,298,783,116



Total Expenditure
$21,294,896,030



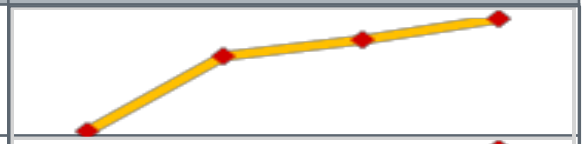
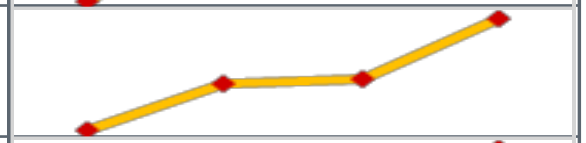
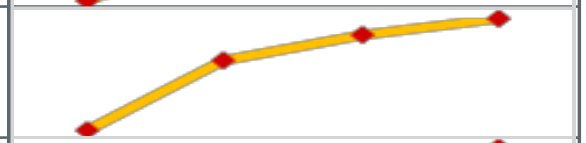
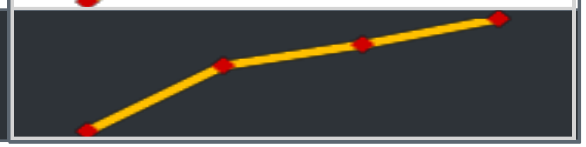
Total Expenditure
$24,139,058,485



- Expansion and new eligibility thresholds increased access with two main effects:
  - ABD individuals used expansion as a “front door” to eligibility
  - CFC parents transitioned into expansion group

Source: Ohio Department of Medicaid Forecast Book, 2016-2017.
*ABD includes dually-eligible population

Compound Annual Growth Rate: 2014-2017

	4 Year CAGR	Trend
CFC	2.9%	
ABD	3.1%	
Expansion	66.4%	
Other	24.7%	
Overall	8.6%	

- Growth in expansion spending significant as population is enrolled

Source: Ohio Department of Medicaid Forecast Book, 2016-2017.
*ABD includes dually-eligible population

Financing Model

How Medicaid is Financed

- Federal Medical Assistance Percentage
- State GRF
- Eligibility

How Medicaid Maximizes Revenue

- Turning State GRF into Matching Funds
- Episodic Based Payments
- Taxes and Fees for Non-GRF
- Managed Care Utilization Control
- Pay for Performance
- Rate Construction

Value Drivers

Case Mix and Acuity

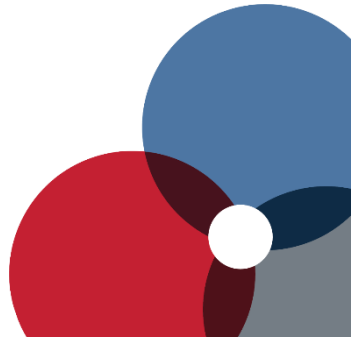
- Makeup of population in Medicaid
- Medical diagnoses and comorbidities
- Demographic Trends

Cost Centers

- Hospitals
- Nursing Facilities
- Pharmacy
- Managed Care
- Social Determinants: Economics, Racial Disparities & Other Non-Medical Factors

Policy Innovation Tactics During Kasich Administration

- Pay for Performance in Managed Care
- Episodic Based Payments
- Comprehensive Primary Care



Strategic Intent

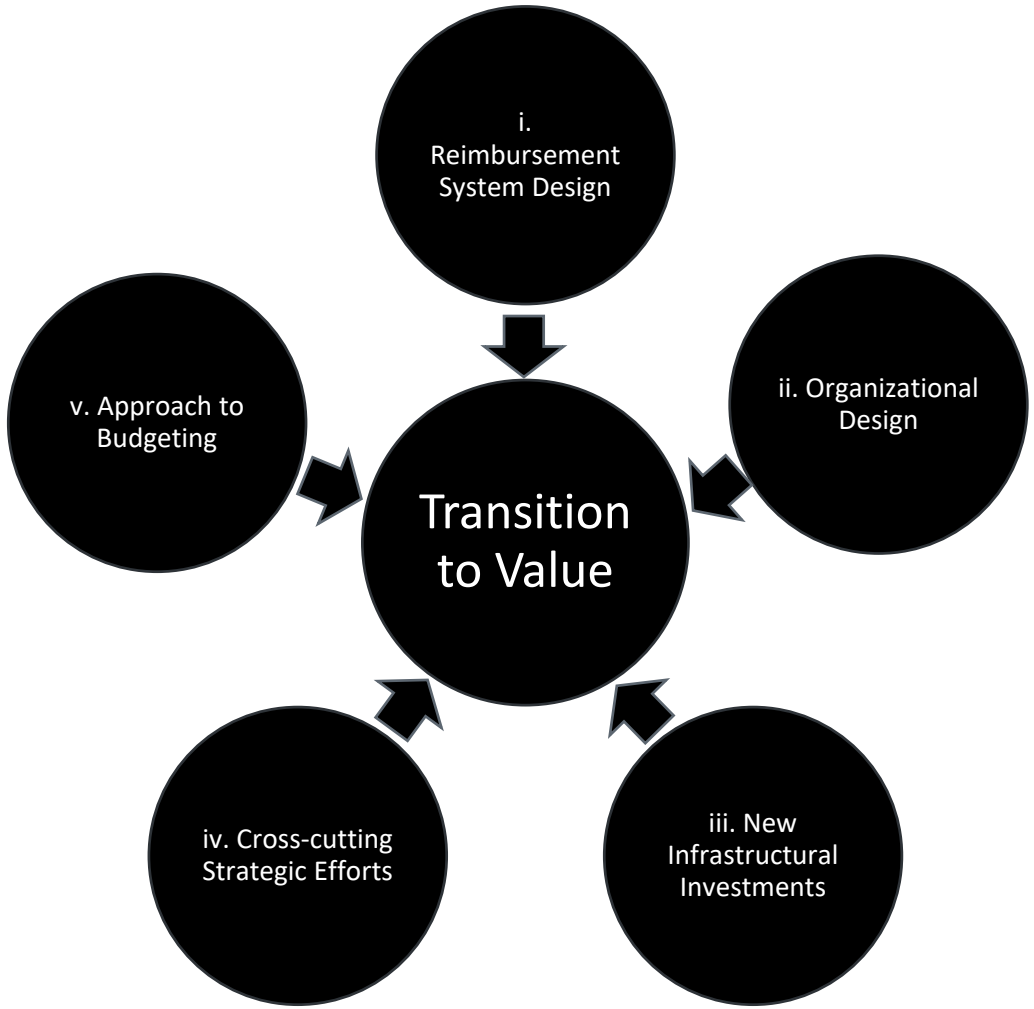
The Major Moves or Actions the Department is Making Currently, or Has Made, During the Kasich Administration

The system is fragmented, uncoordinated and low-value

In order to contain cost and improve outcomes, the administration:

1. Modernized: Expanded access, transitioned to more home and community settings and privatized through managed care
2. Streamlined: Consolidated departments, reformed managed care administration and made investments in information technology
3. Moved Toward Value: State Innovation Model, State Health Assessment and State Health Improvement Plan

Policy Strategy



i. Transition away from fee-for-service into more capitated and at-risk environments
   - Notable projects include the MyCare Ohio Program and Behavioral Health Redesign

ii. Heterogeneous Diversification
   - Transitioning more populations into managed care

iii. Significant Investments in IT Infrastructure
   - Eligibility (OIES) and claims (MITS) have been focus

iv. Departmental Elevation to Cabinet-Level with Strategic Center at Office of Health Transformation
   - Reforms have included changes to line item budgeting, managed care contract administration, and relationship to other Medicaid-financed agencies

v. Significant Leverage of Federal Financing via Affordable Care Act
   - Hallmarks include SIM, OIES, MITS, BIP

Policy Strategy: CFC

i. Prevention and Increasing Access
   - Expansion allowed more parents to access coverage between 90 and 138 % of the FPL

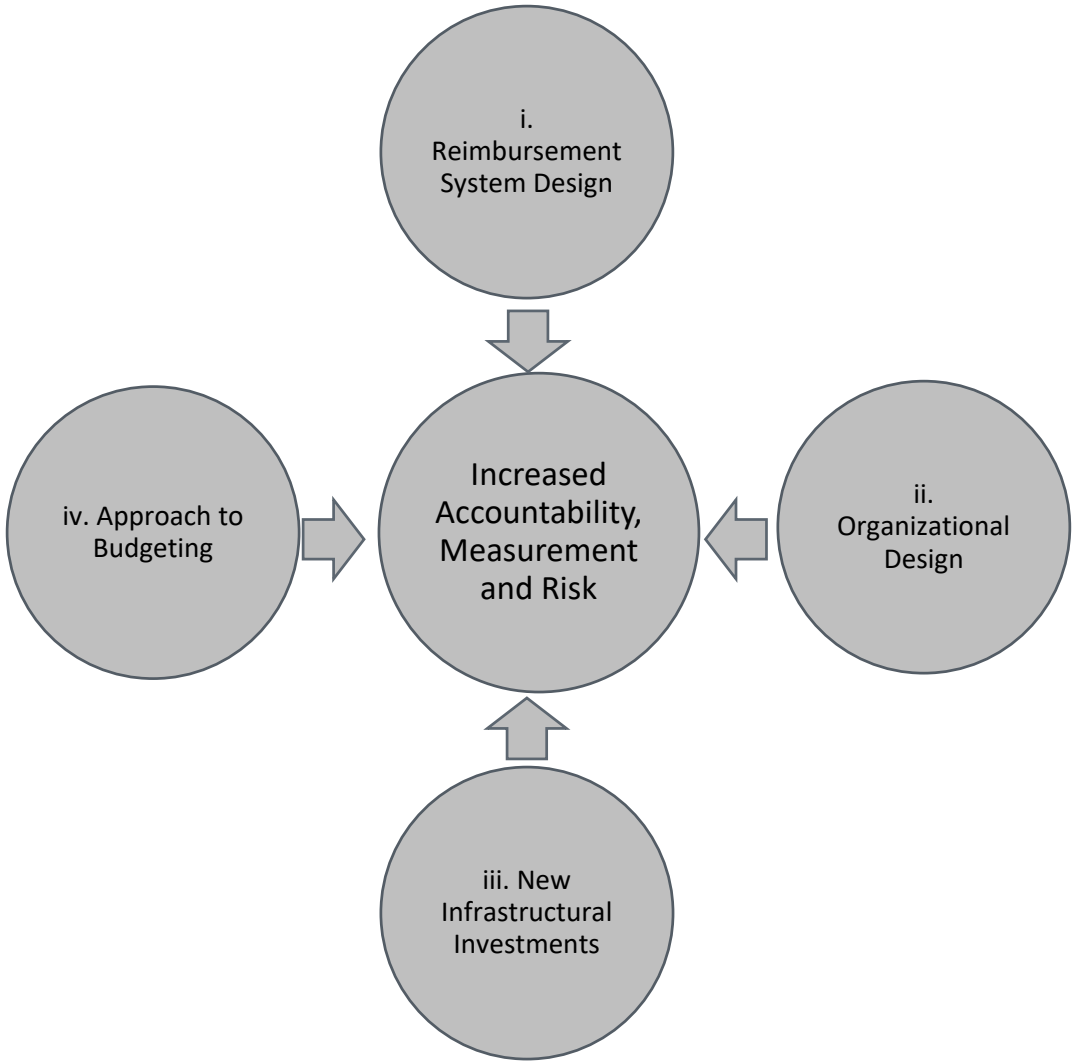
ii. Managed Care

iii. Population Health
   - Infant mortality, HEDIS measures concentrated on chronic diseases, including specific childhood-related measures (e.g. immunizations)

iv. State Health Assessment (SHA) and State Health Improvement Plan (SHIP)

v. Maximizing Revenue, Limited Children's Health Insurance Plan (CHIP) Participation

Policy Strategy: ABD



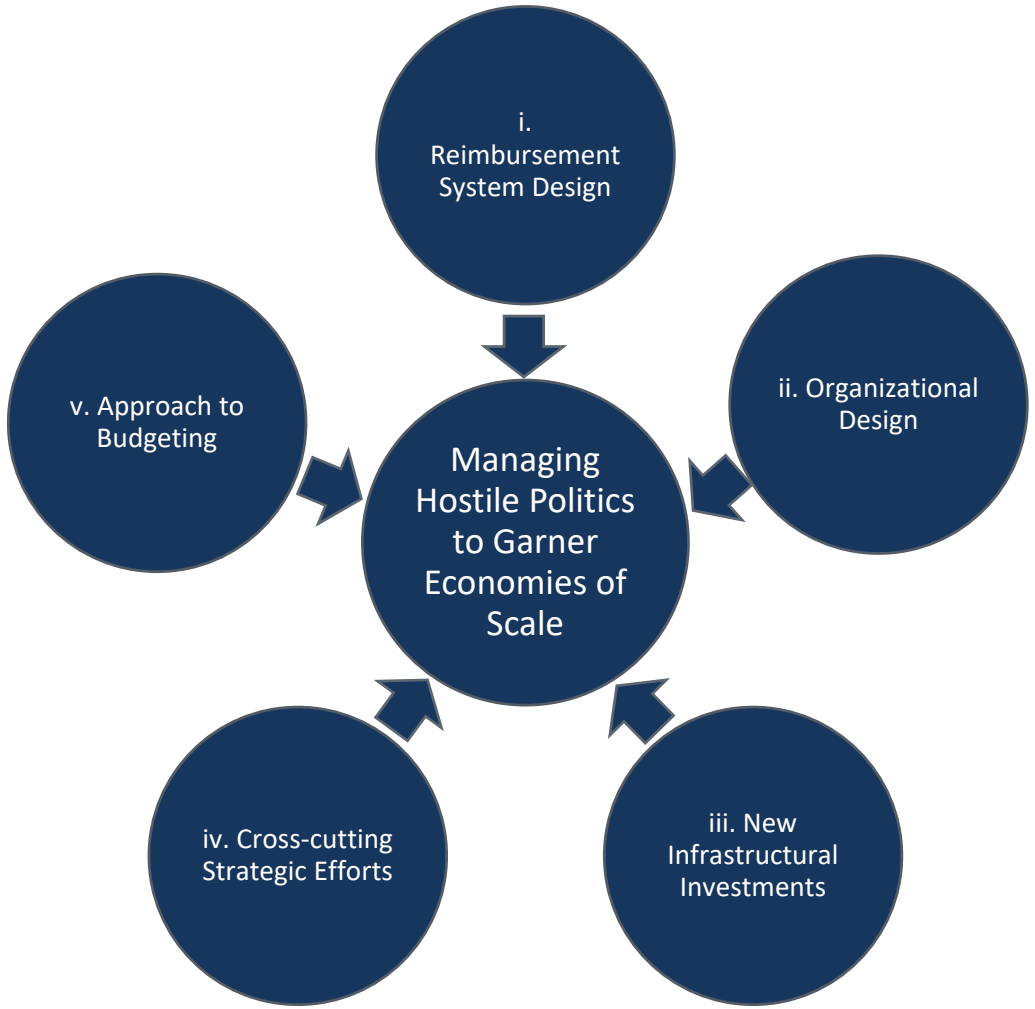
i. Greater Case Management and Quality-Based Reform
- Attempt to remove nursing facilities (NF) reimbursement from statute (continuously fail despite lower national quality ranking)
- Medicaid elevation

ii. Privatization, Centralization & Community-Based Settings
- More managed care (Managed Long Term Services and Supports (MLTSS), behavioral health redesign, MyCare Ohio Waiver)
- Disallow Developmental Disability Boards to act as providers
- Increase in funding for, and consolidation of, waivers for home and community based services (HCBS)

iii. Increased Data Utilization
- Require more codes and licensure for behavioral health providers (National Correct Coding Initiative and Mental Health Parity)
- Independent provider electronic visit verification (EVV)

iv. Try to Privatize, Leverage Federal Funding
- General Assembly consistently sides with industry in regulatory scope
- Balanced Incentive Program to transition more into HCBS

Policy Strategy: Expansion



i. Leverage Federal Funds, Legislative Oversight
- Funding primarily federal
- Target of General Assembly policy focus, compromising administration's ability to manage (waivers, JMOC, Controlling Board, rate oversight, state plan limitations)

ii. Managed Care
- Population relies on MCOs

iii. New Eligibility Process via Waiver
- Eligibility process being made more complex given political environment

iv. Value-based Design & Elevation
- SIM
- Expansion freed significant local resources to address behavioral health population
- Expansion provides scalability of purchase power and access to implement broad, long-term reforms focused on prevention and risk

v. Keep Costs Low & Negotiate with Legislature
- Super-majority in House and Senate puts pressure on administration to complicate expansion eligibility and the associated funding

Policy Strategy: Other

i. Varies, Focused on Specialized Populations

ii. Eligibility Designed for At-Risk or Complex Populations
   - E.g. Women with breast and cervical cancer

iii. Expansion Displaced Some Need for Categories
   - E.g. family planning

iv. Stakeholder Interests Varied and Specialized