

### Health Care: A Key Investment

Accessible, affordable health care is important for all Ohioans and helps us to learn, work and enjoy a quality life. The fiscal year 2010-2011 biennium Executive Budget includes strategies to increase access to health care services for individuals who may lack access today. This special analysis provides an overview of Governor Strickland’s policy priorities for Medicaid and other health care initiatives, including:

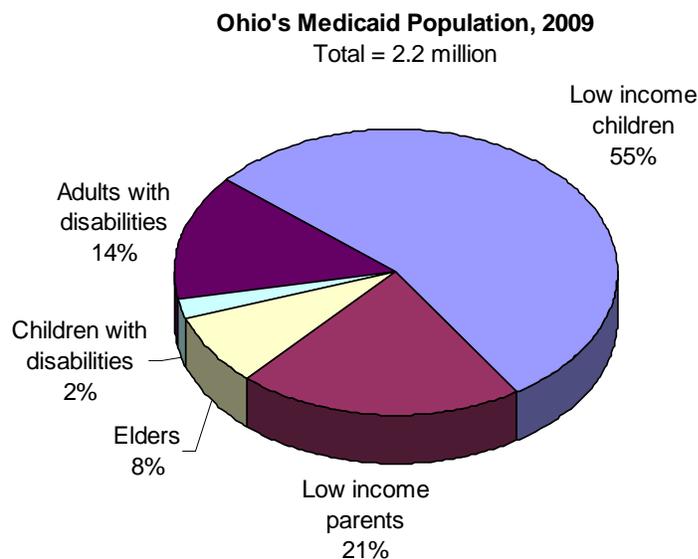
- Protecting eligibility and service levels within Ohio’s Medicaid program;
- Implementing a unified long term care budget to assure Ohioans have access to a broad range of choices in long term care settings in every community;
- Extending access to health care for approximately 110,000 uninsured Ohioans; and
- Creating efficiencies through enhanced coordination and the use of information technology.

### Protecting Eligibility & Services within Ohio’s Medicaid Program

The Medicaid program provides a broad array of medically necessary services including inpatient and outpatient hospital care, physician services, prescription medications, medical supplies and equipment, nursing, therapies and behavioral health care to vulnerable Ohioans. In fiscal year 2008, Medicaid paid for 40 percent of newborn births in Ohio and 65 percent of all nursing home care.

Ohio Medicaid provides health care and related services for two main eligibility groups: low income children and parents, and elders and people with disabilities. The first group, known as “Covered Families and Children,” has the largest participation, encompassing 1.2 million low-income children and 458,000 low-income parents. The second group, known as “Aged, Blind & Disabled,” includes approximately 51,000 children, 175,000 elders, and 310,000 non-elderly adults with disabilities.

**Figure D-11: Ohio’s Medicaid Population, 2009**

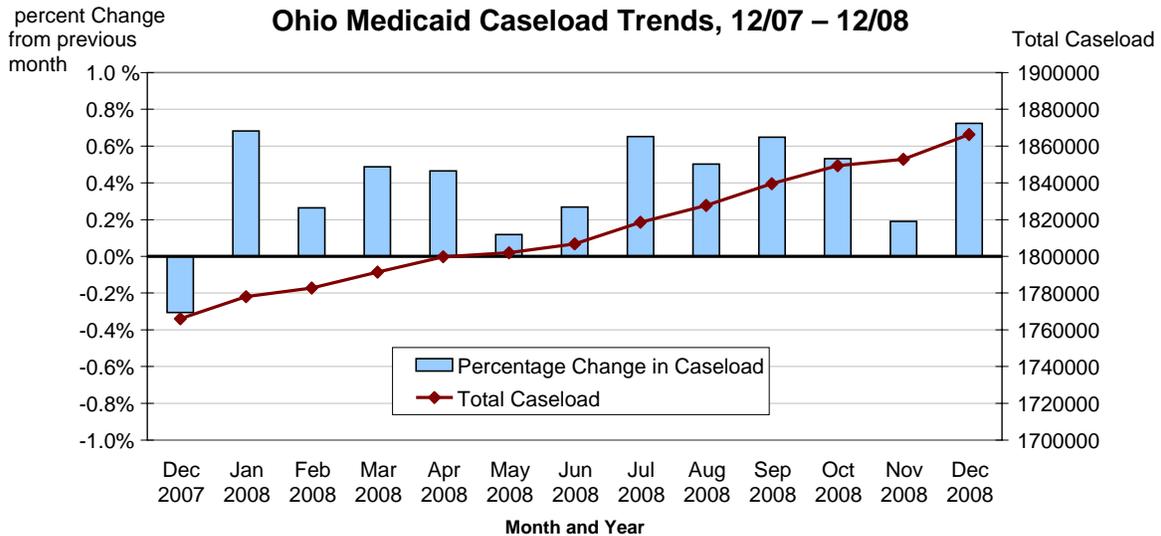


While individuals enrolled in the Aged, Blind & Disabled (ABD) program represent only 24 percent of the total Medicaid population, these individuals tend to have more costly health care needs and therefore account for a higher percentage of total Medicaid costs. In fiscal year 2008, the ABD population accounted for 67 percent of service costs while the Covered Families & Children population accounted for only 33 percent of costs.

Since December 2007, Ohio’s Medicaid caseload has grown by more than 110,505 enrollees (approximately 6 percent). A difficult economy and increased awareness of Medicaid from publicity about

recent expansions are likely contributors to the growth. The graph below illustrates that caseload change through December 2008.

**Figure D-12: Ohio Medicaid Caseload Trends, December 2007 through December 2008**



**Collaboration to Fund and Administer Medicaid Services**

As Ohio’s Single State Medicaid Agency, the Ohio Department of Job and Family Services (ODJFS) is responsible for managing the vast majority of the state’s Medicaid budget. This includes paying for Medicaid managed care premiums and most services available via a traditional Medicaid card. Additional responsibilities include managing the state’s Medicaid relationship with the federal government, adjudicating Medicaid claims, and drawing down all Medicaid matching funds from the federal government. ODJFS delegates certain responsibilities of the Ohio Medicaid program to sister state agencies as outlined below.

- The Department of Mental Retardation and Developmental Disabilities (ODMR/DD) provides both institutional and community based Medicaid services. ODMR/DD operates ten developmental centers which provide institutional services to approximately 1,475 citizens. In partnership with county boards of MR/DD, the department manages two Medicaid waivers which serve approximately 18,000 individuals. These programs enable people with developmental disabilities to live in a community setting instead of an institution. In fiscal year 2008, ODMR/DD’s total Medicaid expenditures were approximately \$1.1 billion.
- The Department of Mental Health, in partnership with county Alcohol, Drug Addiction and Mental Health boards, provides community mental health services to approximately 200,000 Medicaid consumers. These services include counseling, psychotherapy, diagnostic assessments and crisis intervention. The department’s Medicaid expenditures in fiscal year 2008 were approximately \$450 million.
- The Department of Alcohol and Drug Addiction Services and its local boards provide community addiction and treatment services to more than 34,000 Medicaid consumers. The department’s fiscal year 2008 Medicaid expenditures were approximately \$70 million.

- The Department of Aging manages three Medicaid waiver programs, including PASSPORT, Choices, and the Assisted Living waiver. PASSPORT provides care to elders in their own homes. Choices is a geographically limited subset of PASSPORT which allows Medicaid consumers to self direct their care, including choosing their own caregivers. The Assisted Living waiver provides Medicaid funding for care in assisted living settings. The Department of Aging maintains contractual relationships with Area Agencies on Aging to manage various aspects of the PASSPORT and Choices programs, serving more than 27,800 consumers in state fiscal year 2008. In this same period, more than 600 consumers participated in the Assisted Living program. The department's fiscal year 2008 expenditures for Medicaid services were approximately \$397.1 million.

In December 2007 Governor Strickland created a new coordinating entity, known as the Executive Medicaid Management Administration (EMMA). The EMMA Council includes an executive director, the cabinet directors of ODJFS and the Medicaid sister agencies, OBM, and the state Medicaid director. The council evaluates opportunities for increased efficiency and assists in the establishment of statewide priorities and work plans for Medicaid-related initiatives.

### **Federal Economic Stimulus**

The Executive Budget includes an enhanced Federal reimbursement rate for the Medicaid program, known as FMAP, based on information in the pending economic stimulus bill, the American Recovery and Reinvestment Plan of 2009. This enhancement is allocated in two parts:

- A general 4.9 percent increase in the federal reimbursement rate to all states, which begins October 1, 2008 and continues through December 31, 2010; and
- A reduction to the state share of Medicaid expenses based upon each state's unemployment experience. The bill provides a reduction to the state share of Medicaid expenses across three tiers depending on growth in unemployment. The reduction factor is based on the state's current average level of growth in unemployment for a consecutive three month period compared to its lowest rate of growth in a consecutive three month period since January 1, 2006. The Executive Budget assumes that the unemployment reduction factor will be effective between January 1, 2009 and June 30, 2010.

In order to be eligible for the enhancement, states cannot employ more restrictive eligibility standards, methodologies or procedures than those that were in effect on July 1, 2008, although eligibility expansions are permitted. Further, states are not allowed to deposit any funds into any reserve or rainy day fund that is attributable, directly or indirectly, to the FMAP increase. Finally, states may not increase the amount of state share payments required from any political subdivision than what was required as of September 30, 2008.

The availability of enhanced FMAP during the fiscal year 2010-2011 biennium will impact the general revenue fund (GRF) in two ways. First, it will draw additional federal revenue into the GRF for every state GRF dollar that is spent by ODJFS (effectively increasing the state's buying power). Secondly, the fact that non-GRF Medicaid funds will be drawing enhanced FMAP rates will enable Ohio to defray a greater portion of estimated Medicaid expenditures to these funds, thereby helping to compress the overall need for GRF to support Medicaid. This, in turn, helps the state to balance the overall GRF fund balance.

### **Fiscal Year 2010-2011 Biennium Medicaid Expenditures**

As noted earlier, the nation's current economic challenges have impacted Medicaid caseload and the overall need for this critical safety net service. The Executive Budget protects funding for Medicaid so that eligibility and services can continue at or near existing levels. Highlights include:

- Fully funded PASSPORT program, which will avoid waiting lists in fiscal years 2010 and 2011;
- Access to health care for children (0 to 300 percent of federal poverty level); and
- Continued Individual Options waiver services established during fiscal years 2008 and 2009 pursuant to the *Martin* settlement agreement.

**ODJFS Expenditures:** The ODJFS-administered portion of the Medicaid program represents approximately 85 percent of all Medicaid spending. When taking into account all funding sources necessary to support this spending, fiscal years 2010 and 2011 Executive Budget recommendations are as follows:

**Figure D-13: Fiscal Years 2010 and 2011 Executive Budget Recommendations**

Fund Type	Fiscal Year 2009	Fiscal Year 2010	Fiscal Year 2011
General Revenue Fund (GRF) <sup>1</sup>	\$9,877,719,907 <sup>2</sup>	\$8,775,641,219	\$10,902,582,112
Other (non-GRF) funds	\$1,986,131,735	\$3,821,227,972	\$2,984,736,483
Total	\$11,863,851,642	\$12,596,869,191	\$13,887,318,595

GRF appropriations for fiscal years 2010 and 2011 include the use of enhanced federal reimbursement that will be deposited to the GRF as reimbursement for ODJFS Medicaid expenditures pursuant to the forthcoming stimulus bill. In fiscal year 2010 the enhanced reimbursement estimated for deposit to the GRF is \$135.0 million and in fiscal year 2011 the amount is \$148.7 million.

As the table above indicates, despite the use of these additional enhanced resources there is a notable decrease in GRF funding from fiscal year 2009 to fiscal year 2010. In fiscal year 2010, the Executive Budget recommends funding a greater portion of Medicaid expenses through the use of non-GRF Medicaid funds, including:

- Use of enhanced federal reimbursement amounts that will be drawn into non-GRF funds as a result of the federal stimulus (\$336.4 million); and
- Increased resources that will be collected from various provider franchise fees (\$408.7 million in state collections).

In fiscal year 2011, ODJFS Medicaid funding returns to its historical reliance on the GRF and at the same time uses fewer non-GRF resources than were used in fiscal year 2010:

- Use of enhanced federal reimbursement amounts that will be drawn into non-GRF funds as a result of the federal stimulus (\$93.3 million); and
- Increased resources that will be collected from various provider franchise fees (\$483.4 in state collections).

**MR/DD Expenditures:** The payment of Medicaid claims in the Mental Retardation/Developmental Disabilities (MR/DD) system is a shared state and local responsibility, with the state providing 56 percent of the funding for Medicaid eligible services, which includes the Level One and Individual Options waivers, targeted case management, and the developmental centers. The Department of Mental Retardation and Developmental Disabilities' projected Medicaid spending in fiscal year 2009 is \$241.5 million. Fiscal year 2010 GRF spending for Medicaid services is \$202.1 million, a 16 percent decrease from fiscal year 2009. In fiscal year 2011, GRF Medicaid spending is projected to increase by 20 percent to \$242.4 million. Reductions in GRF spending for Medicaid are offset by projected increases in federal Medicaid match as established in the federal stimulus bill proposal. The state earned share of enhanced federal reimbursement is estimated at \$54.1 million in fiscal year 2010 and \$13.1 million in fiscal year 2011.

The county boards of MR/DD earned share of enhanced federal reimbursement is an estimated \$54.9 million in fiscal year 2010 and \$12.6 million in fiscal year 2011. Under the federal stimulus provisions, the state must distribute the non-federal share savings back to the local entity that provided the non-federal share.

<sup>1</sup> Medicare Part D expenditures are not included.

<sup>2</sup> Fiscal year 2009 assumes GRF appropriation increases from the Medicaid Reserve Fund (HB 119) and the Budget Stabilization Fund transfer (HB 562).

**Aging Expenditures:** The Department of Aging receives Medicaid reimbursement for long term care services under the PASSPORT and Assisted Living waivers, and the Program of All-Inclusive Care for the Elderly (PACE) program. GRF costs for services only in fiscal year 2010 are estimated at \$110.3 million, which generates an enhanced FMAP reimbursement of \$28.4 million. Total spending for the long term care program is projected to total \$500.8 million in fiscal year 2010, which includes GRF spending for services and administration, enhanced FMAP reimbursement, and federal/other funding of \$339.4 million. These levels will provide no wait lists for PASSPORT consumers and provide services to approximately 30,200 consumers. This will also fund the PACE program for 880 people and the Assisted Living waiver for 1,800 consumers. Total GRF spending in fiscal year 2011 increases to \$160.6 million as the FMAP reimbursement rate is not as high in fiscal year 2011; therefore the GRF funding will increase. Enhanced FMAP totals \$7.4 million; federal and other sources total \$359.2 million for a total long term care program cost of \$527.2 million. This level will again provide no wait lists on PASSPORT and services for 31,900 consumers, and the same levels for PACE and Assisted Living. In addition, the long term care program is projecting to receive \$27.5 in enhanced FMAP reimbursement.

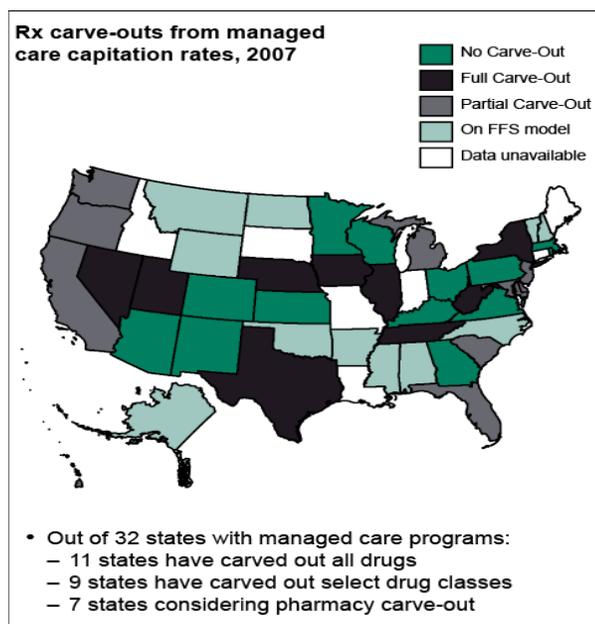
**Behavioral Health Expenditures:** In the behavioral health system, the Department of Alcohol and Drug Addiction Services and the Department of Mental Health disburse state dollars to Alcohol and Drug Addiction Services (ADAS), Alcohol, Drug Addiction, and Mental Health Services (ADAMHS), and County Mental Health (CMH) boards that then use these subsidy dollars and other local non-federal public funds, such as levy dollars to pay Medicaid claims and provide other non-Medicaid, services. The estimated non-federal share of mental health Medicaid costs is \$179.1 million in fiscal years 2010 and 2011. The estimated non-federal share of Medicaid costs for drug and alcohol addiction services is \$31.5 million in fiscal year 2010 and \$32.1 million in fiscal year 2011. For mental health Medicaid expenditures, ADAMHS/CMH boards are projected to receive enhanced federal reimbursement of \$18.0 million in fiscal year 2010 and \$4.4 million in fiscal year 2011. For alcohol and other drug addiction services Medicaid expenditures, ADAMHS/ADAS boards are estimated to receive enhanced federal reimbursement of \$3.2 million in fiscal year 2010 and \$0.8 million in fiscal year 2011. Under the ARRP, the state must distribute the non-federal share savings back to the locals.

### **Medicaid Managed Care Changes**

In fiscal year 2009, spending on Medicaid managed care represents approximately 39 percent of all ODJFS Medicaid expenditures. As of December 2008, more than 1.28 million people are enrolled in a Medicaid managed care plan. To effectively manage Medicaid within the current managed care program within Ohio Medicaid, it will be necessary to leverage some resources within the program differently.

- ***Carve out the pharmacy program from Medicaid managed care in order to maximize drug rebates.*** Like other states, Ohio is able to benefit from significant pharmacy rebate arrangements that are available only to state Medicaid programs. The managed care plans are not able to take advantage of this rebate structure and thus have not been as successful in recouping dollars for re-investment. In order to maximize efficiencies through volume purchasing, the Executive Budget “carves out” the pharmacy benefit from managed care and returns its administration to ODJFS. This is expected to generate \$5.2 million (all funds) in savings and cost avoidance in fiscal year 2010 and \$235.5 million (all funds) in fiscal year 2011. This proposal is subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). The graph below illustrates the status of managed care pharmacy programs across the country:

Figure D-14: Managed Care Pharmacy Programs Nationwide



Source: NASMD data /Ohio Business Roundtable Analysis

- **Pay Medicaid managed care plans on a retrospective, rather than prospective, basis.** With the exception of Medicaid managed care, all other Ohio Medicaid providers are paid after services are rendered. The Executive Budget aligns the payment timeframes for managed care plans with these other providers. This is expected to result in a one-time cost avoidance of \$270.4 million (all funds).
- **Modify Medicaid managed care tax participation to address forthcoming revenue loss.** Ohio currently generates annual revenue of \$520 million (all funds) through a franchise tax of 5.5 percent charged to Medicaid managed care corporations that are licensed to do business in Ohio. Recent changes in federal law will discontinue Ohio's Medicaid managed care franchise tax program effective October 1, 2009, resulting in the loss of this revenue. The Executive Budget removes the Medicaid managed care exemption to the existing health insuring corporation tax, thereby including the Medicaid plans in this structure. The rate structure for the plans will be modified to recognize their new responsibility to pay this tax; thus creating an effective "hold harmless" for the plans while leveraging federal reimbursement to support the overall Medicaid program. Additionally, Ohio's Medicaid managed care plans have proposed to be added to another part of the existing state tax structure via the state sales and use tax. The sales and use tax is levied at the same percentage as the current Medicaid managed care franchise fee and does not represent a tax increase; furthermore, the plans' participation in this tax will be recognized in their Medicaid reimbursement rate.

#### Nursing Facility Reimbursement Changes

As noted earlier, Ohio's Medicaid program funds approximately 65 percent of all nursing facility care in the state. It is second only to managed care in total expenditures for the state Medicaid program. The Executive Budget for fiscal years 2010 and 2011 includes two reimbursement changes related to nursing facilities.

- **Pay nursing facilities for Medicaid services based on a standard price rather than on the reported costs of individual facilities.** This action will complete the implementation of a strategy that was established in H.B. 66, the fiscal year 2006-2007 operating budget. A phase-in period of approximately four years was anticipated in H.B. 66 so facilities would have sufficient time to modify their business models to prepare for the eventual full implementation of the price-based model. The full

implementation of the price-based approach is expected to save \$55.9 million (all funds) in fiscal year 2010 and \$56.3 million (all funds) in fiscal year 2011 from continuing current policy.

- ***Modify the nursing facility franchise fee from \$6.25 per bed per day to \$11 in order to maximize federal reimbursement for nursing facility services.*** Medicaid rates for nursing facilities will be increased to recognize the collection of this increased fee, which is expected to generate approximately \$122.2 million state share in fiscal year 2010 and \$162.9 million state share in fiscal year 2011.

### **Hospital Reimbursement Changes**

An annual hospital assessment is instituted of 1.27 percent of total facility costs for fiscal year 2010 and 1.37 percent of total facility costs for fiscal year 2011 and every assessment program year thereafter. The additional fee will be collected over the course of three payments during each state fiscal year and used to support the Medicaid Program. A five percent rate increase for inpatient and outpatient hospitals is planned in the Executive Budget effective January, 2010. This fee is expected to generate \$282.8 million dollars in fiscal year 2010 and \$315.6 million dollars in fiscal year 2011. This fee is separate from the established assessment fee currently used to support the state's Disproportionate Share Hospital program. This program is unaffected by this change.

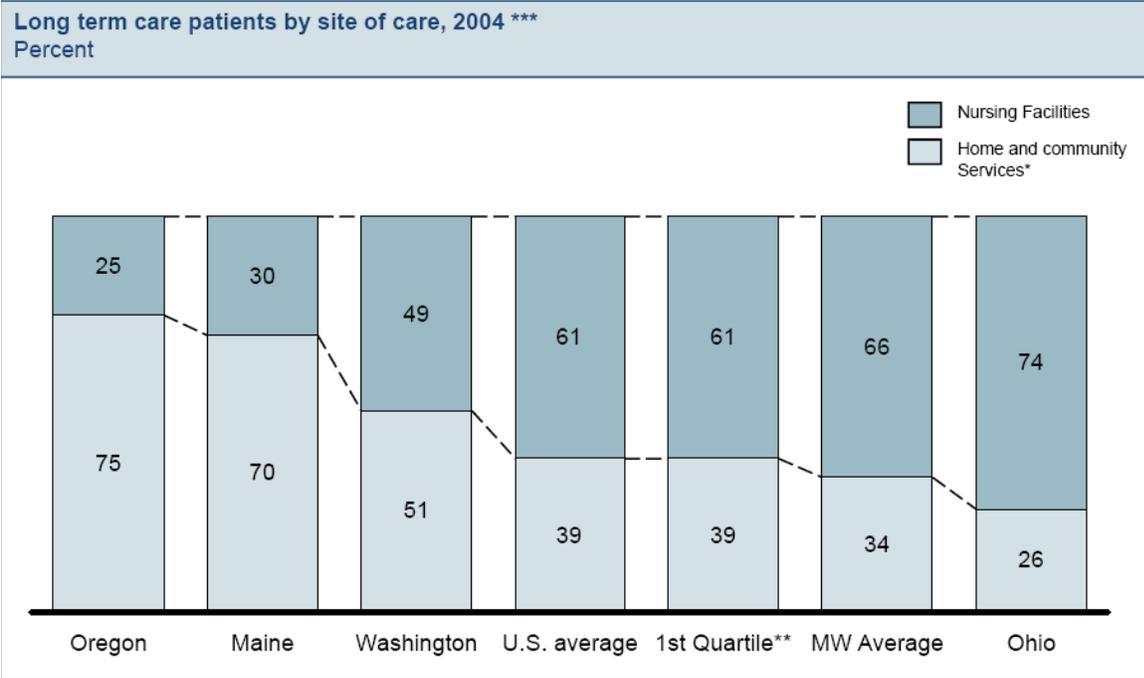
### **Implementing a Unified Long -Term Care Budget: Balanced Services and Supports**

Approximately two million Ohioans are age 60 or older; as a group, they account for more than 17 percent of the state's population. Beginning in 2006, about 12,000 baby boomers turn 60 each month. One of the many challenges Ohio faces is how best to provide needed long-term care services and supports to this growing population segment who, research has shown, will not only need these services, but will demand they be provided differently than in the traditional models of institutional care.

- According to the Scripps Gerontology Center at Miami University, the number of Ohioans of all ages who will need long-term services and supports will increase by 14 percent (43,600 consumers) between now and 2020. Prevalence of disability increases with age; currently one in three people over the age of 60 have at least one disability.
- The 85-plus age group is the fastest growing in the state, and approximately half of them have a long-term disability. According to the 2000 Census projections, nearly 217,000 Ohioans are in this group.

Much discussion has occurred in Ohio in the last few years regarding the need to "rebalance" the state's publicly funded long term care system. Consumers would like to see more community-based options that enable elders and people with disabilities the opportunity to live in a setting of their choice. When compared to other states, Ohio has offered more institutional options than community options in the long term care arena.

**Figure D-15: Long Term Care Patients by Site of Care, 2004**



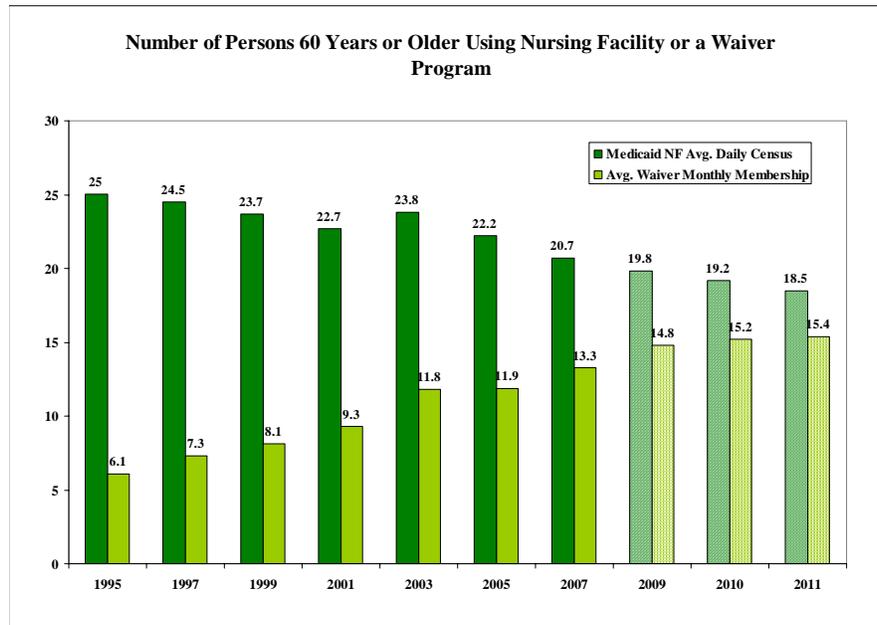
Source: AART data, Ohio Business Roundtable Analysis

In H.B. 119, the fiscal years 2008-2009 operating budget, the Legislature charged the director of the Department of Aging to lead an inclusive workgroup, which consisted of members of the legislature, state agencies, and members of the stakeholder community, to develop a Unified Long Term Care Budget (ULTCB). On May 30, 2008, after ten months of work, the group presented its recommendations to the Governor and the General Assembly. As the workgroup’s mission stated, the recommendations would “create a budget for long-term care services and supports that unifies the budgeting process for facility-based and home-based services and that supports Ohio’s ability to accurately forecast expenditures for these services in future years.” Many of the recommendations require significant changes in technology, the implementation of the new Medicaid Information Technology System (MITS), as well as additional funding. Nonetheless, the framework has been designed and planning continues to implement the recommendations in four phases.

The fiscal year 2010-2011 Executive Budget includes the implementation of phase one of the unified long term care budget, which focuses on Ohioans who become eligible for Medicaid-funded long-term care services and supports because they need nursing facility equivalent care. This phase includes both nursing facility services and home and community based “waiver” services administered by the Departments of Aging (PASSPORT, Assisted Living, and Choices) and Job and Family Services (Ohio Home Care Waiver) that provide alternatives to nursing facility care.

In fiscal year 2008, nursing facilities served more than 54,700 consumers at a cost of \$2,543.5 million. During the same year, home and community based Medicaid waivers managed by the Department of Aging served more than 27,800 people at a cost of \$397.1 million. The graph below illustrates the utilization trends for these two types of services in recent years by people aged 60 and older.

**Figure D-16: Number of Persons 60 Years or Older Using Nursing Facility or Waiver Program**



\*number of persons = per 1,000 persons age 60 or older in Ohio

The demand for community based services is expected to increase in the future as many elders choose to age in place rather than move to an institutional setting. In fiscal years 2010 and 2011, the Department of Aging projects to divert an additional 2,245 people from nursing facilities to home and community based services using a “no wrong door” model to facilitate consumer access to services, community collaboration, and follow up assessments for those entering nursing facilities for short rehabilitation stays.

The Executive Budget supports Ohioans who seek community-based care through the following strategies:

- Funding PASSPORT enrollment without a waiting list in each year of the biennium;
- Continuing Ohio’s Home Choice program, which is funded by the federal Money Follows the Person grant. Home Choice facilitates the return home for those Ohioans who have been living in an institutional setting for at least six months, would like to return to the community and could be healthy and safe in that environment;
- In fiscal years 2010 and 2011, GRF line items for PASSPORT, Assisted Living, and PACE are combined in the Department of Aging;
- Proposing enhanced regional collaboration, facilitated by Ohio’s Area Agencies on Aging, to improve consumer linkage to eligibility and services as well as the creation of a public portal for information on long-term services and supports that can be accessible by consumers;
- Ensuring nursing facility residents are supplied information and assistance needed to relocate to community settings to receive long-term care services and supports through a follow-up assessment process;
- Permitting the Director of Health to periodically assess the need for long-term care facility beds, and allows for the transfer of nursing facility beds between counties as needed (up to 10 percent);

- Providing for a continuation of the ULTCB workgroup; and
- Expanding the Ohio Long-term Care Consumer Guide to include information about providers beyond nursing facilities and assisted living facilities.

**State Coverage and Quality Initiative – Access to Affordable Health Care**

While Medicaid provides accessible health care to more than two million Ohioans based on income or disability, many others do not qualify for the program and thus continue to lack access to affordable health coverage. To address this problem, Ohio participated in the Robert Wood Johnson Foundation’s State Coverage Initiative (SCI). As part of SCI, the Governor appointed a bipartisan team, which worked closely with a broad-based coalition of stakeholders, to develop strategies to expand coverage to more Ohioans and make coverage more affordable. After a year-long process of uncovering the facts, analyzing the coverage system, and modeling proposed reforms, the SCI team reached consensus on a set of recommendations contained in a report to the Governor dated July, 2008.

The SCI team’s recommendations are a comprehensive approach to covering Ohio’s uninsured residents. Many of the recommendations require a level of funding that is not available in this budgetary environment; nonetheless, a number of the recommendations can be implemented now and begin to cover more Ohioans in these challenging economic times.

Ohio is also participating in the Commonwealth Fund’s State Quality Improvement Institute, working to implement a comprehensive set of strategies to transform Ohio’s health care system into a high quality, cost-effective, high performing system. More than 240 stakeholders have been involved in developing the Ohio Health Quality Improvement Plan which will be finalized during spring 2009.

The Executive Budget begins to implement the SCI recommendations with policy changes that will enable coverage for an estimated 110,000 additional Ohioans over time, and provides funding to assist in the implementation of the Ohio Health Quality Improvement Plan, at a total cost of \$10 million in fiscal year 2010 and \$16 million in fiscal year 2011 in general revenue funds.

As related to health coverage and quality initiatives, the Executive Budget contains the following provisions:

***Health Care Coverage and Quality Council:*** The Executive Budget creates the Health Care Coverage and Quality Council, which is a quasi-public private entity to implement coverage expansion programs and an advisory committee to continue to meet to work on health system reform. The Council will have a broad-based membership representing all parts of the health care system. The Council has specific responsibilities and is funded by the Department of Insurance budget at a cost of \$479,575 per year.

***Transparency and Reporting Requirements for Health Insurance Rates and Loss Ratios:*** The SCI report recommended measures to increase administrative efficiencies to ensure that premiums paid by consumers pay for medical expenses to the greatest extent possible. The first step in implementing this recommendation is to gather the right information. Currently, insurers only report aggregate information which is not specific enough to determine whether additional regulation is advisable. The Executive Budget requires insurers to report loss ratio information to the Department of Insurance for their individual market and small group business.

***Uninsured Ohioans with Health Conditions Should Have Affordable Coverage Available Through Ohio’s Open Enrollment Programs:*** Currently, people who are not eligible for employer-sponsored coverage or public programs must buy coverage in the individual market. People who are older and/or have health conditions can be denied coverage, issued policies with riders that exclude coverage for existing ailments, or issued coverage at extremely high premium rates. This means that older and less healthy people are in effect locked out of the individual market under current conditions and have nowhere else to go.

To address this issue, the SCI report recommended several reforms to transform the individual health insurance market. As some of these recommendations have significant budgetary implications both for the state and consumers, which are not appropriate in these economic times. Nonetheless, because “the problems with the individual market cannot be ignored,” reforms are needed to make coverage affordable for people in poor health. Ohio’s open enrollment program is intended to serve people who cannot find affordable coverage due to health conditions. Ohio’s open enrollment programs as currently constructed do not work because premiums are unaffordable for almost everyone.

The Executive Budget includes a statutory change to reduce premium rates for all open enrollment coverage to one and one-half times the lowest premium rate for new or existing business for the same or similar coverage for individuals with the same or similar case characteristics. Insurance carriers will be required to accept open enrollment applicants up to an amount equal to 4.5 percent of the insurer’s individual market business. Pre-existing conditions will be reduced by creditable coverage for all open enrollment coverage.

Based on actuarial modeling of these reforms, 52,000 more Ohioans will gain individual health coverage, and rates for open enrollment coverage will be reduced significantly. Individual market rates overall will rise on average by 5 percent. There is no fiscal impact to the state.

***Require Group Policies to Offer Coverage to Dependents Up to Age 29 and Extend the State Tax Deduction for Employer Coverage to Higher Age Children and Other Dependents:*** In Ohio, approximately 371,000 Ohioans between the age of 19 and 29 do not have coverage. The SCI report noted that a simple, cost effective way to get young adults access to health care is to add them to their parent’s health insurance policy even in cases where the young adult is beyond the traditional age of dependency for insurance purposes. The Executive Budget implements this recommendation by requiring group policies to offer coverage to dependent children up to age 29.

The Executive Budget will concurrently make employer coverage more affordable for many Ohioans by extending the state tax deduction to employer coverage of older adult children (ages 19-29) and other dependents. Together, these two reforms will provide coverage to 21,650 uninsured Ohioans with an estimated loss of state tax revenue of \$6.0 million in fiscal year 2011.

***Extend State Continuation Coverage to 12 Months and Apply it to Any Job Loss:*** Under Federal law, employers with less than 20 employees are not required to offer COBRA coverage. The only option for these workers is state continuation coverage. The Executive Budget extends continuation coverage from 6 to 12 months, and such coverage should be available to all employees losing their job, not just those eligible for unemployment compensation.

***Require Employers to Give Workers an Opportunity to Buy Health Insurance with Pre-Tax Dollars Through Section 125 Cafeteria Plans:*** An estimated 303,000 uninsured Ohioans are employed by companies that do not offer health insurance, or are not eligible for coverage that is offered. Providing these workers with the chance to buy coverage through a Section 125 (cafeteria) plan will allow them to use pre-tax dollars to pay their premiums. For workers at moderate income levels, this is a savings of 21 to 34 percent off the cost of coverage. For higher income workers, the savings can exceed 40 percent.

The Executive Budget requires employers to adopt Section 125 plans to allow employees to buy health coverage using pre-tax dollars. This requirement is phased in over time to allow employers, and small employers in particular, sufficient time to adopt such plans. The Ohio Health Care Cost and Quality Council will also make recommendations and take steps to help employers to understand and implement the law.

It is estimated that 37,000 more Ohioans will become insured as a result of this reform once fully implemented. There will be no fiscal impact in this biennium due to the phased implementation schedule.

***Improve Regulatory Oversight of Provider Networks and Allow the Superintendent of Insurance to Order Independent Reviews of a Health Claim Denials:*** Under current law, regulatory oversight of health insuring corporation provider networks is divided between two state agencies: the Department of Insurance and the Department of Health. To improve efficiency and coordinate regulatory functions, the Executive Budget will consolidate all authority over provider networks to the Department of Insurance. The Executive Budget will also give the superintendent of insurance authority to order an insurer to initiate an independent review of health care claim denials without the consumer having to take any action.

***Study Health Coverage Financing:*** In order to continue to implement the SCI recommendations, further study is needed to explore how health coverage programs can and should be financed going forward. This study will analyze Ohio's current health care system and financing strategies that can support and sustain affordable coverage expansion programs, improve the efficiency of the health care system, and avoid negative impacts.

***Implementation of the Ohio Health Quality Improvement Plan:*** The Executive Budget provides funding to assist with the implementation of strategies and tactics reflected in the Ohio Health Quality Improvement Plan, which will be finalized during the spring of 2009. These strategies and tactics will specifically focus on the areas of improving chronic care management, promoting health and reducing disease and injury, improving patient safety, and improving efficiency and decreasing cost in the healthcare system. More than 240 public and private stakeholders are involved in the creation of this plan.

***Ohio Health Information Exchange Center:*** The Executive Budget provides funding to advance the implementation of health information technology, which is a key element of progress toward health care efficiency and reform. Federal recovery dollars provide an opportunity to leverage state dollars and draw down federal match. For example, an investment of \$5 million for health information technology may draw down more than \$50 million federal dollars. Parts of this goal will be accomplished through continued support of the Ohio Health Information Exchange Center, which is a collection of services and data that bring together the necessary information to create a comprehensive view of the individual patient, thereby improving the overall delivery of healthcare and lowering costs.

## **Create Efficiencies through Enhanced Collaboration & Information Technology**

### **Increased Third Party Liability (TPL) for Health Care**

Approximately twenty percent of Ohio Medicaid enrollees have health care coverage from some other insurance carrier, including Medicare. Medicaid programs are required by Federal law to be the "payer of last resort" for health care services. If another insurer or program has the responsibility to pay for medical costs incurred by a Medicaid-eligible individual, that entity is generally required to pay all or part of the cost of the claim prior to Medicaid making any payment. This is known as "third party liability" or TPL. Examples of third parties liable for health care services include commercial health insurance, Medicare, employer-sponsored health insurance, auto insurance, settlements from a liability insurer, workers' compensation, long-term care insurance, and other State and Federal programs.

The Ohio Medicaid program has implemented an extensive TPL program to assure that Medicaid is only paying for services that are not covered by another insurer. Successful TPL functions rely on several strategies:

- Avoiding costs up front before Medicaid pays, also known as up front "cost avoidance;"
- Collecting payments that have been made in error (also known as "pay and chase"); and
- Capturing and updating insurance coverage information for all Medicaid enrollees. The Federal Deficit Reduction Act of 2005 strengthened the authority of states to obtain commercial insurance coverage files for cross reference with Medicaid enrollment information. Ohio has made great strides in collecting insurance coverage files from commercial insurers, improving up front cost avoidance for Ohio Medicaid.

### **Increasing Automation and Use of Technology**

Medicaid Information Technology System (MITS) offers opportunities for automation and paper reduction. Many Medicaid service providers have already moved to submitting their Medicaid claims in an electronic format via electronic data interchange (EDI). But despite the recent growth in the use of EDI transactions, many aspects of the Ohio Medicaid program still rely on paper being sent back and forth between the state and Medicaid providers and consumers. A large part of the rationale for developing the Medicaid Information Technology System (MITS) was to reduce or eliminate manual and other paper intensive processes. Consequently, many MITS business requirements focus on these goals.

Some previously paper processes have already been converted to electronic means including using the existing Ohio Medicaid web portal to directly enter and submit claims and check Medicaid eligibility for Medicaid consumers. In addition, since July 2007, providers have been able to access Medicaid Remittance Advice online through the Ohio Medicaid web portal at the following internet address: <https://medicaidremit.ohio.gov/default/home.jsf>.

However, once fully implemented, MITS will offer additional opportunities for the Medicaid program to reduce, or in some instances, completely eliminate paper processes. Although MITS will not completely eliminate paper transactions, it will offer many opportunities to move to electronic alternatives. Following are just a few of the opportunities for paper reduction that are available currently or will be expanded or newly available with the implementation of MITS.

- **Provider Claims Submission:** Using the current Medicaid web portal (see address above) Medicaid providers using professional claims (on form HCFA 1500) can submit them via direct data entry. Once implemented, MITS will expand this capability to include additional types of Medicaid claims including additional professional, dental and limited institutional claims.
- **Claims Status and Adjustments / Resubmissions:** With MITS implementation, Medicaid providers may check the status of any claim submitted regardless of how submitted (paper, web portal, EDI, etc.). Providers may also submit claims adjustments or resubmit corrected claims.
- **Prior Approval for Medical Services and Equipment:** With MITS implementation, requests for Medicaid prior approval can be submitted electronically using the Medicaid web portal. The only prior approvals requiring documentation in addition to the online submission will be those requiring submission of a study model or physical exhibit that cannot be submitted in an electronic format.
- **Submission and Renewal of Provider Applications:** Medical service providers seeking to participate in the Ohio Medicaid program will be able to complete and submit a provider application on line using the Medicaid web portal. Existing providers whose provider agreements are expiring may also submit application renewals. Independent providers serving Medicaid consumers enrolled in waiver programs will be able to submit their required annual background checks.

### **Electronic Prescribing**

Beginning March 2009, ODJFS will begin offering electronic prescribing (“E-Prescribing”) to all Medicaid providers who prescribe or dispense prescription medications within the traditional fee for service Medicaid system. This system will be voluntary, allowing any eligible provider to request access to the system and personal training to use it. The ODJFS system will have the benefit of offering online access to the individual prescription histories of Medicaid consumers. Consequently, the first target group for implementation will be hospital emergency departments who do not usually have access to patient records. Other provider types will be phased in following hospital emergency departments.

The system will be accessible via the internet and will not require providers to invest in equipment other than a computer with internet access. This program represents a step forward and will be especially useful for those providers that have not yet invested in additional hardware and software, the program that ODJFS will use is a step forward.

Having online, real time records of a patient's prescriptions will help health care providers determine both potential contributors to the illness or reason for emergency department visit and ensure that any medications prescribed will not interact with the patient's current prescriptions.

**Eligibility Suspension for Medicaid Enrollees who are Institutionalized**

Federal Medicaid funds may not be used to pay for health care for individuals incarcerated in government operated facilities or individuals between ages 22 and 64 admitted to a mental health treatment institution. When a Medicaid enrolled Ohioan is admitted to a state prison, youth detention facility, state mental health center, or county and city jail, their Medicaid eligibility is terminated and must be re-established upon their release. ODJFS, in collaboration with other state agencies, is pursuing the option to suspend, rather than terminate, Medicaid eligibility when an enrollee is incarcerated. By reinstating "suspended" Medicaid eligibility, individuals released from facilities may be able to obtain uninterrupted access to medical care, especially prescription drugs to treat mental illness or other chronic medical conditions, when they are released. Reducing this gap in coverage should reduce recidivism.

It should be noted that this policy change will only address individuals who had Medicaid eligibility prior to incarceration and continue to meet eligibility post release. ODJFS is pursuing other initiatives to expedite Medicaid applications for individuals who were not Medicaid enrolled when they were admitted to an institutional setting.

**Conclusion**

Despite the current economic climate the nation is weathering, Governor Strickland remains committed to providing affordable and accessible health care to every Ohioan. The Executive Budget continues the momentum to invest in health care access in pursuit of this goal. Within the Medicaid program, the eligibility expansion for children to 300 percent of the federal poverty level is funded. The Executive Budget also contains provisions that will expand access to approximately 110,000 Ohioans who are uninsured as implementation of the State Coverage and Quality Initiative occurs.

The challenge to fund Medicaid services in a difficult budget environment is bolstered by the temporary availability of federal stimulus resources. Additionally, modifications to a number of the state's existing provider fees will help to leverage more federal resources in support of services.

The Executive Budget continues the momentum of the Unified Long term Care Budget initiative that was created in HB 119. Opportunities for elders to use the PASSPORT program without the development of a waiting list are protected. Policy reform related to nursing facility reimbursement is implemented in accordance with HB 66, and Ohio's Certificate of Need program is revised to enable a better distribution of nursing facility availability throughout the state. Additionally, local collaboration is emphasized in order to connect Ohioans with options for long term care services.