



## Medicaid Efficiency and Cost-Containment Strategies

Medicaid provides comprehensive health services to approximately 2 million Ohioans, including low-income children and their parents, as well as frail seniors and people with disabilities. However, Medicaid spending is growing at an unsustainable rate and Ohio has an opportunity to make changes in Medicaid that transform Ohio's entire health care system.

[Advocates for Ohio's Future](#) (AOF) supports Governor Kasich's goal of containing health costs and making Ohio's Medicaid program more effective. We offer the following strategies to transform the Medicaid system into one that provides higher health care quality, while reducing spending. We understand this is not a comprehensive list. Some of these strategies could produce actual savings to the Medicaid budget in the next biennium while others would produce significant savings or greater return on investment in the future. We understand that these are not easy choices, and are eager to support the administration in implementing these and other strategies that improve quality and reduce spending growth. We also encourage the state to take advantage of federal funding available through the Affordable Care Act and elsewhere to assist in pursuing improvements.

We urge the administration to utilize these cost-saving measures rather than reducing Medicaid eligibility or benefits.

Finally, we welcome the opportunity to meet with the administration for a more in-depth discussion of these recommendations. We hope to work with you, as well as advisory groups such as the Ohio Health Coverage and Quality Council, Unified Long-Term Care Budget Workgroup, and Ohio Drug Abuse Taskforce, to develop public will for pursuing evidence-based strategies for improving quality and reducing spending growth.

## **Proposals That Can Realize Savings in the Next Biennium**

### **I. Prioritize the redesign of Medicaid Payment Policies: Restructure payments to promote quality improvement and reduce unnecessary expenditures.**

The current payment system rewards providers who provide more care, and more care does not necessarily lead to better outcomes. A new payment system should reward providers who provide high quality care.

- A. Change Medicaid Payment Policies for hospital care to require improvements in quality and reductions in unnecessary expenditures.
  - 1. Reduce reimbursement rates to hospitals with excessive, potentially preventable events.
    - a. New York's Medicaid program achieved significant savings, including a reduction in inpatient hospital spending by \$600 million, within three years.
    - b. Maryland expanded the CMS list of hospital acquired complications (HACs) to a larger set of potentially preventable complications and readmissions to realize immediate cost savings.
  - 2. Improve transitions from hospitals by mandating and subsidizing long-term care consultations for vulnerable older adults and populations with disabilities about available home and community based alternatives to institutional care. This can be done, in part, by redeploying current assessment staff and ensuring access to hospitals by Area Agencies on Aging.
  - 3. Change Ohio's disproportionate share hospital (DSH) distribution formula to prioritize care that is efficient and effective.
- B. Restructure Medicaid Managed Care Plan reimbursements to improve quality and reduce unnecessary expenditures.
  - 1. Require transparency and strengthen accountability of Medicaid Managed Care Plans on quality and spending: Without measuring and reporting, we cannot improve value.
  - 2. Require performance and outcomes measures of managed care plans and tie them more closely to payment.
  - 3. Change capitation rates from being driven by encounter data to a formula that rewards reductions in preventable expenditures.
  - 4. Review and adjust allowable administrative rates for managed care plans; rates of 10-12% of total the total premium for administration are excessive in a mature Medicaid managed care market. Administrative costs do not increase proportionately as caseloads grow. Cap the growth in allowable administrative costs that is due solely to covering larger numbers of Ohioans and not to providing needed supportive services to achieve performance and outcome measure for managed care.
  - 5. Review Ohio's insurance regulations for capital and surplus requirements for Medicaid managed care. Regulations add costs to the system and may be excessive for Medicaid managed care plans, given Ohio's current system structure.

- C. Modernize Ohio’s Medicaid reimbursement system: Out-date reimbursement structures fail to reflect advancements in treatment modalities and over time can compromise program integrity.
  - 1. Reduce costly outlier claims by adopting updated payment methodologies; use most recent diagnosis related groups (DRGs) and so-called “Groupers”.
  - 2. Limit payments to hospitals that do not contract with Medicaid managed care plans to Medicaid fee-for-service rates.
  - 3. Pursue opportunities to increase federal matching funds for services reimbursable by Medicaid currently not being billed to Medicaid. Potential opportunities include exploration of 1915(i) state plan amendment to provide home and community based services, which could include homemaker/home health aide, personal care, adult day health, habilitation and respite care and services for people with chronic mental illness that are not currently available.
  - 4. Bill Medicare for eligible services now being paid by Medicaid (Note: We believe that recommendations may exist that have not yet been fully implemented).
  - 5. Reset DRGs for newborns to reflect savings from the Ohio Perinatal Quality Collaborative.
- D. “Transform primary care to a system that keeps people as healthy as possible, prevents chronic disease and coordinates care to improve quality of life and reduce chronic care costs and enables older adults and people with disabilities to live with dignity in the setting they prefer.” Executive Order 2011-12. For Medicaid patients at risk for chronic disease, adopt the “Patient-Centered Health Home” model of practice that emphasizes readily accessible, comprehensive, coordinated care, and active involvement of the patient and family in health care decisions.
  - 1. Take full advantage of the new “Health Home” option from CMS that provides 90% federal match for medical home services.
    - a. Include consumer advocacy organizations and Medicaid consumers in planning, implementation, and monitoring to optimize savings; the Ohio Health Coverage and Quality Council developed a toolkit to assist in consumer engagement to improve outcomes.
  - 2. Create “health homes” for high-cost, high-need patients to reduce avoidable, adverse, and unnecessary services.
    - a. Illinois saved \$220 million in the first two years.
  - 3. Institutionalize organized, coordinated consumer advocate and patient input to ensure maximum success at reducing avoidable expenses and improving compliance and outcomes.
  - 4. Restructure payments, with a phase-in period, to Medicaid Managed Care Plans to reduce high rates of avoidable emergency room use.
  - 5. Incentivize providers to use the medication web portal to coordinate prescriptions with medications prescribed by other treating physicians.
- E. Recalibrate hospital reimbursement annually as required by rule (OAC 5101:3-2-07.3). To the best of our knowledge, hospital recalibration has not been undertaken since FY 2006.

- F. Examine current pharmacy policy and benefit design to maximize patient adherence and cost effectiveness.
  - 1. Eliminate prescription drug copayments to increase patient adherence and appropriate utilization of prescribed maintenance medications
  - 2. Implement recommendations of the Prescription Drug Abuse Task Force, available at <http://www.odh.ohio.gov/ASSETS/895B95C591534F7A82A815A69A00011E/OPDATF%20final%20report.pdf>
  - 3. Review state drug formularies for Medicaid and state institutions, balancing clinical efficacy, access to medication equivalents within a drug class, and potential for abuse with cost effectiveness when establishing the formulary and utilization management requirement.
  - 4. Establish clear criteria to evaluate new medications or newly approved uses of medications prior to adding them to the drug formulary or establishing utilization management strategies. Base decisions on clinical efficacy, not only price.
  - 5. Regardless of the pharmacy benefit management structure, maintain a single formulary, utilization management protocol, and prior authorization process and maintain the exemption from prior authorization for psychiatrists prescribing atypical antipsychotics and antidepressants.

## **II. Balance Long-Term Care Spending to Improve Care**

- A. Tighten up the front door to nursing homes by:
  - 1. Maintaining open enrollment in home- and community-based waivers (PASSPORT, Assisted Living, and Ohio Home Care).
  - 2. Ensuring unbiased hospital assessments to provide more access to home care options at critical times when consumers needing long term care and their family caregivers are making decisions.
  - 3. Offering consultations with recuperative care nursing home patients on temporary Medicare and/or Medicaid to ensure their leaving nursing homes.
- B. Balanced Incentive Payment Program (BIPP), an opportunity under the Affordable Care Act:
  - 1. Ohio should apply to receive higher match for home- and community-based services. Create more waiver opportunities for people under 60 who are at risk of a nursing home placement:
  - 2. Apply the principles of the Home First law for those in the PASSPORT, Assisted Living, and PACE programs under the Ohio Home Care Waiver to all disabled individuals, when waiting lists exist. Use criteria for imminent risk of nursing home admission regardless of age to allow participation in home- and community-based waivers as appropriate.
- C. Coordinate state and federal housing policy with health care policy.
  - 1. Incorporate housing needs into the broader view of Medicaid and health and human services overseen by the Health Transformation Office in order to break down additional barriers preventing some individuals from accessing home- and community-based care.

2. Establish specific responsibility for in state coordination of long-term housing policy to enable people to live safely in communities instead of nursing homes.
- D. Revise Certificate of Need policies to align the nursing home bed supply with true consumer demand as more home and community alternatives are utilized.

### **III. Other recommendations for saving money in the next biennium**

- A. Develop and implement a meaningful quality of care evaluation system for all of long term care services and provide a cost reimbursement system based on the quality of care the consumer receives. Reduce payment for care that falls below established standards. Reward those who provide quality care based on an individual care plan developed in consultation with the consumer, the care planner, service provider and the family representative or consumer advocate who meet at regular intervals based on the consumer's need and implemented care plan. Explore and expand consumer directed models of home and community based long term care (cash & counseling model)
- B. Incorporate disease prevention strategies that are rated either "A" (strongly recommended) or "B" (recommended) by the US Preventative Services Task Force (USPTF) for Medicaid recipients
- C. Update and address information technology capabilities to better coordinate care, inform policy and management decision making, streamline claims processing, and improve accountability across the Medicaid programs. Implementation of MITS should be prioritized. Additionally, support the development of and incentives for implementation of electronic health records and population management systems, and enable the use of telehealth technology to enhance capacity and support access to needed services.

## **Transformative Proposals That, If Implemented Now, Will Produce Savings or Increase Value in Future Years**

### **I. Prioritize redesign of Medicaid payment policies to incentivize quality improvement and reduce unnecessary expenditures.**

- A. Change Medicaid payment policies for hospital care to incentivize improvements in quality and reductions in unnecessary expenditures. Implement bundled payments for episodes of care to incentivize provider communication and coordination.
- B. Support payment for development of integrated systems that are paid based on patient outcomes, such as Accountable Care Organizations as defined in the Affordable Care Act.
- C. Incentivize Medicaid Managed Care Plans (and other providers) to improve quality and reduce unnecessary expenditures by strengthening performance and outcomes measures on managed care plans, including denied claims, prompt payment of claims, prior authorization policies, and rates. (Please note: AOF would prefer to see Ohio

explore greater use of other evidence-based models of managed care and care management, especially for the most vulnerable populations).

- D. Integrate payment for behavioral health with physical health.
  - 1. Elevate behavioral health funding to the state level.
  - 2. Improve community-based behavioral health Medicaid services. Intensive community-based mental health services, such as Assertive Community Treatment (ACT) and Intensive Home Based Treatment (IBHT) should be added as Medicaid-funded services as well as other critical services such as peer support and family counseling. State regulations governing the provision of these services need to be changed to facilitate their application in Ohio. In addition, Ohio must ensure that Medicaid behavioral health services are provided in adequate amount, duration, and scope to meet their intended purpose in all areas of the state.
- E. Increase transparency for consumers and policy makers on quality measures.
  - 1. Quality standards for managed care plans: require ODJFS to publish Pay for Performance Incentive Reports on Medicaid Managed Care Plans, HEDIS measures used by Ohio, and the plans' HEDIS scores.
  - 2. Mandate that ODJFS establish Quality Report Cards and publish them on their website, as in Michigan.
  - 3. Require the state to publish hospital infection rates more prominently, including development of easy-to-read comparison charts based on Ohio's Hospital Compare website.
  - 4. Increase transparency on pharmaceutical use to determine use of evidence-based formularies and providers' prescribing practices.
  - 5. The state must post data in a centrally located, easily searchable, and up to date on the web.
- F. Take advantage of opportunities for system transformation made available under federal health reform.
  - 1. For example – Explore the addition of Attendant Services & Supports to Ohio's state Medicaid plan. Under the Affordable Care Act, for the first time federal and state Medicaid dollars can be spent on non-medical personal assistance (activities of daily living, one month rent, utility deposit, household goods. Such an action would help sustain the services provided under Ohio's Home Choice program which ends in 2016.