BUILDING FOR OHIO'S NEXT GENERATION

BUDGET OF THE STATE OF OHIO FISCAL YEARS 2018–2019

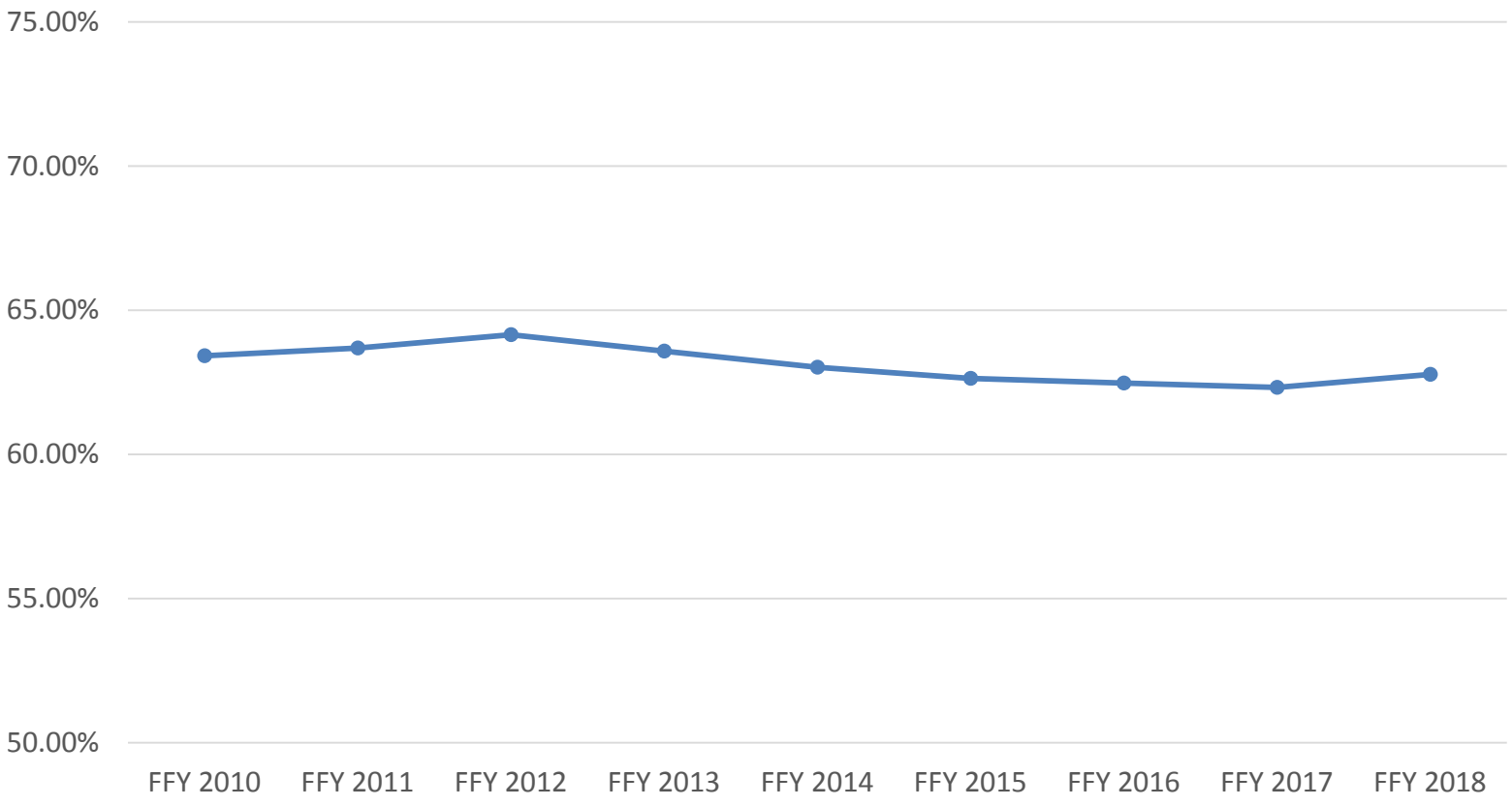
Ohio Department of Medicaid:
FY18-19 Budget Priorities

House Finance Subcommittee on Health and Human Services
March 8, 2017

Barbara R. Sears, Medicaid Director

2011 Ohio Crisis	vs.	Results Today
• $8 billion state budget shortfall • 89-cents in the rainy day fund • Nearly dead last (48th) in job creation (2007-2009) • Medicaid over-spending required multiple budget corrections • Ohio Medicaid stuck in the past and in need of reform • More than 1.5 million uninsured Ohioans (75% of them working)		• Balanced budget • Over $2 billion in the rainy day fund • 448,500 private-sector jobs created over the past six years • Medicaid budget under-spending was $1.9 billion (2012-2013), $2.5 billion (2014-2015), and $1.3 billion (SFY 2016) • Ohio Medicaid embraces reform • Extended Medicaid coverage

Regular FMAP Over Time



Source: U.S. Department of Health and Human Services

Medicaid Enrollment Overview

- Current Enrollment: 3,054,806
- 86% covered by a managed care plan
- Children in Custody, Adopted Children, BCCP Individuals, Medicaid eligible individuals enrolled in BCMH Program are currently served by a managed care plan
- As of January 1, 2017 there are 714,997 covered in the expansion category
  - All enrolled or enrolling in private managed care plans
- Long-term services and supports: approximately 88,000 served by HCBS waivers; 56,000 living in long-term care facilities

Joint Medicaid Oversight Committee (JMOC)

Slowing Ohio's Medicaid Per Capita Spending:

- Since the creation of JMOC in May 2014, year-over-year growth in per capita Medicaid spending has slowed
- Spending at the per member per month (PMPM) level has been significantly lower than was originally projected
  - JMOC 2016 PMPM Target = 2.9% (actual 1.2%)
  - JMOC 2017 PMPM Target = 3.3% (actual < 2.6%)
- ***Lower-than-budgeted PMPM produced savings of $1.6 billion across all funds in fiscal years 2015 and 2016***

http://www.jmoc.state.oh.us/reports

Ohio Medicaid Annual Growth Projections (calculated on a Per Member Per Month basis)

State Fiscal Year	JMOC (Optumas) Upper Bound	Medical CPI	JMOC (Optumas) Target	Executive Budget		
				(All Agencies)	(Excluding DD)	(All Agencies Disaggregated)
2018	3.80%	3.30%	3.30%	2.24%	1.64%	1.90%
2019	4.00%	3.30%	3.30%	6.38%	-0.83%	1.54%
Avg.	3.90%	3.30%	3.30%	4.29%	0.39%	1.72%

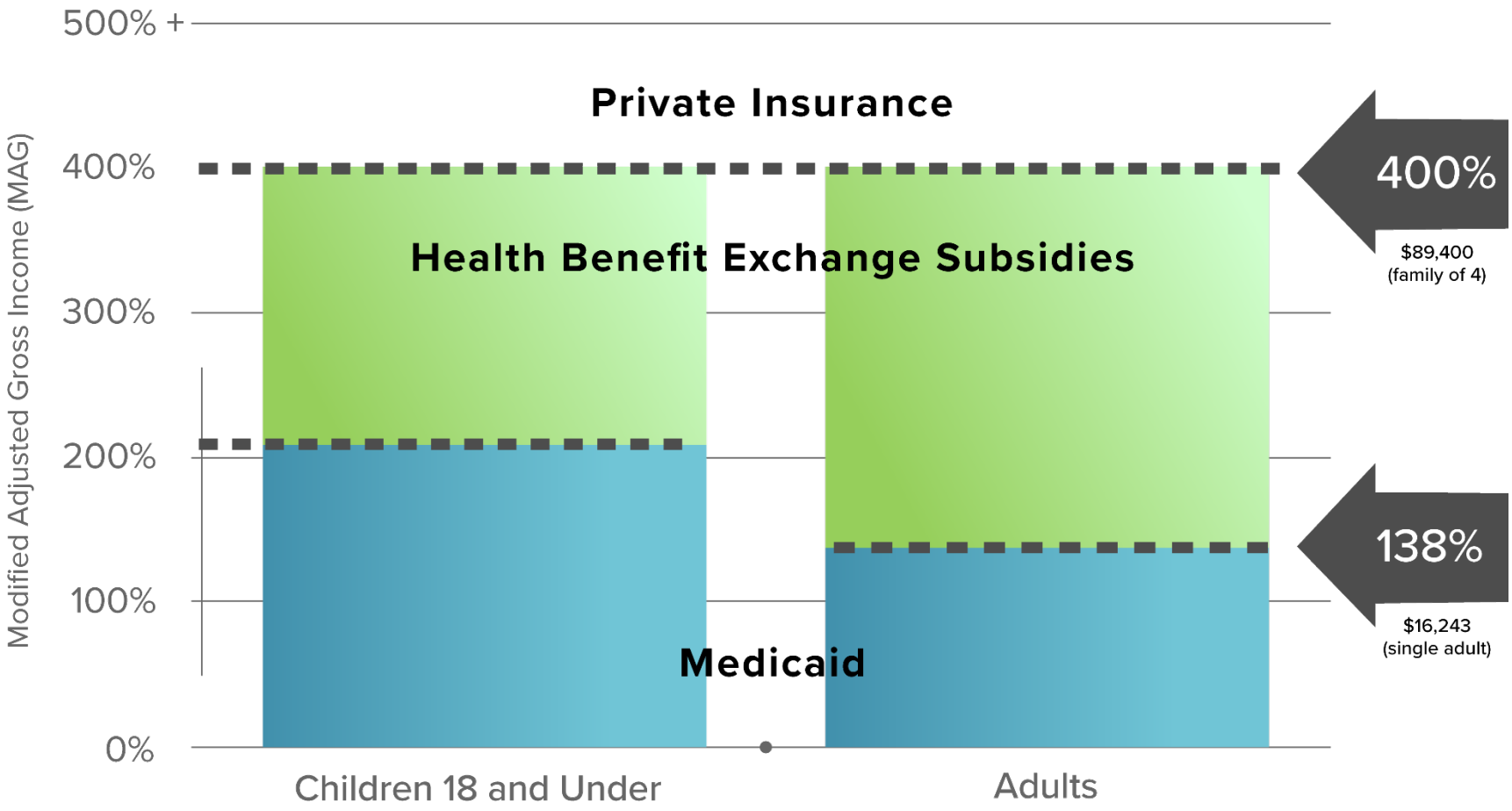
Ohio Medicaid Spending

Ohio Medicaid Executive Budget Impact

Executive Budget	SFY 2018		SFY 2019	
	All Funds	State GRF	All Funds	State GRF
	$28,562,648,375	**$ 6,343,489,075**	**$29,661,214,530**	**$ 6,701,698,756**
Percent Growth Rate	**8.6 %**	**9.4 %**	**3.8 %**	**5.6 %**
Executive Budget				
Improve Care Coordination	$ (315,866,270)	$ (865,396,597)	$ (464,297,238)	$ (971,438,063)
Prioritize Home and Community Based Services*	$ 8,711,448	$ 4,394,746	$ 75,017,942	$ 29,536,064
Provide Choices in Ohio's Developmental Disabilities System	$ 25,153,022	$ 9,558,148	$ 93,042,941	$ 35,356,317
Reform Provider Payments	$ (209,525,000)	$ (86,224,802)	$ (469,868,032)	$ (185,421,141)
Improve Program Performance	$ (115,594,873)	$ (97,865,121)	$ (187,686,624)	$ (70,929,160)
Subtotal	**$ (607,121,673)**	**$(1,035,533,626)**	**$ (953,791,011)**	**$(1,162,895,983)**
Total Medicaid Budget	**$27,955,526,702**	**$ 5,307,955,449**	**$28,707,423,519**	**$ 5,538,802,773**
Percent Growth Rate After Policy Change	**6.3 %**	**-8.5 %**	**2.7 %**	**4.3 %**

* Ohio Department of Developmental Disabilities HCBS programs are included in the total for "Provider Choices" not "Prioritize HCBS"

Simplified Income Eligibility Levels

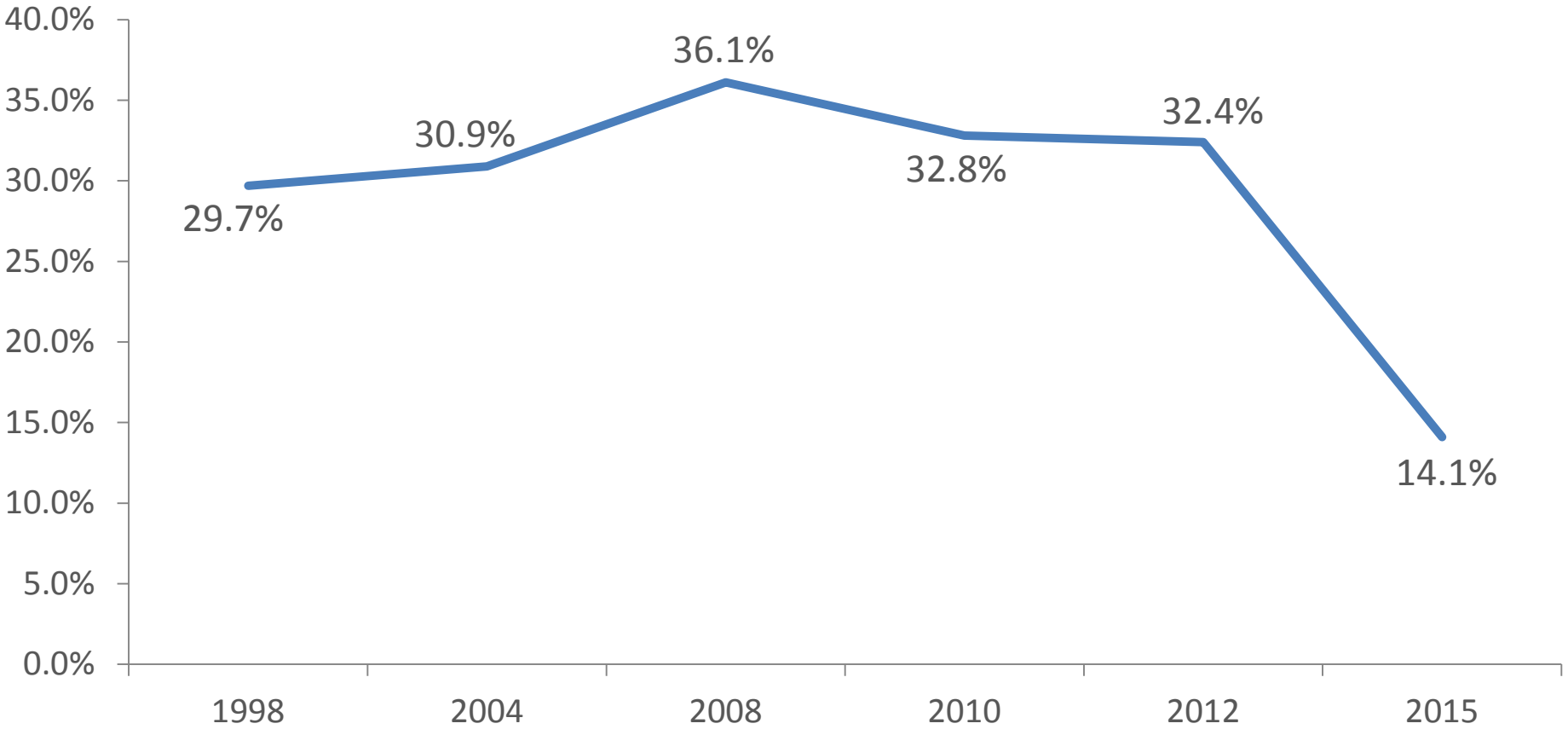


Maintain Coverage

Maintain Health Care Coverage for Very Low Income Ohioans

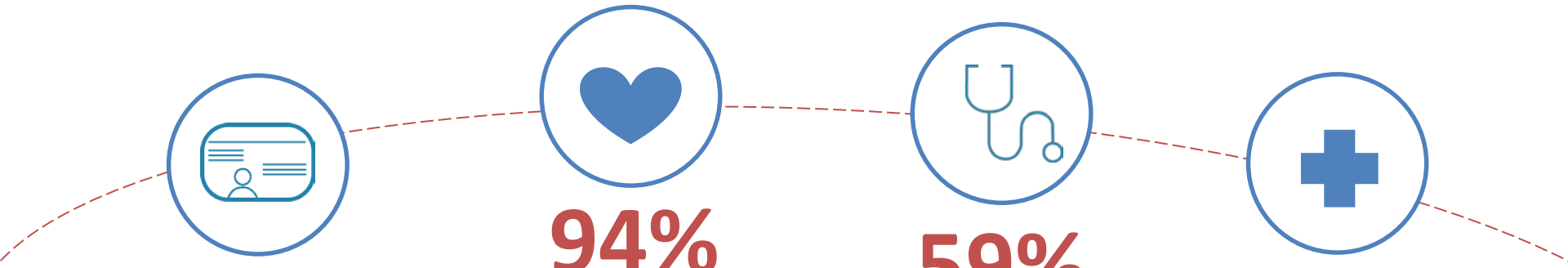
- Ohio Medicaid Currently Covers:
  - Children up to 206 percent of the federal poverty level (FPL)
  - Pregnant women up to 200% FPL
  - Adults up to 138% FPL
  - Individuals who are aged, blind or disabled (ABD) up to the Federal Benefit Rate (FBR)—$735 per month or $8,820 annually

Percentage of adult Ohioans with family income at or below 138% of the federal poverty level without insurance from 1998-2015



Source: Ohio Medicaid Assessment Survey

Key Findings: Access and Utilization



56%
Reduction in uninsured rate among low-income Ohio adults

94%
Report improved or the same access to care

59%
Without a usual source of care obtained one since enrollment

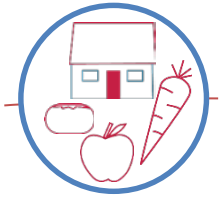
34%
Report visiting the emergency department less since enrollment

89% had no health insurance at the time of enrollment

Key Findings: Behavioral Health and Employment

62%
With depression diagnoses received antidepressants

48%
Report improvements in self-rated health



59%
Found it easier to afford food

48%
Found it easier to afford housing

52%
Found it easier to continue working

75%
Found it easier to look for a job

45%
Reductions of individuals with medical debt

44%
Found it easier to pay off debt

Group VIII Enrollees: What Does Medicaid Mean To You?

More freedom. Less worries. I was an addict for 3 years before getting Medicaid. Because of Medicaid I'm not an addict

Prioritize Home and Community Based Services

Ohio Recognized for Investment in HCBS Programs

- In 2016, CMS recognized Ohio for leading the nation in HCBS spending relative to total Medicaid spending
- The Home Choice program ranks first nationally in transitioning individuals with mental illness, and is ranked second in overall transitions
- More than 9,400 Ohioans enjoy new found independence through Home Choice

Prioritize home and community based services

- Serve almost 100,000 Ohioans in home and community based settings across all waiver programs
- Increase rates for home and community based services in nursing facility level of care waivers by $61 million
- Projected increased rates for home and community based services provided in waivers administered by DODD by $12.9 million in 2019

Improve Care Coordination

Move to Managed Care

- Extends the benefits of care coordination to all remaining populations
- New populations enrolled in Medicaid managed care beginning July 1, 2018:
  - Individuals receiving community and facility based long term services and supports who are in a nursing facility or on a nursing facility level of care waiver
  - Participants in the Medicaid Buy-in Program for workers with disabilities
  - Individuals dually eligible for Medicaid and Medicare who are not participating in the My Care Ohio program
  - Eligible individuals receiving refugee medical assistance
- Implement new Managed Medicaid Long-Term Services and Supports (MLTSS) program

Managed Medicaid Long-Term Services and Supports (MLTSS) program

- Medicaid enrollees with the most complex needs – those who could benefit most from care coordination – are currently excluded from managed care
- Implement MLTSS program through a competitive procurement
  - Goal is to select at least three plans to participate
- Work with health plans on the timing of managed care payments to minimize any one-time costs related to converting FFS payments into MLTSS

Rationale for moving to MLTSS

- Provides the benefits of care coordination to Medicaid enrollees who have the most complex needs
- Creates a system where health care providers are incentivized to keep patients healthy and eliminate gaps in service;
- Strengthens the focus on quality measurement, including both quality of life and quality of care, in order to achieve better outcomes;
- Ensures transparency, accountability, effectiveness and efficiency of the program; and
- Ensures long-term sustainability of the system as demand for LTSS grows by controlling costs.

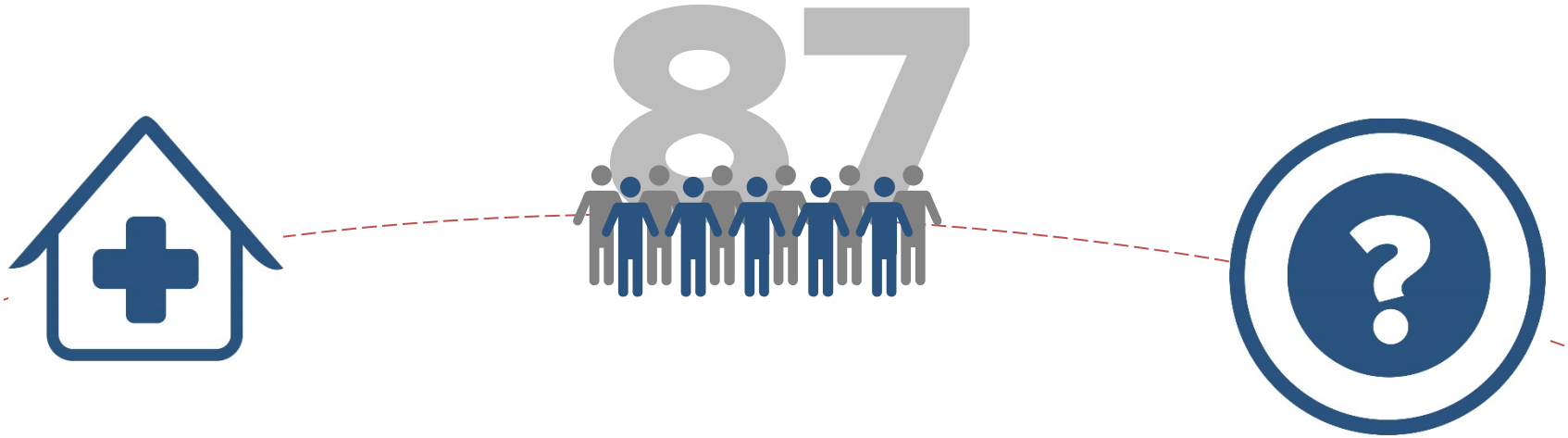
Nursing Facility Evacuated Quickly and Safely

WITH MANAGED CARE PLAN

- 100 residents enrolled in managed care had to be evacuated when nursing facility's air conditioning failed during humid, 90-degree days.
- Many residents had complex mental health care needs and had lived in the facility for many years.
- Care managers moved all residents into appropriate, air-conditioned facilities within five days

Near Evacuation Unlikely to Have Gone Well

WITHOUT MANAGED CARE PLAN



- 87 non-managed care residents were in in potential danger when furnace failed in November.
- NF did not have required emergency backup plan. NF's plan was to take residents to hospital.
- Fortunately, heat was fixed before evacuation was required. However, without organized coordination of managed care plan, long-term ombudsmen would have had to evacuate the residents with less efficiency and speed.

Implement a Multi-dimensional Quality Strategy for MLTSS

- Standardize healthcare measures used nationally (HEDIS)
- Individual satisfaction survey (CAPHS)
- ODM specific measures

Examples of Measures

- Nursing home diversion & transition measures
- Reducing pressure ulcers in nursing home residents
- Appropriate follow-up after in-patient psychiatric stay
- Controlling high blood pressure

A Story from MyCare

E. was homeless, addicted to heroin, had significant health care issues and resisted outreach efforts.

Care manager connected with her at detox, referred her for home health care services, and persuaded her to continue detox treatment and therapy.

E. learned to manage her medical, addiction and psychiatric issues through her treatment.

She now has her own home, is working full-time and has health insurance through her employer.

Ensuring MLTSS Success in Ohio

- Based on key elements identified by the National Association of States United for Aging and Disabilities for a successful MLTSS program, Ohio plans to adopt:
  - Strong care coordination requirements and structure
  - Network adequacy standards
  - Provider contracting and training at start-up
  - Consumer protections (ombudsman, strong choice counseling)
  - Strong state agency management controls and health plan accountability mechanisms (contract language and financial consequences)

Ohio Medicaid Managed Care Organization (MCO) Sales Tax

- CMS ruled that Ohio must eliminate MCO sales tax by July 2017
- Three states (CA, PA and MI) had similar tax
- August 2016: Initial discussions with CMS to comply with guidance
- November 2016: Formal proposal submitted to CMS
- December 2016: Received CMS approval to replace current tax program with an alternative that eliminates projected state budget shortfalls of over $1 billion

Ohio Medicaid MCO Sales Tax Replacement

Impact on Collections by Type of Plan (SFY 2018)

Type of Plan	Tax Range	Member Months	Annual Collection
Medicaid MCO	$26 to $56 per member month	30.8 million	$854 million
Non-Medicaid Major Medical Plan	$1 to $2 per member month	2.7 million	$4 million
TOTAL			$858 million

Reduce Pharmacy Costs

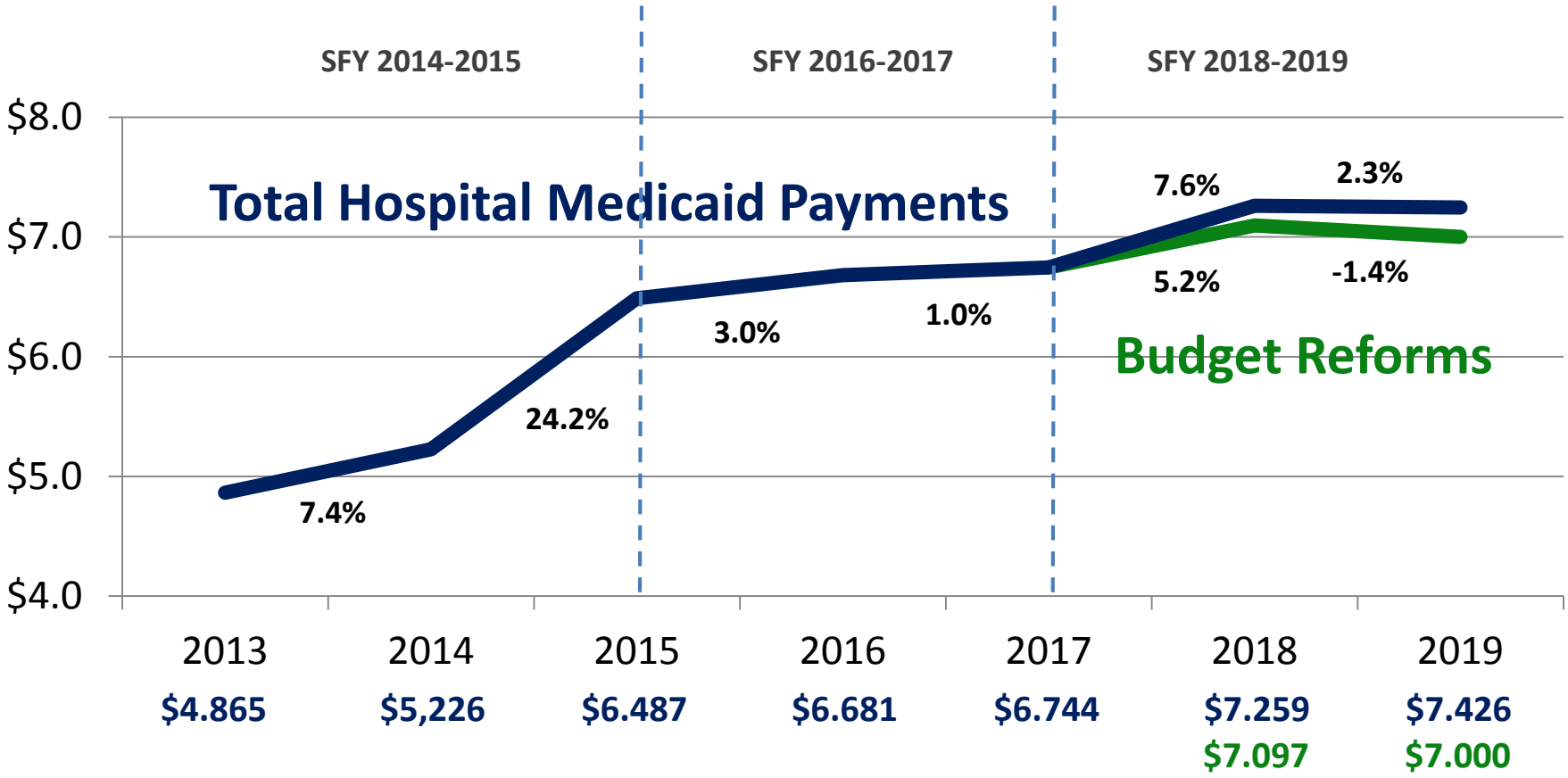
Reduce Pharmacy Costs

- Adopt a single preferred drug list
  - Increases rebates by $13.9 million in 2018 and $27.8 million in 2019.
- Enhance drug rebate collections
  - Recovers approximately $10 million annually in rebates the state has not previously invoiced to manufacturers
- Update and increase pharmacy dispensing fees
  - Additional pharmacy fee offset by a reduction in drug payments for net savings of $20 million over the biennium
- Copies federal discount drug pricing
  - Saves $40 million annually

Reform Hospital Payments

Ohio Medicaid Hospital Spending

(All Funds in billions)



Source: Ohio Department of Medicaid (January 2017).

Ohio Medicaid Hospital Spending

- Eliminates ICD-10 coding inflation
  - 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
  - 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
  - Saves $87.5 million ($27.1 million state share) in 2018 and $175.0 million ($54.3 million state share) in 2019

Reform Nursing Facility Reimbursement

Reform Nursing Facility Reimbursement

- Resets unintended payment gains resulting from a new payment methodology
  - 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
  - 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
- Creates an opportunity to negotiate better rates through managed care

Example: Summary of Prices SFY 17

Effect of NF Rate Reduction	Weighted Per Diem Rate	Estimated Medicaid days	Estimated Patient Liability	Net Payment
Rate as at 01/01/17	$ 193.24	16,547,833	$ 546,744,420	$ 2,650,928,834
Rate as at 01/01/16	$ 177.33	16,547,833	$ 546,744,420	$ 2,387,652,811
Increase	**$ 15.91**			$ 263,276,023
Estimated increase to SFY 2017 per diem rates was...				$ 150,000,000

Nursing Facility Per Diem Rates Example

Summary of Per Diem Rates		
1	Ancillary and Support Price	$ 61.15
2	Capital Price	$ 10.17
3	Direct Care Rate	$ 91.19
4	Tax Rate	$ 0.00
5	Add-On per ORC 5165.15(A)	$ 16.44
6	Sub-Total (Line 1 - Line 5)	$ 178.95
7	Critical Access Nursing Home Rate Add-On**	$ 0.00
8	Deduction per ORC 5165.15 (B)	$ -1.79
9	Quality Payment Rate per ORC 5165.25 (B)(1)	$ 1.74
10	Total Rate	$ 178.90

**In accordance with Ohio Revised Code, Section 5165.23 (B),

a five percent increase will be added to Critical Access Nursing Facilities.

Pay for Value

Ohio's State Innovation Model (SIM) progress to date

Comprehensive Primary Care

- **Care model and payment model** design in place for model to reach 80 percent of Ohio's population
- **Statewide provider survey** gauged readiness
- **Infrastructure plan** in place for attribution, enrollment, scoring, reporting, and payment
- **Ohio CPC performance report** designed with provider/payer input
- **All payers applied for Ohio to be a statewide Medicare CPC+ region**

Episode-Based Payment

- **13 episodes** designed across seven clinical advisory groups (CAGs)
- **30 additional episodes** under development to launch in 2017
- **Nine payers** released performance reports on first wave of 6 episodes
- State set **thresholds for performance** payments across Medicaid FFS and MCPs on first wave of episodes
- State released **performance reports** aggregated across Medicaid FFS and MCPs on second wave of 7 episodes
- **Executive Order** and rule require Medicaid provider participation

Multi-payer participation is critical to achieve the scale necessary to drive meaningful transformation

Anthem Blue Cross

MEDICAL MUTUAL

aetna

UnitedHealthcare

MOLINA HEALTHCARE

CareSource

PARAMOUNT ADVANTAGE

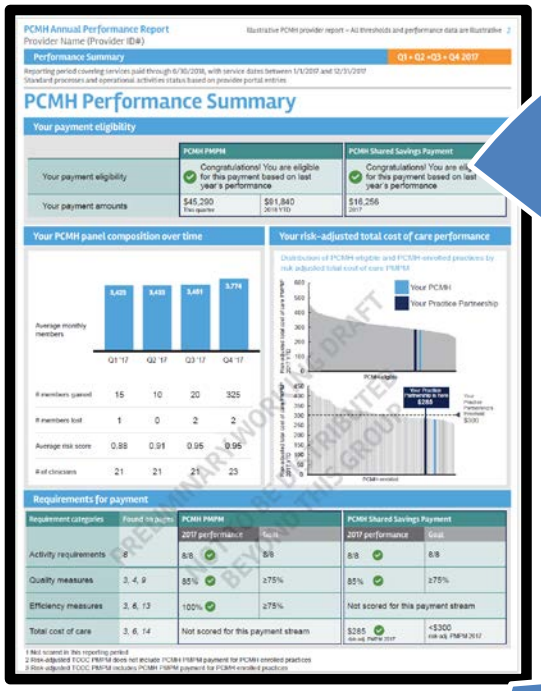
buckeye health plan

Increase access and transparency to comprehensive primary care

- As part of our efforts with our State Innovation Model (SIM) grant work, we will invest $124 million over two years in comprehensive primary care
- Financially reward primary care practices that do more to keep patients well
- Make health care price and quality information more transparent
- Create greater accountability between episode providers and primary care
- Set clear priorities to improve population health

Make Health Care Price and Quality Transparent

Primary Care Performance Report



Episode Performance Report

Referral

Patient Activity Report for Primary Care

Report

Ohio CPC "Early Entry" Practice Eligibility
(January 1, 2017 to December 31, 2017)

Required

- **Eligible provider type and specialty**
- **One of the following characteristics:**
  - Practice with 5,000+ attributed Medicaid individuals and national accreditation[1]
  - Practice with 500+ attributed Medicaid individuals determined through claims-only data at each attribution period and NCQA III accreditation
  - Practice with 500+ attributed Medicaid individuals at each attribution period and enrolled in Medicare CPC+
- **Commitment:**
  - To sharing data with contracted payers/ the state
  - To participating in learning activities[2]
  - To meeting activity requirements in 6 months

Not required

- **Planning** *(e.g., develop budget, plan for care delivery improvements, etc.)*
- **Tools** *(e.g., e-prescribing capabilities, EHR, etc.)*

1 Eligible accreditations include: NCQAII/III, URAC, Joint Commission, AAAHC
2 Examples include sharing best practices with other CPC practices, working with existing organizations to improve operating model, participating in state led CPC program education at kickoff

Practices currently enrolled in the Ohio CPC Program: Early Entry

- Adena Medical Group / Adena Pediatrics
- AxessPointe/Arlington
- AxessPointe/Barberton
- AxessPointe/Kent
- Braxton Cann Health Center
- Butler County Community Health Consortium, dba Primary Health Solutions
- Butler County Community Health Consortium, dba Primary Health Solutions
- Butler County Community Health Consortium, dba Primary Health Solutions
- Central Ohio Primary Care Physicians
- Children's Hospital Medical Center
- Cleveland Clinic
- Collinwood Health Center
- Columbus Neighborhood Health Center, dba PrimaryOne Health
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- Columbus Neighborhood Health Center, dba PrimaryOne Health
- Columbus Neighborhood Health Center, dba PrimaryOne Health
- Columbus Neighborhood Health Center, dba PrimaryOne Health
- Community Action Committee of Pike Co. aka Valley View Health Centers
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- Community Health Care, Inc.
- East Cleveland Health Center
- Elm Street Health Center
- Fairfield Community Health Center
- Fairfield Community Health Center
- Family Health Care of Northwest Ohio, Inc.
- Fayette County Memorial Hospital Medical and Surgical Associates
- Five Rivers Family Health Center
- Five Rivers Medical Surgical Health Center

Practices currently enrolled in the Ohio CPC Program : Early Entry (cont.)

- Five Rivers Pediatric Center
- Healthsource: Batavia Family Practice & Ob/Gyn
- Healthsource: Eastgate Pediatrics
- Healthsource: Georgetown Pediatrics
- Healthsource: Hillsboro Health Center
- Healthsource: Loveland
- Healthsource: Mt Orab
- Healthsource: New Richmond Family Practice
- Healthsource: Seaman
- Healthsource: Washington Court House Family Practice
- Healthsource: Wilmington
- Healthsource: Wilmington
- Hopewell Health Centers, Inc.
- Hough Health Center
- HPWO Gene Wright Community Health Center
- HPWO Kenton Community Health Center
- Lake Health Physician Group
- Locust Pediatric Care Group
- Lorain County Health & Dentistry
- Lorain County Health & Dentistry
- Lorain County Health & Dentistry
- Lower Lights Health Center
- Lower Lights Nursing Center
- Marietta Health Care Physicians Inc.
- Marietta Memorial Hospital
- MARY RUTAN HOSPITAL INTERNAL MEDICINE
- Mercy Defiance Clinic
- Mercy Health Physicians Cincinnati, LLC
- Mercy Health Physicians Lorain, LLC
- Mercy Health Physicians North, LLC
- Mercy Health Physicians Youngstown, LLC
- Mid-City Pediatrics, Inc.
- Millvale Hopple Health Center

Practices currently enrolled in the Ohio CPC Program : Early Entry (cont.)

- Muskingum Valley Health Centers
- Nationwide Children's Hospital
- Neighborhood Family Practice - Franklin Blvd office
- Neighborhood Family Practice - Puritas Avenue
- Neighborhood Family Practice - Ridge Road Office
- Neighborhood Family Practice - Tremont
- Northern Ohio Medical Specialist, LLC
- Northside Health Center
- OhioHealth Primary Care Physicians
- OSU Family Practice Services
- OSU General Internal Medicine
- Pediatric Associates Inc.
- Pediatric Associates of Lancaster, Inc.
- Pediatric Associates of Mt Carmel
- Pioneer Physicians Network, Inc.
- Price Hill Health Center
- PriMed Physicians Wright Dunbar
- Promedica Central Physicians, LLC
- Providence Medical Group
- Rocking Horse Community health Center
- Senders Pediatrics
- Southeast Health Center
- St. Rita's Professional Services, LLC
- Summa Health Medical Group @ 195 Wadsworth Rd
- Summa Health Medical Group @ 265 W Portage Trail
- Superior Health Center
- Talbert House Health Center dba Centerpoint Health
- The Christ Hospital Medical Associates, LLC
- The Free Medical Clinic of Greater Cleveland
- West Side Pediatrics

Ohio Comprehensive Primary Care (CPC) Program Requirements and Payment Streams

Requirements	8 activity requirements	4 Efficiency measures	20 Clinical Measures	Total Cost of Care
	▪ *Same-day appointments* ▪ *24/7 access to care* ▪ *Risk stratification* ▪ *Population management* ▪ *Team-based care management* ▪ *Follow up after hospital discharge* ▪ *Tracking of follow up tests and specialist referrals* ▪ *Patient experience*	▪ *ED visits* ▪ *Inpatient admissions for ambulatory sensitive conditions* ▪ *Generic dispensing rate of select classes* ▪ *Behavioral health related inpatient admits*	▪ *Clinical measures aligned with CMS/AHIP core standards for PCMH*	
	Must pass 100%	**Must pass 50%**	**Must pass 50%**	
Payment Streams				
PMPM	***All required***			
Shared Savings	***All required***			***Based on self-improvement & performance relative to peers***
Practice Transformation Support	***TBD for select practices***			

Report transparency and performance on high-cost episodes of care

- Share savings with health care providers that achieve high quality at low costs
- Make health care price and quality information transparent
- Create greater accountability between episode providers and primary care
- Set clear priorities to improve population health

Ohio's episode timeline

Wave 1

Perinatal, asthma, COPD, Acute PCI, Non-acute PCI, total joint replacement

Reporting only → Performance Y1 → Performance Y2 → Performance Y3

Wave 2

URI, UTI, cholecystectomy, appendectomy, upper GI endoscopy, colonoscopy, GI hemorrhage

Reporting only → Performance Y1 → Performance Y2

Wave 3

Preliminary: HIV, Neonatal (3 episodes), Hysterectomy, Pancreatitis, Skin and soft tissue infection, Diabetic ketoacidosis, Lower back pain, Headache, CABG, Cardiac valve, Congestive heart failure, Breast cancer surgery, Breast medical oncology, Mastectomy, Otitis, Pediatric acute lower respiratory infection, Tonsillectomy, Shoulder sprain, Wrist sprain, Ankle sprain, Knee sprain, Hip/Pelvic fracture, Knee arthroscopy, Spinal fusion exc. cervical, Spinal decompression, Adult pneumonia, Syncope, Lung cancer medical oncology, Lung cancer surgery, Lung cancer radiation, ADHD, Oppositional defiant disorder

Reporting only → Performance Y1

Design Reporting

Make health care cost and quality transparent

- Combine health care price and quality information to determine value
- Focus first on the most “shoppable” services
- Create a framework to help consumers choose high-value health plans and providers
- Set clear priorities to improve population health
- Build public support for price and quality transparency

Improve Program Performance

Implement a competitive transportation brokerage system

- As early as July 2019 , responsibility for non-emergency medical transportation will transition from a county-based system to a regional-based brokerage model.
- Funding will transition from the Ohio Department of Job and Family Services to the Ohio Department of Medicaid.
- Ohio will be able to draw down more federal funds (from 50% to 62% match) saving over $6.8 million annually.

State-based transportation brokerage model

- Ohio Medicaid will contract with third party transportation broker(s) to manage non-emergency medical transportation.
- Contracts with the transportation broker and transportation providers will include standards to ensure consistent response times, scheduling and provision of transportation services for individuals, regardless of where they are located within the state.
- Contracts will utilize existing local transportation resources.
- This model will streamline the process for Medicaid enrollees to secure reliable transportation and access care.

Fraud Detection

- In 2016, ODM referred 664 cases to the Attorney General's MFCU, including those from managed care plans.
- The MFCU of the Attorney General recorded:

137 indictments

127 convictions

$63.4 million in recovery

- According to MFCU, Ohio is a **national leader** in managed care plan fraud referrals.

Coordinate efforts to fight fraud, waste and abuse

- Fully integrate FFS claims data and Medicaid managed care encounter data to enhance fraud, waste, and abuse detection
- Creates incentives for managed care plans to establish special investigative units
- Limits managed care plans' liability for any credible allegation of fraud the plan reports and Ohio Medicaid pursues
- Saves $5.0 million ($1.5 million state share) in 2018 and $10.0 million ($2.9 million state share) in 2019

Protect and reform services for children with medical handicaps

- Program was founded in 1919 in response to the polio epidemic
- Currently, Ohio Department of Health's program for children with medical handicaps pays for health care services for children with special health care needs who are uninsured, underinsured, or whose insurance does not cover the services they need
- Approximately 40,000 current enrollees with 50% already enrolled in Medicaid
- Executive Budget will preserve medically necessary services for every child currently enrolled in the BCMH program, but reform the program and clarify income and benefit limits for any child applying to or entering the program on or after July 1, 2017

Protect and reform services for children with medical handicaps

Ohio Department of Health Current BCMH Program	Ohio Medicaid CMH Program After January 1, 2018
I. • **Income eligibility up to 500 percent of poverty** • **ODH and counties share program costs** • **~20,000 non-Medicaid children in this group** • **Children enrolled in this group prior to July 1, 2017 will be grandfathered and see no change**	IV. • Income eligibility = 225+ percent of poverty • ODM covers program costs (counties do not) • New program rules apply January 1, 2018 for any individual enrolled on or after July 1, 2017 • Comparable services to the ODH BCMH program
II. • **Upper income limit = 200 percent of poverty** • **ODH and counties share program costs** • **~20,000 Medicaid eligible children in this group** • **Children in this group will be automatically enrolled in the new program January 1, 2018**	III. • Upper income limit = 200 percent of poverty • ODM covers program costs (counties do not) • Comparable services to the ODH BCMH program

Create a new, mostly federally-funded lead abatement program

- Require ODH to partner with Ohio Medicaid to leverage up to $5 million each year in SCHIP funding for lead abatement activities
- Ohio Medicaid will file a State Plan Amendment to cover the lead abatement activities provided through the ODH program
- Approximately $4.8 million each year will be used for remediation and associated testing services for homes under lead hazard orders, and the remaining $200,000 each year will be used to establish a Registry of Lead Safe Housing for non-owner occupied rental housing

Rebuild Community Behavioral Health System Capacity

'Over Budget Neutral' Investments:

- Total of **$53.4M above budget neutrality** point due to below updates and all previously communicated updates in response to stakeholder feedback

1. Rate increases for Registered Nurse (RN) and Licensed Practical Nurse (LPN) services
2. Rate increases for all Evaluation and Management (E&M) services
3. Modification of the required years of experience for individuals to render Therapeutic Behavioral Services (TBS)
4. Coding guidance for ASAM Outpatient Level of Care 1, SUD Group Counseling

**Please keep in mind that all proposed changes are still subject to approval by CMS*

Rebuild Community Behavioral Health System Capacity

Ohio's Behavioral Health Transformation:

- **Elevation.** Shifted Medicaid match responsibility from local mental health and addiction treatment systems to the state
- **Expansion.** Extended Medicaid coverage to 500,000 residents with behavioral health needs who previously relied on county-funded service or went untreated
- **Modernization.** Updated Medicaid behavioral health billing codes to match national insurance standards and expanded services for individuals with the most intense needs
- **Integration.** Moving the Medicaid behavioral health benefit into managed care beginning January 1, 2018

Rebuild Community Behavioral Health System Capacity

The Governor's Budget Modernizes the Medicaid Benefit:

- Revises services coding for the first time in decades (provider manuals are posted online)
- Expands Medicaid rehabilitation options and supports a new Specialized Recovery Services program (replaces spenddown)
- Moves all Medicaid behavioral health services into managed care January 1, 2018, as required by the last budget
- Provides Medicaid reimbursement for freestanding psychiatric hospitals beginning July 1, 2017

Rebuild Community Behavioral Health System Capacity

The Governor's Budget Strengthens Community Supports:

- Assists prisoners with addiction transition to the community
- Encourages community innovations to avoid incarceration
- Supports addiction treatment for court-involved individuals
- Strengthens community prevention services
- Reduces preschool expulsions
- Continues support for Strong Families, Safe Communities
- Supports crisis hotlines and adds a text option
- Supports residency and traineeship programs for in-demand behavioral health professionals

Reduce drug abuse and overdose deaths

- Medicaid Pre-Release Enrollment initiative began in 2014 to provide access to health services, improves health outcomes, and reduce recidivism for former Ohio inmates
- Rule changes to recognize Governor's Cabinet Opiate Action Team (GCOAT) recommendations, such as:
  - adding acupuncture as a service
  - refining the guidelines for safer prescribing for acute pain by prescribing non-narcotics to help patients use fewer narcotics, while still managing pain.
  - building episodes of care to include measures related to safer opioid prescribing
  - adding to the Board of Pharmacy effort to automate OARRS checks at point of prescribing in electronic health records

Personal Responsibility

Premium Payments for Adults Above 100 % of Poverty

- Currently requires copayments for everyone **except** children, pregnant women, and persons who are aged, blind or disabled (ABD). There are no premiums in the current program.
- The Executive Budget requires childless, non-pregnant adults who have income between 100-138 percent modified adjusted gross income (MAGI) to pay a monthly premium to the Medicaid program.

Premium Payments for Adults Above 100 % of Poverty

- If approved by CMS, monthly premium amounts will be calculated using a similar methodology as used in the private sector and capped to not exceed two percent of household income.
- The average monthly premium charge is not to exceed $20.

Infant Mortality

Infant Mortality—Medicaid Specific Investment

- Continue to invest $26.8 million at the local level over the biennium to support community initiatives through the Medicaid managed care plans to help new moms and moms-to-be have successful pregnancies and healthy children beyond their first year of life
  - Increasing home visiting nurse capacity in at-risk neighborhoods
  - Enhancing Centering Pregnancy care
  - Hiring additional community health workers
  - Introducing fatherhood projects including boot camps for dads
  - Providing clinics with training for assessment and referral in at-risk neighborhoods
  - Providing transportation services for pregnant mothers to Centering Pregnancy and Help Me Grow programs

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