



Department of Medicaid

John R. Kasich, Governor

John B. McCarthy, Director

October 1, 2014

**Semi-Annual Cost Containment Report
State Fiscal Year 2014: July 1 – December 31**

Dear Sirs and Madams:

Section 5162.131 of the Revised Code requires the Ohio Department of Medicaid to report semi-annually on the cost-containment initiatives related to the administration of Ohio's Medicaid program. I hope that this report provides valuable insight regarding our agency's efforts to modernize Medicaid and bolster accountability to Ohio's taxpayers.

As we move ahead with this truly unique endeavor, I look forward to a continued collaboration between our agency and members of the Ohio General Assembly.

Sincerely,

A handwritten signature in blue ink that reads "John B. McCarthy". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

John B. McCarthy
Director

CC: Ohio House Speaker Bill Batchelder
Ohio Senate President Keith Faber
Ohio House Minority Leader Tracy Maxwell Heard
Ohio Senate Minority Leader Joe Schiavoni
Joint Medicaid Oversight Committee Executive Director Susan Ackerman
Legislative Service Commission Director Mark Flanders

Cost Management Initiative Updates

1) Prioritize Home and Community based services

In conjunction with the Governor's Office of Health Transformation, the Ohio Department of Medicaid is working to rebalance Medicaid spending toward less expensive home and community based long-term services and supports. The renewed focus on home and community care will provide new opportunities for residents to live with dignity in the setting they prefer – especially their home – instead of a higher-cost setting like a nursing facility.

UPDATE: In 2013, it was announced that Ohio would receive \$169 million in enhanced federal medical assistance percentage (FMAP) through the Balancing Incentive Program (BIP). The program provides additional reimbursement dollars for community-based long-term services and supports in states that make certain structural changes to their long-term care delivery systems. This additional funding stream will provide Ohio with the opportunity to develop a person-centered, “no wrong door” approach to long-term care delivery.

Ohio is also currently pursuing “waiver harmonization,” which will incrementally align program design across all nursing facility level of care waivers. If successful, this effort will result in significant changes to the State’s existing 1915(c) waivers (PASSPORT, Choices, Assisted Living, Ohio Home Care and Transitions Carve-Out) that will create greater efficiency and improve consumer outcomes.

2) Reform Health Plan Payments

By the close of 2013, more than 1.7 million Ohioans were receiving health insurance via a Medicaid managed care plan. Ohio Medicaid pays the five private health plans monthly, per person, using a “capitation rate” similar to health insurance premiums. In addition to launching a new Medicaid managed care program in July 2013, the Ohio Department of Medicaid has championed a number of reforms aimed at improving overall health outcomes for Medicaid beneficiaries and reducing costs to Ohio taxpayers.

UPDATE: Since July 1, 2013, ODM has successfully reformed the health plan payments by implementing two key provisions contained in the SFY14-15 Executive Budget. These provisions are:

- Reducing prior authorization (PA) requirements for pharmaceuticals by 5 percent
- Capping the managed care rate trend growth at 3 percent

A primary goal of Ohio Medicaid has been to control the growth of managed care rates which, given current market trends, were at a danger of growing by large measure.

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Realizing that such a potential growth would simply prove unsustainable, Ohio Medicaid capped the managed care rate trend.

Both the managed care and prior authorization provisions have already led to the accrual of significant savings. For the first half of FY 14, the Department has seen \$22.1 million in pharmaceutical savings, and \$79.4 million in savings by way of capping the managed care rate growth trend.

3) Reform Hospital Payments

Executive Budgets passed in 2011 and 2013 included measures to update hospital reimbursements. The Jobs Budget of 2011 made way for a much-needed revision to the decades-old diagnosis-related group (DRG) reimbursement system. The SFY14-15 biennial budget looked to further reform hospital payments with provisions aimed at reducing hospital readmissions, improving direct medical education, and extending health care coverage to more low-income Ohioans.

UPDATE: Both the inpatient hospital diagnosis related grouper (DRG) and inpatient hospital prices were updated effective July 1, 2013. These particular modifications paved the way for the State of Ohio to continue with its pursuit of Medicaid modernization and statewide payment reform. The grouper and base rate changes were both budget neutral in order to comply with Am. Sub. H.B. 153.

In order to appropriately prepare for the extension of Medicaid coverage to newly eligible individuals, a five percent rate add-on for inpatient hospital services was eliminated and became effective for all dates of discharge on and after January 1, 2014. Hospital base rates for all non-children's hospitals and graduate medical education rates for all hospitals were reduced by five percent.

ODM was prevented by Section 323.103 of Am.Sub.H.B. 59 from eliminating the five percent rate add-on for outpatient hospital services.

All hospital inpatient capital rates – both fee-for-service and managed care – were reduced to 85 percent of prospective cost with no subsequent cost settlement. Additionally, modifications were made to control the cost of outpatient services effective for services provided on and after January 1, 2014.

Work has already commenced on a number of additional hospital reforms, including an effort to reduce hospital readmissions, implementation of the children's quality

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improvement program, a measure to improve direct medical education funding and the adjustment of DRG-exempt hospital rates.

4) Reform Nursing Facility Payments

Since 2011, the Kasich Administration has introduced a number of reforms aimed at improving reimbursement practices for nursing facilities and incentivizing quality care. The Administration's primary goal is to achieve better health, better care and reduce costs, and create incentives that foster continuous improvement in services.

UPDATE: In its provisions concerning nursing facility services, the Executive Budget made further progress in advancing Ohio Medicaid's focus on person-centered care and quality. Improved quality measures will be implemented for the fiscal year 2015 rate-setting. Providers also will soon have to achieve one clinical measure in order to receive the full quality incentive payment.

The Distinct Part Advisory Workgroup, created by the General Assembly, has already convened several times in fiscal year 14 and is preparing a report with recommendations related to the role of non-Medicaid distinct parts in the delivery system in the future.

5) Reform Other Provider Payments

The Executive Budget of 2013 (House Bill 59) featured a series of provider payment changes aimed to save Ohio taxpayer dollars over the SFY14-15 biennium. These policy proposals were in addition to other changes addressing health plans, hospitals, nursing facilities, and home and community based long-term care. Areas concerning payment loopholes, physician services, radiology, and E-prescribing were addressed.

UPDATE: The department has made changes in payment for professional services to bring pricing policies more in line with Medicare payment methodology and to achieve consistency across provider types. The following changes were implemented effective for dates of service on or after January 1, 2014:

1. Medicaid has extended the site differential to additional care settings where physicians, advanced practice nurses and physician assistants are not incurring the full practice expense. This includes services provided in hospitals, nursing facilities,

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ambulatory surgery centers, inpatient psychiatric facilities, and community mental health centers.

2. Medicaid has implemented a reduction in payments for multiple procedures performed by the same provider on the same date of service to the same beneficiary. Services now subject to this pricing change include skilled therapies and certain advanced imaging procedures.
3. Medicaid has implemented a change in Medicare Part B cost sharing for non-institutional providers to bring it in line with cost sharing for institutional Part A and Part B and Part C for all provider types.

6.) Fight Fraud and Abuse

Ohio Medicaid is committed to seeking out instances of provider fraud and abuse and ensuring that these individuals are held accountable for their actions. In order to ensure strong financial stewardship, the state has undertaken an aggressive effort to identify, recover, and prevent instances of overpayment and fraud. In its collaboration with the Office of the Ohio Attorney General and the Auditor of State's Office, Ohio Medicaid has placed program integrity at the forefront of its work.

UPDATE: Funding was included in the SFY14-15 budget to hire additional staff for purposes of on-site provider audits. Such audits would include unannounced “quick hit” audits and reviews of Medicaid providers in order to assess that certain providers possess adequate supporting documentation for all services rendered and billed to Ohio Medicaid. This work is still in the implementation phase and, at this time, no cost savings can be attributed to it. While “quick hit” audits through the Department’s Surveillance and Utilization Review Section (SURS) have yet to be initiated, SURS is aggressively requesting provider records through the mail to verify that support documentation exists for paid claims.

The Department has also moved forward in complying with the federal requirement of incorporating a Recovery Audit Contractor (RAC) in reviewing Medicaid provider claims. The charge of the RAC is to identify occurrences of underpayments and overpayments in billing. Based on the current contract, the RAC receives 10 percent of collections that it makes possible. Collections for the first half of FY14 total \$374,171 (all funds).

Ohio Medicaid began SFY14 with CGI Federal as its RAC contractor. However, as of July 2014, that contract has been terminated by mutual agreement with CGI Federal, following a request made to do so by CGI. The RAC contract will be re-procured.

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Ohio Medicaid currently holds a contract with Permedion to review the clinical necessity of inpatient and outpatient Medicaid claims. Approximately 1,500 retrospective reviews are performed each month. This total falls well within the Department's performance expectation. Collections for the first half of FY14 were \$17,432,923.31.