Office of Health Transformation
Reform Provider Payments

Governor Kasich's Budget:

- *Supports performance payments for comprehensive primary care*
- *Reduces hospital reimbursement 2.2 percent in 2018 and 5.7 percent in 2019*
- *Moves nursing facility reimbursement into managed care*
- *Adopts a single preferred drug list for the Medicaid pharmacy benefit*

Background:

When Governor Kasich took office in 2011, Ohio Medicaid largely paid for medical services through an outdated fee-for-service (FFS) program that paid high-quality providers the same as lower-quality providers, and rewarded the volume of services provided, not the value of those services. For example, Ohio was using prospective payment methods developed in the 1980s to pay for hospital services. This volume-based approach did nothing to reward quality or efficiency. Similarly, the then-high level of spending on nursing facilities limited Ohio's capacity to invest in home and community based services, amplifying an institutional bias in Medicaid's long-term services and supports delivery system.

Transformation Strategy:

As one of his first priorities, Governor Kasich directed Ohio Medicaid to modernize its outdated reimbursement policies. A cornerstone of the Administration's strategy has been to establish a definitive relationship between what a provider is paid and the effectiveness of the services provided. In some cases, the result has been rate reductions, but in others Ohio Medicaid increased reimbursement or redirected resources to services that provide greater value.

Governor Kasich's first budget (enacted in 2011) began the process of resetting payment rules to reward value instead of volume. A new hospital inpatient reimbursement system was installed in July 2013 based on All Patient Refined Diagnosis Related Groups (APR-DRGs). Ohio Medicaid built the system using a transparent and inclusive process, engaging hospitals, health plans and others over a period of 18 months to analyze data, develop policy, and assess fiscal impacts. The first budget also completed the transition from a cost-based Medicaid payment system for nursing facilities to a price-based system. It reduced nursing facility rates 5.8 percent in 2012 and saved Ohio taxpayers $360 million over two years.

Governor Kasich's second budget (enacted in 2013) reauthorized temporary assessment programs and supplemental payment programs for hospitals that would otherwise have expired, reduced taxpayer payments for hospital capital projects, and proposed to expand

Medicaid to cover very low-income adults, many of whom might otherwise be a source of uncompensated care for hospitals. Extending Medicaid coverage, which took effect in January 2014, resulted in Ohio's hospitals receiving a 24 percent increase in Medicaid payments in 2015. With regard to nursing facilities, the second budget focused on improving quality and establishing better oversight, while otherwise allowing the reimbursement reforms of the first budget to stabilize.

Governor Kasich's third budget (enacted in 2015) authorized a new hospital outpatient reimbursement system based on Enhanced Ambulatory Patient Groups. The new system is on track to be turned on in July 2017, along with an APR-DRG pricing update. For nursing facilities, the third budget proposed an increase in funding, primarily driven by rebasing the cost year on which rates are based from 2003 to 2013. It also updated the resource utilization group (RUGs) methodology used to measure resident acuity.

Executive Budget Proposal and Impact:

The Executive Budget continues to place a high priority on modernizing outdated FFS systems, and rejecting Medicaid spending increases that are not tied to quality improvement. It invests in primary care while reducing hospital, nursing facility, and pharmacy spending. ***Overall, these provisions reduce the state share of Medicaid spending $272 million over two years (Table 1).***

Table 1. Ohio Medicaid Executive Budget Impact: Reform Provider Payments

Executive Budget	SFY 2018		SFY 2019	
	All Funds	State GRF	All Funds	State GRF
Physician				
Increases reimbursement for comprehensive primary care	***$ 51,600,000***	***$ 13,575,273***	***$ 72,000,000***	***$ 19,134,848***
Hospital				
Eliminates ICD-10 coding inflation	$ (75,000,000)	$ (21,953,956)	$ (75,000,000)	$ (21,953,956)
Protects high-Medicaid hospitals from rate reductions	$ -	$ -	$ (175,000,000)	$ (54,250,000)
Defaults to FFS without a managed care contract	$ (87,500,000)	$ (27,125,000)	$ (175,000,000)	$ (54,250,000)
Subtotal	***$ (162,500,000)***	***$ (49,078,956)***	***$ (425,000,000)***	***$ (130,453,956)***
Nursing Facility				
Resets unintended payment gains	$ (88,125,000)	$ (32,901,469)	$ (117,500,000)	$ (43,868,625)
Increases and reforms payments for low acuity residents	$ (10,500,000)	$ (3,919,650)	$ (21,000,000)	$ (7,841,400)
Provides specialized services in nursing facilities	$ -	$ -	$ 21,631,968	$ 5,407,992
Subtotal	***$ (98,625,000)***	***$ (36,821,119)***	***$ (116,868,032)***	***$ (46,302,033)***
Pharmacy				
Adopts a single preferred drug list	***$ -***	***$ (13,900,000)***	***$ -***	***$ (27,800,000)***
TOTAL	**$ (209,525,000)**	**$ (86,224,802)**	**$ (469,868,032)**	**$ (185,421,141)**

PHYSICIAN

Ohio trains more physicians than it retains, in part because primary care reimbursement is low. Ohio ranks fifth among states in the number of public medical school enrollees per capita but 24th in terms of active primary care physicians per capita.[1] Only 44 percent of physicians who graduate from medical school in Ohio stay in Ohio. The Executive Budget provides $124 million over two years in performance-based incentive payments to reward and retain primary care doctors who do more to keep people well and hold down the total cost of care. The Budget:

- ***Reports performance on high-cost episodes of care.*** Across the U.S. there is growing consensus that changing the way we pay for health care is critical to improving health outcomes. The current volume-based FFS system rewards more care but not necessarily better care. In 2013, the Governor's Office of Health Transformation convened Ohio's largest health insurance plans – Anthem, Aetna, Medical Mutual, UnitedHealthcare, CareSource, Buckeye, Molina, and Paramount – to help design value-based models that reward better health outcomes. The plans, working with state officials and medical experts, designed a nation-leading episode-based payment model that reduces the incentive to overuse unnecessary services and financially rewards providers that achieve better health outcomes.

  Ohio Medicaid will use the episode-based payment model to increase reimbursement for low-cost, high-quality specialists and to recover payment from high-cost providers (the episode model is budget neutral for the state). Ohio Medicaid currently reports performance on 13 episodes and another 34 are on track to launch in 2017. The quality metrics in many of the episodes drive improvement on Ohio's greatest public health challenges, including maternal and infant health, mental health and addiction, and chronic disease (for more detail, see *Report Performance on High-Cost Episodes of Care*).

- ***Improves access to comprehensive primary care.*** In parallel to the development of an episode-based payment model, in 2015 OHT convened Ohio's largest health insurance plans – Anthem, Aetna, Medical Mutual, UnitedHealthcare, CareSource, Buckeye, Molina, and Paramount – to develop a value-based primary care payment model that financially rewards practices that hold down costs by preventing disease and managing chronic conditions. With the help of the plans and input from 800+ stakeholders, including nearly 600 clinicians and staff from primary care practices, OHT developed a comprehensive primary care (CPC) payment model to adopt across Medicaid and commercial insurance statewide.

  In January 2017, Ohio Medicaid enrolled the first group of 92 primary care practices into the CPC program. These practices earn an additional $4 per member per month on average by engaging in activities that are known to keep patients well. Many also have the opportunity to earn a performance bonus if they hold down the total cost of care

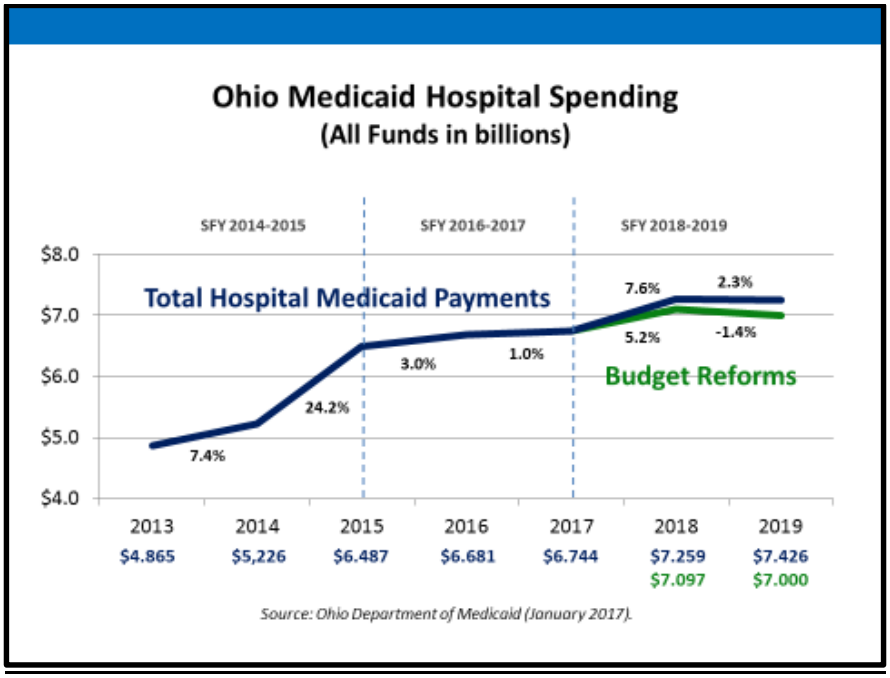
[1] Association of American Medical Colleges, 2011 State Physician Workforce Data Book (2011).

while meeting quality and efficiency targets. The CPC clinical quality metrics drive improvement on Ohio's greatest public health challenges, including maternal and infant health, mental health and addiction, and chronic disease (see *Improve Access to Comprehensive Primary Care*). The Budget includes $51 million in 2018 and $72 million in 2019 to support practices already enrolled in CPC and, beginning in January 2018, allows Ohio Medicaid to open enrollment to any primary care practice in Ohio that wants to earn more by meeting the CPC activity requirements and quality targets.

HOSPITAL

Ohio Medicaid spending on hospital services increased 37 percent from 2013 to 2016 because previously uninsured Ohioans gained coverage through the Medicaid expansion. Ohio Medicaid is projected to spend $7.3 billion on hospital services in 2018 and $7.4 billion in 2019. The Executive Budget reduces this amount by $163 million in 2018 (2.5 percent) and $425 million (5.7 percent) in 2019 (Figure 1 and Table 1). Even after the proposed reduction, total Medicaid spending on hospitals in 2019 will be over 40 percent higher than it was in 2013.

Figure 1.



- ***Eliminates ICD-10 coding inflation.*** The International Classification of Diseases (ICD) is a clinical cataloging system used by the health care industry and government agencies to properly note diseases on health records and assist in medical reimbursement decisions. The tenth edition (ICD-10) was adopted in October 2015 to account for modern advances in clinical treatment and to offer more classification options compared to the

ICD-9 version it replaced. As a result of the conversion, hospital spending increased, not related to an increase in the volume or quality of services provided, but as a result of how those services are coded. The Executive Budget adjusts Medicaid hospital reimbursement to eliminate ICD-10 coding inflation. This provision saves $75.0 million ($22.0 million state share) in 2018 and $75.0 million ($22.0 million state share) in 2019.

- ***Protects high-Medicaid hospitals from rate reductions.*** The Executive Budget requires Ohio Medicaid to establish criteria to identify high Medicaid volume hospitals. Once the new peer group is established, then the department will have the option to tier future Medicaid rate adjustments in a way that mitigates any disproportionate impact on hospitals that have a high volume of Medicaid business. This mechanism will be used to calibrate a one-time reduction in hospital reimbursement that will save taxpayers $175.0 million ($54.3 million state share) in 2019.

- ***Defaults hospital reimbursement to FFS without a managed care contract.*** Medicaid managed care plans on average pay hospitals 104 percent of the Medicaid FFS rate. The Budget requires Medicaid reimbursement to default to FFS rates for hospitals that do not to contract with a Medicaid managed care plan. This change will allow hospitals and health plans to compete based on the quality and availability of services instead of leveraging the requirement to meet access standards. This provision saves $87.5 million ($27.1 million state share) in 2018 and $175.0 million ($54.3 million state share) in 2019.

NURSING FACILITY

Ohio Medicaid spending on nursing facilities is projected to increase 7.7 percent in state fiscal year 2017. From that higher level, the Executive Budget proposes to reduce nursing facility spending $99 million (3.3 percent) in 2018 and $117 million (3.9 percent) in 2019. The Budget:

- ***Resets unintended payment gains resulting from a new payment methodology.*** As required in the last budget, in 2015 Ohio Medicaid updated the resource utilization groups (RUGS) methodology that is used to measure resident acuity and then calculate reimbursement. As a result of the transition to RUGS – not a change in enrollment or quality – actual nursing facility reimbursement exceeded the state's projections that were used when enacting 2015-2016 spending levels. The Executive Budget requires Ohio Medicaid to use RUGS IV but adjust reimbursement in line with the spending levels originally envisioned in the budget. This provision saves $88.1 million ($32.9 million state share) in 2018 and $117.5 million ($43.9 million state share) in 2019.

- ***Increases and reforms nursing facility payments for low-acuity residents.*** Low acuity individuals residing in nursing facilities have a significantly lower level-of-care need. In the last budget, the legislature recognized that meant nursing facilities should receive a lower reimbursement for those individuals. However, the legislative solution that resulted in a tiered payment has proven unworkable because it excluded low-acuity

individuals from the facility's quarterly casemix acuity score, which increased the facility's acuity score and reimbursement for all other residents. The Executive Budget allows for a higher rate to apply to all lower acuity individuals, but includes them in the calculation of quarterly casemix scores. This provision saves $10.5 million ($3.9 million state share) in 2018 and $21.0 million ($7.8 million state share) in 2019.

- ***Provides specialized services in nursing facilities.*** Federal law requires Medicaid programs to conduct a Preadmission Screening and Resident Review (PASRR) for every enrollee who applies for admission to a nursing facility to determine if the applicant has a serious and persistent mental illness (SPMI) and/or intellectual or developmental disabilities. A nursing facility is not allowed to admit an individual who has SPMI or an intellectual disability unless the state determines the services provided by the facility are appropriate, including specialized services if the applicant needs them.

  Recent federal guidance indicates Ohio's current definition of specialized services may not comply with federal PASRR requirements. The guidance also clarifies that federal funding is available for specialized services that are paid in addition to standard nursing facility services. Currently, Ohio does not draw federal funding for any PASRR specialized services and state administrative rules forbid individuals with SPMI to receive specialized services for their mental illness while they reside in a nursing facility. This contradicts other state policies in which Ohio permits individuals with developmental disabilities to receive specialized services while residing in a nursing facility.

  Beginning in July 2018, the Executive Budget requires Ohio Medicaid to allow individuals with SPMI or a developmental disability to receive specialized services in a nursing facility, and creates the infrastructure necessary for Ohio Medicaid to cover those services. This provision costs $21.6 million ($5.4 million state share) in 2019.

- ***Creates an opportunity to negotiate better rates through managed care.*** Nursing facilities are the only Medicaid provider group with reimbursement set in statute. As a result, the formula is hard to change and slow to adapt to industry best practice. The current formula, for example, makes no distinction between high-quality and low-quality providers. Every two years, nursing facilities expend significant political capital defending the formula, and the Administration and other stakeholders do the same arguing for reform. The Executive Budget eliminates this political wrangling by moving the entire Medicaid nursing facility benefit into managed care in state fiscal year 2019. As a result, high-quality facilities will be able to negotiate higher rates and low-quality facilities – without the protection of the statutory formula – will have to start competing with their peers based on quality, access, and other factors that matter to residents.

PHARMACY

Ohio Medicaid pharmacy costs are projected to increase 11.4 percent in 2017 and another 10.8 percent in 2018 to $3.9 billion. These rising costs are a challenge for both public and commercial coverage as manufacturer prices continue to rise and high-cost specialty drugs are being used more often for more patients. For Medicaid programs, the increases in drug costs are mitigated somewhat by the Medicaid Drug Rebate Program (MDRP), which rebates over 50 percent of drug expenditures back to the state. The Affordable Care Act expanded the MDRP to drugs purchased through Medicaid managed care plans so, in 2011, Ohio "carved in" the drug benefit as a tool for Medicaid health plans to better integrate the drug benefit and medical care for their members. However, rebate amounts are confidential so the health plans do not know the state's after-rebate cost for drugs and are not able to choose preferred drug lists (PDLs) that have the best net cost to the state. The Executive Budget:

- ***Adopts a single preferred drug list.*** The Executive Budget requires Medicaid FFS and managed care plans to use the same PDL and prior authorization policies beginning in state fiscal year 2018. The PDL is the primary tool used by Medicaid to encourage the use of high quality, low-cost drugs. In general, "preferred" drugs do not require prior authorization and "non-preferred" drugs require either a clinical justification by the prescriber or a trial of one or more preferred drugs. The PDL is reviewed by the Ohio Medicaid Pharmacy and Therapeutics Committee, a group of practicing physicians and pharmacists who review clinical data about drugs and recommend which drugs to prefer. Financial information is considered with the clinical recommendations to arrive at the PDL. Financial information includes the cost to pay the pharmacy and any rebates that may be obtained from the manufacturer, and the budget adds "cost effectiveness" as a criterion for consideration. The federal MDRP mandates a minimum rebate amount for all drugs, but then Ohio Medicaid contracts with individual manufacturers for "supplemental" rebates that further lower the net cost. A single PDL increases Medicaid's bargaining power with manufacturers to seek higher supplemental rebates. This provision is estimated to increase the amount of the rebates that Medicaid deposits into the state general revenue fund by $13.9 million in 2018 and $27.8 million in 2019.

  In addition to the financial benefit to the state, a single PDL ensures that Medicaid health plan members who choose to switch plans will be able to continue their medications without delay. It will also minimize plan switching that results when some members change plans because their drugs are no longer preferred on their current plan. Finally, it relieves administrative burden on prescribers because all Medicaid members will have the same list of preferred drugs, and the provider will not need to keep track of different drug coverage policies for each plan.

- ***Enhances drug rebate collections.*** In 2016, Ohio Medicaid engaged Change Healthcare to administer the MDRP for Ohio. Change Healthcare has a proven track record of collecting all eligible rebates and is expected to recover approximately $10 million annually in rebates the state has not previously invoiced to manufacturers. Ohio

Medicaid is implementing this program now, and the savings that are expected to result are included in the Medicaid baseline.

- ***Updates and increases pharmacy dispensing fees.*** Ohio Medicaid pays pharmacies for the drug cost plus a professional dispensing fee. The Executive Budget includes a new pricing methodology that will better estimate a pharmacy's actual acquisition cost for the drug, and enhances the professional dispensing fee to recognize the full cost of dispensing a prescription to an individual receiving Medicaid. By taking into account all costs related to dispensing, including personnel costs, computer systems, security, and other overhead expenses, Medicaid will increase the professional dispensing fee from the current $1.80 to a tiered fee ranging from $8.30 to $13.64. The tiers are based on the number of prescriptions filled by the pharmacy annually, and calibrated to ensure that small businesses and pharmacies serving rural populations are not adversely affected. The additional pharmacy fee will be offset by a reduction in drug payments for a net savings of $40 million over the biennium, which is already included in the baseline.

- ***Copies federal discount drug pricing.*** The federal Health Resources and Services Administration (HRSA) administers a drug pricing discount program (called 340B) that allows certain safety net providers to purchase drugs at a discount that is roughly equivalent to the Medicaid rate, after rebates. Because the manufacturer has already provided this discount, the drugs are not eligible for the Medicaid Drug Rebate Program. Rather than pay the Medicaid price without rebates, Ohio Medicaid will implement a policy to pay 340B providers at their 340B discounted rate. This policy will save about $40 million annually, with most of the savings coming from lower payments for drugs provided in hospital outpatient departments and clinics. Ohio Medicaid is implementing this provision now, and the savings are included in the Medicaid baseline.

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