Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

Maureen Corcoran, Director

Testimony to the Health and Human Services Subcommittee of the Ohio House of Representatives

Maureen M. Corcoran, Director, Ohio Department of Medicaid

April 3, 2019

Chairman Romanchuk, Ranking Member West, Representatives Kelly, Lipps and Roemer, thank you for the opportunity to be here today. I am Maureen Corcoran, Director of the Ohio Department of Medicaid. I am pleased to present the Medicaid portion of Governor DeWine's executive budget proposal for SFY 2020-2021 to you and the Health and Human Services subcommittee members.

The Ohio Department of Medicaid provides health care coverage for nearly 3 million Ohioans who are served by a network of over 135,000 providers. Ohio Medicaid ensures health care access to low-income adults, children, pregnant women, seniors, and individuals with disabilities, including the following coverage highlights:

- Over half of Ohio births are covered by Medicaid
- More than 1.2 million children are served by Medicaid
- Approximately 36,000 children in foster care are served by Medicaid
- Approximately 23 percent of children (ages 0-20), and 29 percent of adults (age 21 and older) receive behavioral health services

Our Department is made up of approximately 600 professionals dedicated to providing health care coverage and services that improve the quality of life for our enrollees. We focus on strengthening families, and the services and supports we cover give our enrollees a chance to live healthy, productive lives.

In-step with Governor DeWine's priority to promote diversity, the Ohio Department of Medicaid is committed to fostering a diverse workforce. Recently awarded the State's Diversity and Inclusion Award for a diverse, equitable and inclusive work environment, we value our employees and realize our differences make us better equipped to serve Ohio. Appendix 3 gives a complete breakdown of diversity at the Ohio Department of Medicaid.

Our budget focuses on limiting the annual rate of Medicaid program growth while supporting Governor DeWine and Lt. Governor Husted's priorities to help Ohioans who are most in need of our services and supports. My testimony is divided into two major components: first, an overall picture of Medicaid spending and its key drivers and delivery systems, and second, a discussion of our policy priorities for the coming biennium.

Medicaid Spending and Key Drivers of Cost

I'll begin by reviewing the overall JMOC growth rate, and then review specific components within our program. These different components help provide a complete picture of the Medicaid program and allow the Department to adjust spending and policies to ensure it remains sustainable into the future.

JMOC Growth Rate

The Ohio Legislature's Joint Medicaid Oversight Committee (JMOC) sets a target growth rate for the Medicaid budget. Under Section 5162.70 of the Revised Code, the Medicaid director must limit per member per month

(PMPM) growth in the Medicaid program across all Medicaid recipients to the lower of the JMOC rate or the three-year average Consumer Price Index (CPI) for medical services for the Midwest region.

In 2018, JMOC's actuaries recommended setting a range of growth between 2.9 percent and 4.6 percent. Appendix 4 provides more detail on the Optumas projections for the FY 2020-2021 Executive Budget. JMOC voted to establish the growth rate at 3.3 percent for SFY 2020 and 3.4 percent for 2021.

Comparison of JMOC Rate and Medicaid's Proposed Budget

	SFY 2020	SFY 2021
JMOC Approved Growth Rate	3.3%	3.4%
ODM Proposed Budget	3.3%	3.3%

Ohio Medicaid consulted with JMOC's actuaries from Optumas while developing our SFY 2020-21 budget to ensure our methodologies aligned when calculating the growth rate relative to JMOC's parameters. On March 18, 2019, Medicaid received the following statement from Optumas: *"ODM has estimated that these changes result in a 3.3% growth rate for FY2020 and 3.3% growth rate for FY2021. Without auditing the calculations supporting these changes, we note that the changes result in* ***growth rates consistent with the JMOC growth targets for Medicaid."*** The Department appreciates the collaboration of all parties and is pleased with the outcomes of these discussions. As you will see below, coming in under the JMOC growth rate required us to cut spending in some areas while making critical investments and policy changes.

Overall Medicaid Growth Rates

Overall Medicaid Growth Rates (dollars in billions)

	SFY 2019	SFY 2020	% Change	SFY 2021	% Change
Total Budget	$27.1	$28.2	4.0%	$29.4	4.6%
Total GRF State Funds	$5.2	$5.5	6.3%	$6.1	10.8%
Total GRF	$14.8	$15.2	2.6%	$16.6	8.9%

GRF State Share

The proposed GRF state share Medicaid budget for SFY 2020 is $5,517.6 million, and for SFY 2021 is $6,113.2 million. The GRF state share growth rate is higher than the growth in total spending due to a 23 percent decrease in federal reimbursements for the Children's Health Insurance Program (CHIP) and a 3 percent decrease in federal reimbursement for the expansion population (also known as Group VIII). Additionally, baseline non-GRF revenue sources, such as the member month tax and other provider fees, are held flat and therefore do not keep pace with healthcare cost inflation and total program spending.

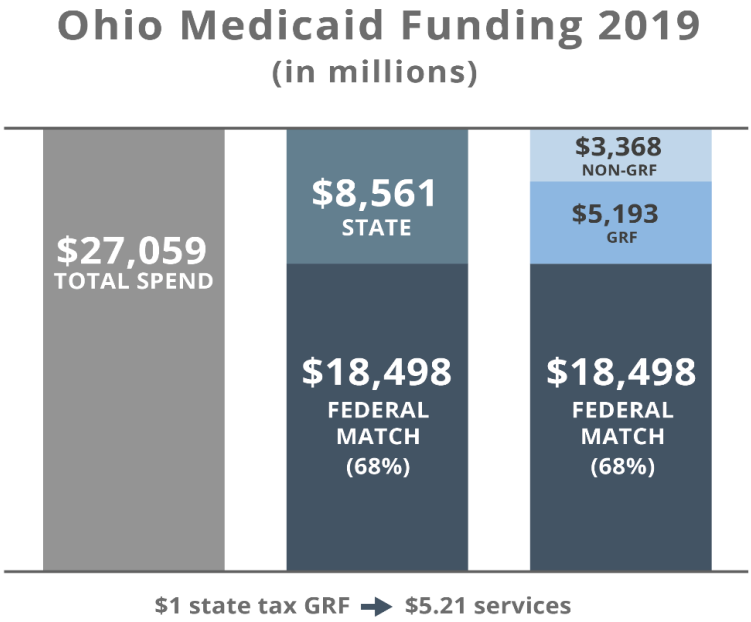
The executive budget includes policy initiatives designed to reduce Medicaid's reliance on GRF while emphasizing strategic investments identified by the DeWine Administration. The budget initiatives outlined in the table below reduce the GRF state share by $50.1 million in FY2020 and $127.0 million in FY2021. See Appendix 5 for all propose policy changes.

Total Medicaid GRF State Share (dollars in millions)

	FY19	FY20	% Change	FY21	% Change
Baseline	$5,192.7	$5,567.6	7.2%	$6,240.3	12.1%
Policy Changes		($50.1)		($127.0)	
Executive Budget	$5,192.7	$5,517.6	6.3%	$6,113.2	10.8%

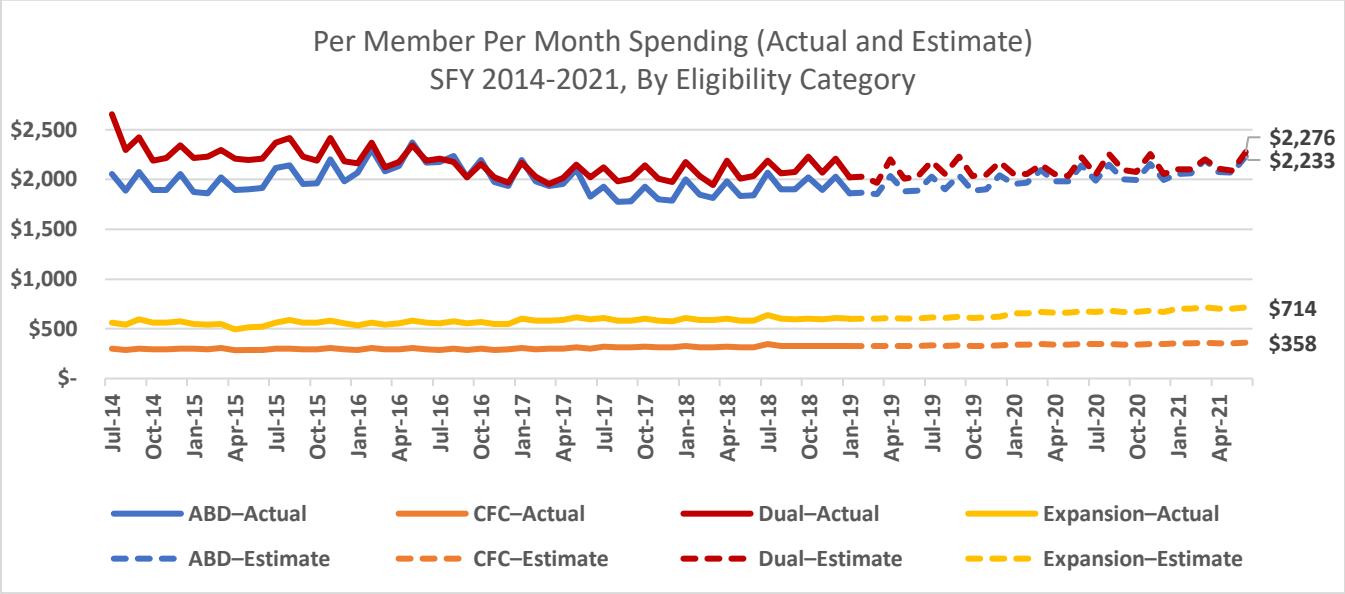
Other State Share

With the exception of Alaska, all states use a variety of provider assessments or local governmental funds to provide an allowable source of funds as the state matching funds. The bar chart gives an example of how Ohio satisfies our state matching funds obligation.



Appendix 1 to this testimony contains a chart that shows Ohio Medicaid's historical and projected rate of growth compared to various other healthcare cost indicators, illustrating that our program is being managed at relatively low growth rates.

Before concluding this section, I want to highlight the differences in per-member per-month (PMPM) costs for the various populations Medicaid covers. As the chart on page four shows, coverage for dual-eligible individuals who have both Medicare and Medicaid and individuals in the aged, blind, and disabled (ABD) category are projected to have a PMPM cost of over $2,200 by the end of the coming biennium. By 2021, individuals in the expansion population are expected to have a PMPM cost of about $700, and individuals in the CFC group (formerly called the covered families and children group) are expected to have a PMPM cost of about $360.



Medicaid Caseload

Ohio Medicaid's caseload peaked in March 2017 when enrollment exceeded 3.1 million individuals. Medicaid enrollment is countercyclical, meaning an improving economy decreases our caseload (with some lag), while a recession increases our caseload.

Ohio Medicaid Peak and Current Caseload

Month	Covered Families/Children	Group VIII-Expansion	Total Caseload
March 2017	1.79 million	725,000	3.1 million
February 2019	1.61 million	613,000	2.8 million

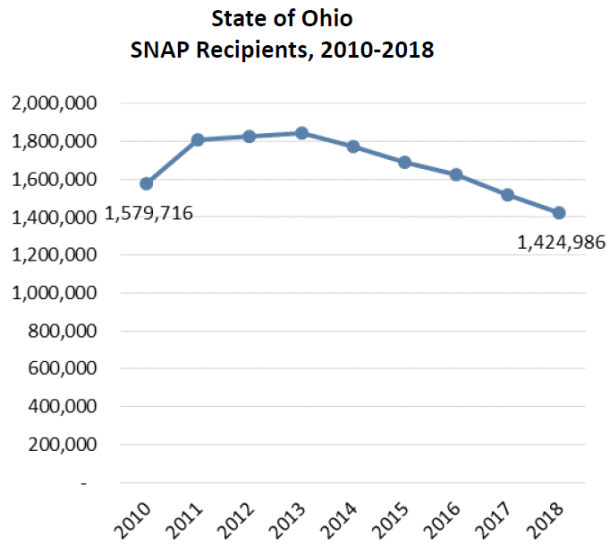
Recent Caseload Changes

While many factors can contribute to changing caseloads, the recent decline in the number of individuals served by the Medicaid program is likely a result of the strong economy. In the beginning of 2018, Ohio's unemployment rate decreased to around 4.5 percent, where it has remained since. Individuals and families in the Covered Families and Children (CFC) and Expansion enrollment categories have eligibility based on family income, so a stronger economy should translate to lower caseload as working individuals and families gain more hours and/or earn higher wages, and non-working individuals have opportunities to enter the workforce.

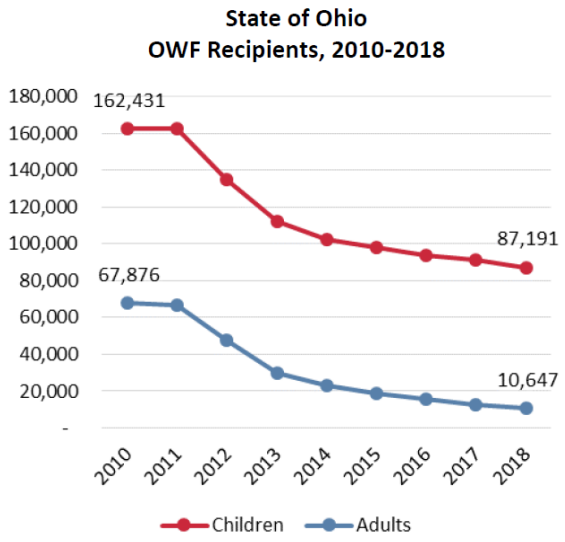
It is also important to note that the magnitude of the enrollment decline over the last 2 years links to Medicaid's redeterminations processes. When Ohio brought our new eligibility system online in 2014, the Centers for Medicare and Medicaid Services (CMS) allowed Ohio to delay routine eligibility redeterminations. During that time and for several months after, the Medicaid caseload, excluding the expansion caseload, grew even as Ohio's economy improved. In typical months, caseload fluctuates in Medicaid as some members lose coverage and others gain coverage. With redeterminations suspended because of the new eligibility system, few members lost coverage in this time period, but people continued to enter the program. When redeterminations resumed, many individuals who retained Medicaid during the suspension period left the program. Redeterminations resumed as Ohio's economy continued to improve, magnifying the overall decline in caseload. In general, there can be two causes for a decline in enrollment: fewer new people coming onto the program or

more people leaving the program. The number of new enrollees has remained fairly stable since the resumption of redeterminations, and we have seen an increase in people leaving the program.

Medicaid's enrollment changes mirror similar changes in other social service programs, as indicated in the following charts.[1]



Source: Ohio Department of Job and Family Services PAMS Report



Source: Ohio Department of Job and Family Services PAMS Report

Our agency forecasts are close to forecasts completed by the Legislative Services Commission; the difference in expenditures is driven by a difference in caseload projections. Appendix 2 to this testimony gives a general comparison of our budget and LSC's estimates.

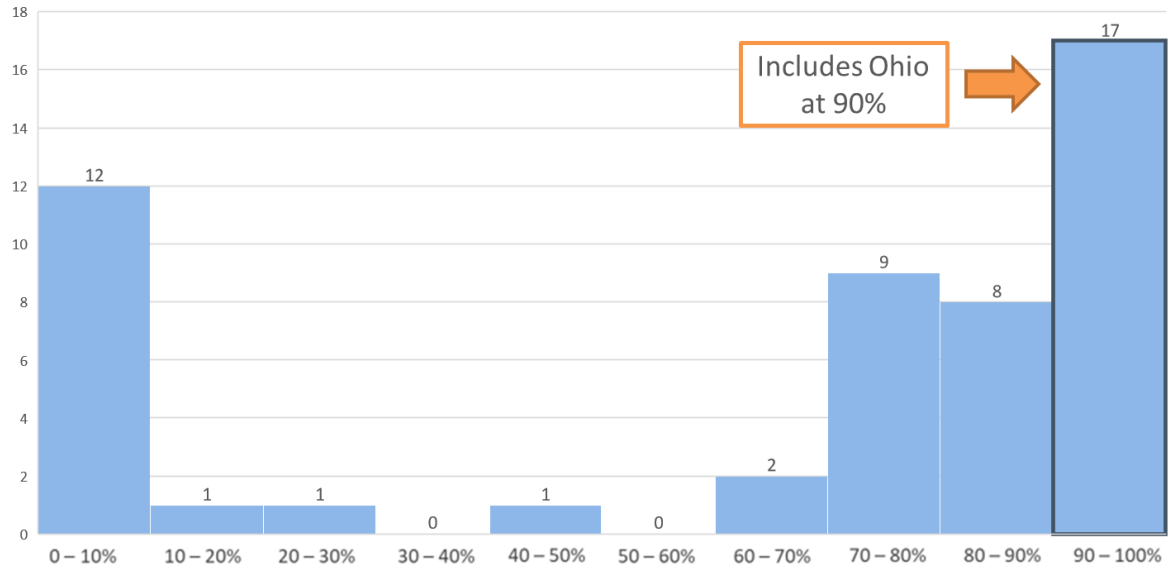
Ohio's Managed Care Platform

Role of Managed Care

In recent years, Ohio has transitioned new populations and services into our managed care program. Today, approximately 90 percent of Medicaid's enrollees are in managed care, and approximately 80 percent of Medicaid-administered spending (which excludes Department of Developmental Disability spending on waivers) is in managed care. Ohio's shift toward managed care is part of a national trend, as seen in the table on page six.

[1]The Center for Community Solutions. State of Ohio.2018. Available at: https://www.communitysolutions.com/wp-content/uploads/2018/04/Ohio2018.pdf

States' Share of Medicaid Population Covered by Managed Care Organizations, as of July 1, 2018[2]



Of the 90 percent of individuals covered by managed care, 2.32 million are covered by regular Medicaid managed care plans and 122,000 covered by the MyCare Ohio plans. Managed care provides Ohio Medicaid and our enrollees with the following benefits:

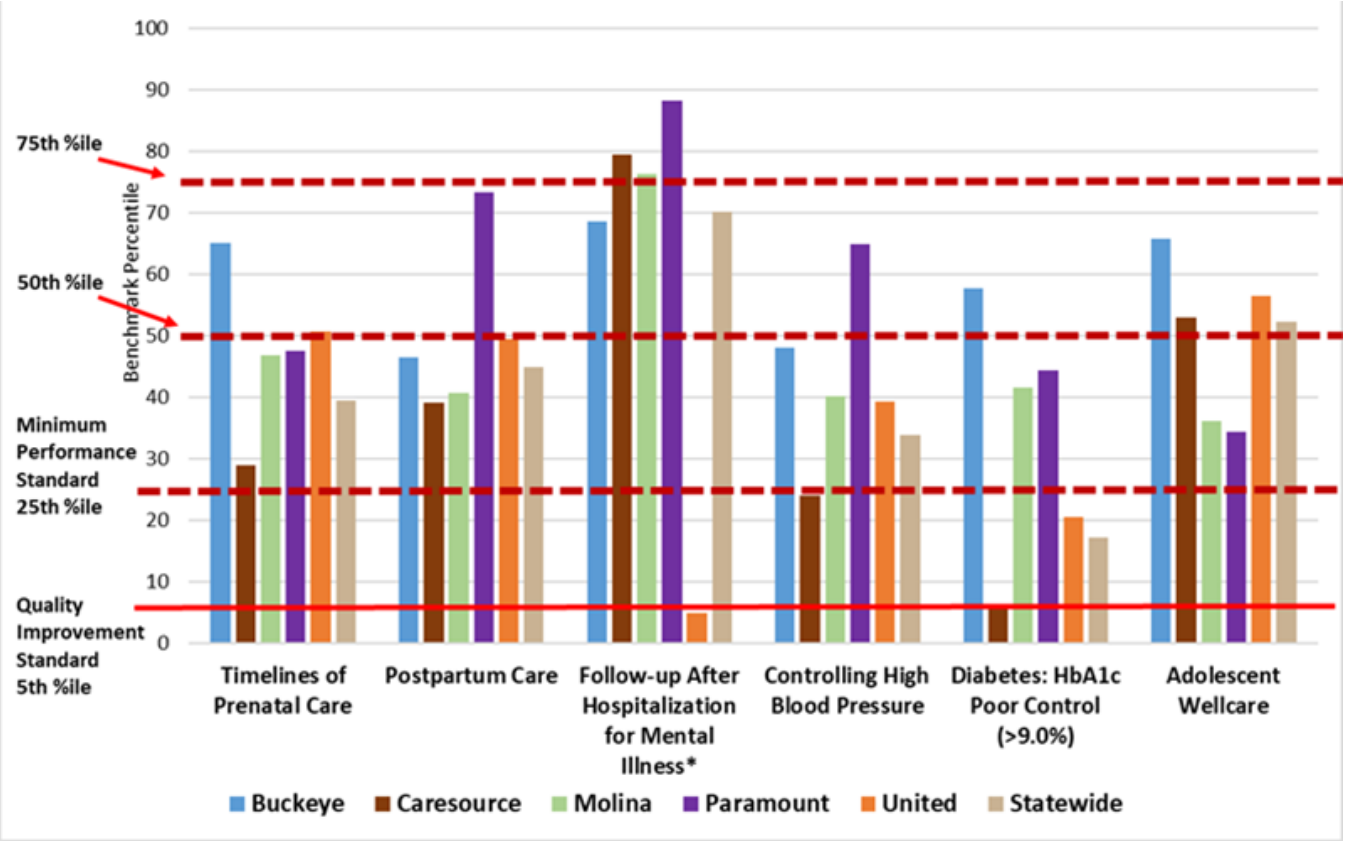
- Budget predictability for the state that mitigates volatility in the market;
- Increased free-market competition for the Medicaid program;
- Individual choice between competing managed care plans;
- Opportunities to pay for value while moving away from a volume-based model;
- Flexibilities to invest in health and wellness programs and unique support services; and
- Coordination of care and supports for members.

Members of this committee know that the Medicaid program has responsibilities to provide high-quality care and improve health outcomes for enrollees while purchasing care at the most affordable cost to taxpayers. The Department of Medicaid is dedicated to managing the program within budget constraints with increasing transparency while helping people move off of the program as their life circumstances improve.

As I have committed to many of you, my door will always be open to you and your staff, and I will always give you realistic and balanced assessments of how I view the Medicaid program and plan performance. My perception is that you may have been presented with an overly rosy, one-sided picture of the program in the past. Medicaid is not simple, and health care is messy.

[2] Kaiser Family Foundation. States Focus on Quality and Outcomes Amid Waiver Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2018 and 2019. October 2018. Available at: http://files.kff.org/attachment/Report-States-Focus-on-Quality-and-Outcomes-Amid-Waiver-Changes-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2018-and-2019

2018 P4P Measures and Plan Results/Estimated Percentiles
Quality Improvement/Minimum Performance Standards – by Measure



* ODM has determined this reported HEDIS result for United does not accurately reflect performance due to data incompleteness. United's recalculation of this rate using complete data is 36.1%. The estimated percentile is 48.7·

Driving Quality Improvement in Managed Care

In recent years, the performance of Medicaid's contracted managed care plans has varied across the broad spectrum of populations they serve, including children, adults, those with chronic conditions, and individuals with behavioral health needs. Despite positive trends in many measures, there is room for improvement. For example, only one-half of adolescents enrolled in managed care received the well care they needed last year. Ohio Medicaid must continue to raise its standards as it works improve the value of health care for enrollees

I'd like to highlight a recent example of how our Department's efforts with the managed care plans can yield very positive results. As Ohio continues to combat the opioid crisis, Ohio Medicaid and the managed care plans are playing a critical role in connecting individuals to treatment and providing other strategies that help improve individuals' health outcomes. For example, our Coordinated Services Program allows managed care plans to "lock-in" high-risk individuals to a single pharmacy that can oversee and review potential prescription drug abuse. Managed care plans may also assign a designated prescriber and offer care management for members through this program. As of March 2019, this program includes 7,062 managed care members, and it's having a real impact. We will continue to collaborate with our sister state agencies, state professional boards,

prescribers, and law enforcement to tackle this problem from multiple fronts and build upon Ohio's 328 million-dose decrease in opiate prescriptions in 2018.[3]

The Department appreciates and values the benefits managed care brings to Ohio. Managed care and its partners have elevated the quality of Ohio Medicaid's services. We now have the unique opportunity to make meaningful changes in our system by increasing transparency through accountability to Ohio's taxpayers, while delivering quality health outcomes to those we serve.

[3] State of Ohio Board of Pharmacy. Opioid Prescribing in Ohio Down 325 Million Doses in 2018. March 2019. Available at: https://www.pharmacy.ohio.gov/Documents/Pubs/NewsReleases/2019/Opioid%20Prescribing%20in%20Ohio%20Down%20325%20Million%20Doses%20in%202018.pdf

DeWine Administration Policy Initiatives: Sustainability, Quality, and Access

The Medicaid program is critical to the overall success of the DeWine-Husted administration and its priorities. The Department's executive budget introduces policy changes that support these priorities while keeping spending at or below national trends. The set of policy changes outlined below target ensuring program sustainability, improving quality, and ensuring access to care for Medicaid enrollees.

Procurement of New Managed Care Contracts: Initial Steps and Process

Within a few weeks of taking Office, Governor DeWine instructed the Department of Medicaid to begin the process of rebidding our managed care contracts. We immediately started this process with a sense of urgency.

The procurement process we are designing will be transparent and inclusive. With the help of national experts, the Department is currently soliciting information from other states that have recently procured or rebid managed care services. Based on this information and other research, we intend to take an innovative and thoughtful approach to developing our new agreements. Our team is also drafting a request for information (RFI) to obtain input from a wide cross-section of respondents, including current and potential managed care organizations, providers, advocates, the individuals whom we serve, and the public at large. This RFI will be released in the coming weeks.

In the spring of 2019, we will initiate a series of regional forums to solicit a discussion about what new and improved systems of managed care could look like and achieve. The Department will set up a website dedicated to the procurement and will solicit less-formal written feedback (via email) from individuals and groups that cannot attend regional forums or prefer to comment online. We will request information about both the challenges and successes of our current managed care system as we prepare the request for applications. There is a lot of work to do, including:

- In-person listening sessions and regional meetings to obtain feedback from individuals served by Ohio Medicaid, providers, advocacy groups, managed care entities, and taxpayers;
- Sharing information throughout the procurement process via a dedicated website hosted by the Department;
- In addition to the RFI, ongoing solicitation of input from stakeholders via both the website and email inbox;
- Careful drafting of the Request for Applications (RFA) for new managed care entities and management of the bid process;
- Developing new managed care provider agreements to ensure that the newly selected managed care plans will be held accountable for services and outcomes;
- Completion of a systematic readiness review with each newly chosen managed care entity; and
- Working with existing plans, providers, and others to ensure a smooth transition toward implementation.

To maintain maximum flexibility, we respectfully request changes to the existing Chapter 5167 of the Ohio Revised Code, which calls for the Department to require Medicaid managed care plans to provide various services for members enrolled in the plans. With an eye towards rebidding the managed care contracts, the proposed rescissions and amendments give the Department more flexibility in charting its future.

Work Requirement and Community Engagement 1115 Waiver Demonstration

On March 15, 2019, Ohio Medicaid received notification from the Centers for Medicare and Medicaid Services (CMS) Administrator, Seema Verma, that Ohio's 1115 waiver application for a work and community engagement

demonstration had been approved. This announcement capped nearly 18 months of work with CMS and set the Department and our partners in the direction of implementation.

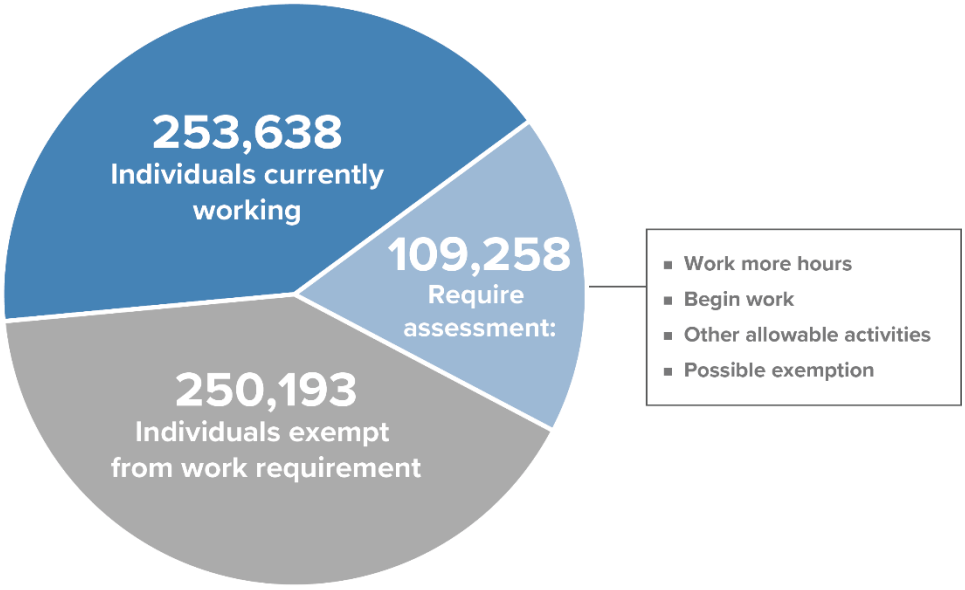
In 2018, 58 percent of Ohio's Medicaid expansion enrollees were employed, and over 41 percent of the expansion population worked at least 20 hours per week.[4] Many individuals in the expansion group reported that Medicaid helps them maintain employment, and 71 percent of expansion enrollees who terminated coverage in 2018 said they disenrolled from the program because they got a job or had increased income.

Individuals exempt from the waiver are those 50 years and older, a caretaker with a minor in the home, those with chronic conditions, and individuals who qualify for SNAP and TANF. Individuals not meeting these requirements will need to be assessed to confirm need to participate in the work requirement and community engagement program.

While many individuals within the Medicaid program work, more can be done to encourage employment and community engagement efforts that promote financial independence and economic stability while improving health outcomes.

The following chart shows our preliminary assessment of the impact on individuals within the expansion population.

Ohio Medicaid Expansion Work and Community Engagement Requirements
Estimated impact based on February 2019 data[5]



[4] Ohio Department of Medicaid. 2018 Ohio Medicaid Group VIII Assessment: A Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment. August 2018. Available at: https://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf.

[5] Ohio Benefits for eligibility, income and demographics (February 2019 extract), Medicaid Information Technology System claims data for chronic conditions, and Ohio Department of Job and Family Services for SNAP/ABAWD exclusions

The Department anticipates releasing more detailed information shortly around our implementation plan. Several changes were made during our final work with CMS, including 1) clarifications and safeguards to prevent loss of coverage for those who are complying with the requirements, 2) for those with the greatest need, establishing a warm handoff to enable job coaching and engagement to secure a job and 3) with the assistance of Innovate Ohio, reducing administrative burden and automating existing systems will maximize the connection with Ohio Means Jobs and minimize the burden on our county partners.

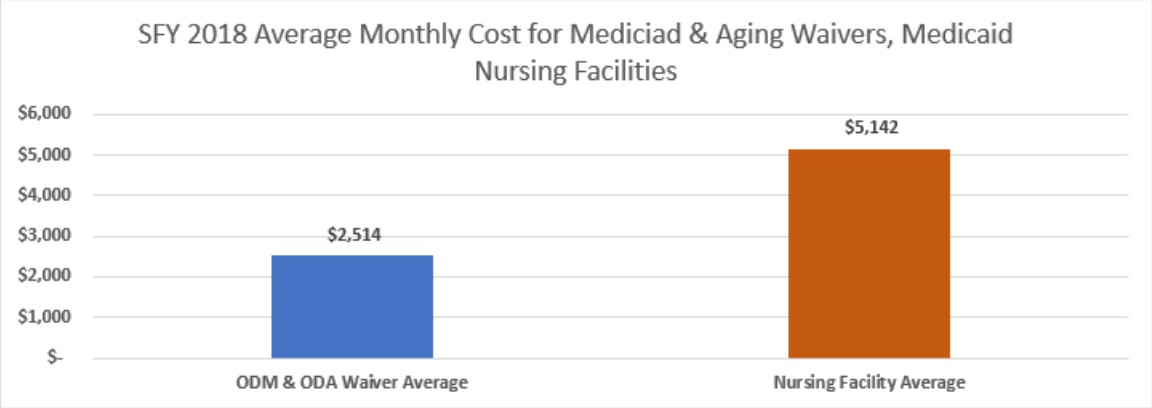
Program Performance, Accountability, and Sustainability

The Department of Medicaid's budget is being submitted under the cap in growth established by JMOC. The reductions and changes outlined below were made to accommodate Governor DeWine's priorities while meeting JMOC's capped growth rate.

- Increasing the Managed Care Withhold: Ohio Medicaid is increasing the managed care withhold from two percent to three percent of managed care capitation payments. This action, separate from the rebidding process, reduces initial budget outlays and encourages quality. This increase in withheld funds demonstrates Ohio Medicaid's strong expectations for managed care plan performance on clinical quality measures. The measures include: cardiovascular disease; diabetes; behavioral health; and healthy children. Each plan will have opportunity to earn back the entire amount withheld by submitting supporting data to the Department, and this change is estimated to save approximately $208.4 million ($62.5 million state GRF) over the biennium.

- Updating Medicaid's Forecast: Medicaid forecasts are completed using rate trend assumptions based on projected health care cost inflation. For the coming biennium, Medicaid is proposing to use a lower-growth rate trend, which encourages financial discipline and reduces projected program outlays by $331.4 million ($99.6 million state GRF) in SFY 2020-2021.

- Eliminating Automatic Rate Increase for Nursing Facilities: The Department of Medicaid recommends eliminating the Medicare market-basket index from the calculation of nursing facility per diem rates. Continuing an automatic rate increase for Ohio Medicaid nursing facility providers based upon an overly-generous inflation factor unnecessarily diverts resources that could be used to assist individuals to move toward settings in their homes and communities, often at a lesser cost. For example, the average monthly cost of all care for adults in waiver programs administered by the Department of Medicaid and the Department of Aging is about $2,514 (annualized $30,163), whereas, Medicaid's average monthly expenses for an individual in a nursing facility totals $5,142 (annualized $61,701).



This effort will decrease spending by $239.6 million ($88.7 million state GRF) over the biennium. It is noteworthy that with the exception of a modest increase for ambulance and wheelchair van services, no other provider increases are being proposed through ODM administered program.

- Updating the Member-Month Reconciliation Process: The Department is proposing a new reconciliation process to ensure appropriate receipt of all managed care fee dollars due to the state, which is estimated decrease state GRF by $33.9 million over the biennium.
- Enhancing Program Integrity: Ohio Medicaid is assuming new program integrity efforts that are expected to reduce expenditures by approximately $15 million ($4.5 million state GRF) over the biennium. Other program integrity efforts are being implemented that are not projected for savings in the 2020-2021 biennium, such as the electronic visit verification, but will reduce unnecessary spending in the future.
- Enhancements to Clinical Program and Interventions: Many of the policy changes proposed in our Invest in Kids and Invest in Recovery initiatives will target investments toward populations and services where we can reduce long-term costs while improving quality of life for the individuals we serve. For example, efforts to curb infant mortality and improve postpartum care, better treat opiate addiction, enhance behavioral health services in schools, and reduce treatment of multi-system youth in expensive out-of-state placements are all areas where expensive care can be eliminated or replaced with less expensive alternatives that emphasize prevention and early intervention.

Modernizing Medicaid's Pharmacy Program & Implementing a Unified Preferred Drug List

Retail Pharmaceutical Profits
(in billions of dollars)[6]

Interest in understanding and pinpointing inefficiencies throughout the prescription drug supply chain is growing across the nation. With consumers and taxpayers facing increasingly high costs for pharmaceuticals, stakeholders are asking questions about opaque pricing and fees as dollars flow between drug manufacturers, wholesalers, retail pharmacies, payors (insurance and managed care), and pharmacy benefit managers (PBMs).

[6] The PEW Charitable Trusts. The Prescription Drug Landscape, Explored. 2019.

Ohio Medicaid's efforts to modernize its prescription drug program include driving toward greater transparency throughout the supply chain and increasing clinical efficiencies through a single preferred drug list. Together, these initiatives will result in greater visibility into ways to optimize the program's pharmacy benefits while harnessing the state's purchasing power.

On January 1, 2019 the Ohio Department of Medicaid began requiring each of its managed care plans to improve pharmacy transparency using a transparent pass-through pricing model, with the goals of moving toward 100 percent transparency, increasing simplicity, maintaining member access to needed pharmaceuticals, and aligning incentives to control pharmacy costs through the managed care plans. Our projections indicate that, at a minimum, the new pass-through model will remain budget neutral for Ohio. Additional strategies are being considered to improve transparency and control of the pharmacy program, and new pharmacy strategies will be a priority as the Department procures new managed care services.

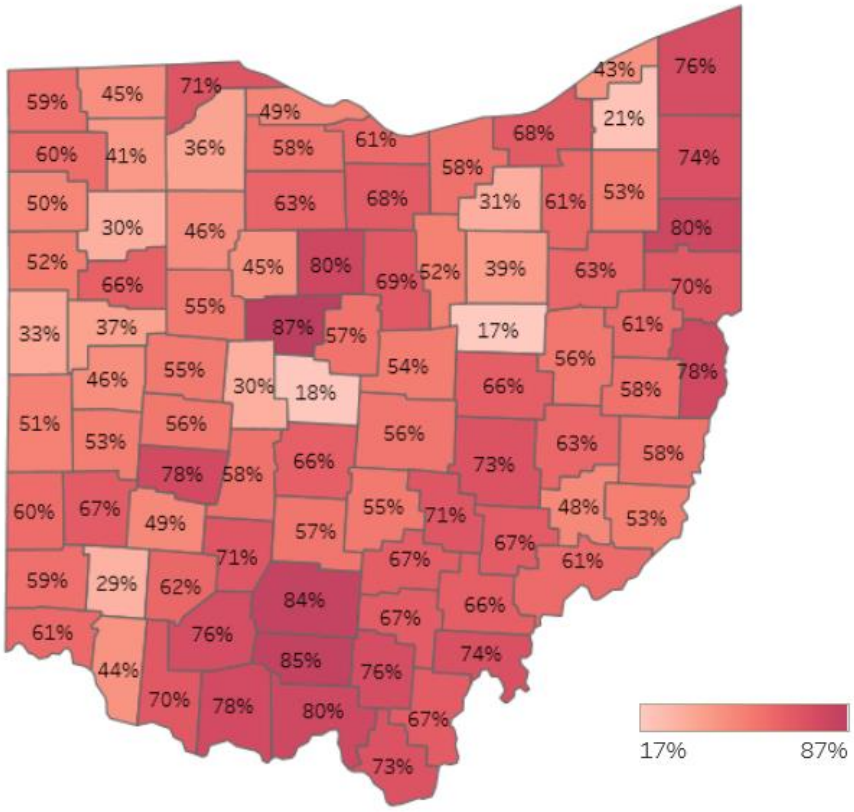
The Department is proposing a new policy to require managed care plans to follow a unified preferred drug list instead of their own formularies. With a unified drug list in place, Ohio providers will be able to learn and utilize a single list of frequently prescribed drugs for members of all five managed care plans and Medicaid's fee for service program. This will greatly simplify and reduce the burden of providing care to Medicaid members while potentially decreasing medication errors. This approach will also give the Department the ability to streamline its approaches to address changing population health needs. Moreover, uniform drug list coverage helps avoid member and provider confusion to drive improved adherence to medications for chronic conditions, improving population health outcomes. The unified preferred drug list is also expected to harness the state's purchasing power, which could offset expenses by $10.5 million in state GRF over the biennium.

DeWine Administration Policy Initiatives: Investing in Kids

Governor DeWine campaigned on the promise of creating Opportunity for Every Ohio Kid. I and all employees at the Department of Medicaid are honored and feel the awesome weight of our responsibility to support Ohio's children and families and the Governor's Office of Children's Initiatives.

Ohio's Medicaid program covers 1.6 million kids. Children within the Medicaid program are eligible because they live in families with low incomes and deserve the same chance at success in life as others with higher means. Coverage also extends to all children in the custody of child protection and those receiving adoption assistance. Medicaid is incredibly important to ensuring coverage and access to care for Ohio's youngest citizens across the state. The chart below shows that in some counties, over 80 percent of children under age 5 are enrolled in our program.

Children under 5 Enrollment by County February 2019[7]



[7] © OpenStreetMap contributors

Ohio Medicaid is dedicated to investing in evidence-based practices and leveraging data analytics to make the greatest impact we can in our children's lives. Our proposed 2020 and 2021 budget makes targeted investments in the following:

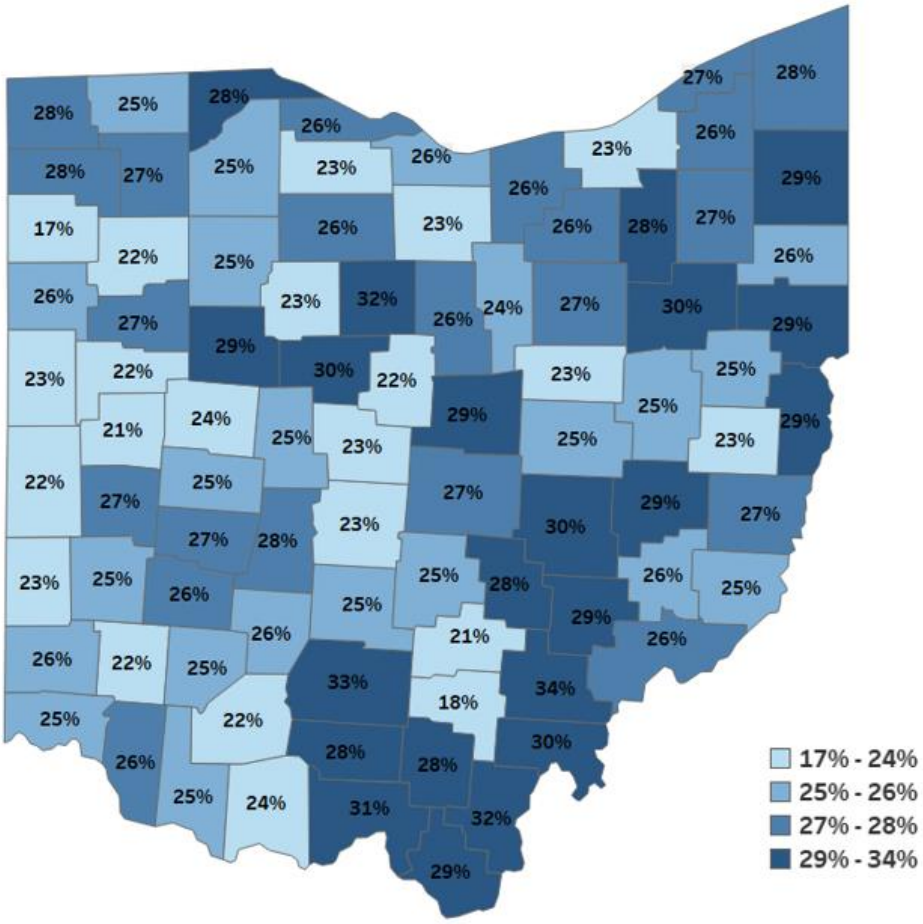
- Healthy Moms and Babies: In the coming biennium, Medicaid proposes investing $47.1 million ($14.1 million State) in home visiting services and continuing our investment of $26 million ($7.8 million State) for infant vitality efforts to reduce the disparity of African American infant deaths in nine targeted communities.
- Behavioral Health in Schools: Medicaid is changing its telehealth coverage with an eye toward facilitating access to behavioral health care in schools. We propose making a $15 million ($4.5 million State) investment in telehealth services and an additional $15 million ($4.5 million State) investment for technical and funding support for community-driven school-related health care initiatives over the biennium. These investments build on Medicaid's existing Medicaid in Schools program and School-Based Health Care Initiative, which we intend to optimize over the coming biennium.
- Child Protection Transformation: Ohio Medicaid is partnering with the Department of Job and Family Services and its Office of Child Welfare Transformation, and with the Governor's Office of Children's Initiatives to implement the Family First Prevention Services Act, which aims to prevent child welfare custody. This will include service and coordination enhancements for children with complex needs and the child protection population. The Department is also reconfiguring its Behavioral Health Care Coordination (BHCC) model, which will be further discussed in the "Investing in Recovery Section" of this testimony, to better meet the needs of a wide range of children, including those who have complex, multi-system needs and require very intensive coordination of services and supports. It is our hope that BHCC for children with complex needs will help prevent placements into more intensive levels of care (i.e. residential treatment) and will help prevent voluntary custody relinquishment due to a family's inability to access necessary care.
- Multi-System Youth: In addition to targeted service enhancements mentioned above for children with complex and multi-system needs, the Ohio Department of Medicaid plans to invest $20 million State Share for multi-system youth innovation over the biennium. Ohio Medicaid will also invest $28 million ($10.4 million State) to fund services for autism spectrum disorders in SFY 2021.
- Wellness for Kids through Comprehensive Primary Care (CPC): Today, 650,000 children, reflecting approximately half of all the children in the Medicaid program, receive care through CPC practices. The Department of Medicaid plans to refine this model of care to honor the wellness and preventive services required for the healthy growth and development of pediatric populations. Adapting this model for the pediatric population will involve a $12 million ($3.6 million State) investment over the biennium.
- Lead Testing and Hazard Control: The Ohio Department of Medicaid, in partnership with the Ohio Department of Health, proposes to invest $10 million ($1.8 million State) for lead testing and abatement activities over the biennium. The Department will also gear its new pediatric CPC program to enhance lead testing and will work with providers and the managed care plans to better track lead testing across the state.

DeWine Administration Policy Initiatives: Investing in Recovery

On the night he took office, Governor DeWine signed an executive order to create the RecoveryOhio Initiative to examine and address our state's epidemic of drug overdoses and mental illness. It is no surprise to this committee that Ohio ranks second worst in the nation for drug overdose deaths and for opioid-related overdose deaths. The number of pregnant women diagnosed with opioid-use disorder has risen over the last decade, leading more babies to experience Neonatal Abstinence Syndrome (NAS). Just 36.64 percent of Ohio's mental health needs are met by our current treatment capacity.[8]

In state fiscal year 2018, approximately 26 percent of all Medicaid enrollees received a behavioral health service, including approximately 23 percent of children (ages 0-20), and 29 percent of adults (age 21 and older).

Percentage of Medicaid Recipients who received Behavioral Health Services in SFY 2018[9]



Ohio Medicaid is collaborating with the RecoveryOhio initiative, the Department of Mental Health and Addiction Services (MHAS), the Department of Health, and other state and local entities to strengthen access to care and improve outcomes for those seeking behavioral health services. In partnership with MHAS, Medicaid continues

[8] Kaiser Family Foundation's State Health Facts

[9] Includes behavioral health inpatient and emergency department with other non-acute/non-emergent behavioral health services (26% or 942,560 Medicaid recipients statewide)

to evaluate the early effects of Behavioral Health Redesign and managed care integration on the comprehensive behavioral health system while working to stabilize the recently restructured behavioral health benefit package of services.

1115 Substance Use Disorder Services Waiver – Design & Implementation

In 2018, the Centers for Medicare and Medicaid Services (CMS) approached the Ohio Department of Medicaid regarding its payment model for SUD residential treatment services. CMS strongly urged the Department to pursue an 1115 waiver for SUD services to ensure continued federal financial participation for individuals served in some residential treatment settings. Ohio Medicaid is working with MHAS to design the waiver application. Pursuing and implementing this waiver will require a $7.5 million ($1.9 million State) investment in its design and evaluation over the coming biennium.

In addition to ensuring continued federal financial participation for SUD services, gaining approval for the 1115 SUD waiver will require significant enhancements to Medicaid's care coordination services. To meet these requirements, Ohio Medicaid and the Department of Mental Health and Addiction Services have been working to design a robust Behavioral Health Care Coordination (BHCC) model targeted at individuals with the most complex and urgent substance use disorder and mental health needs. BHCC will reward practices that affirmatively seek out and engage individuals in care, maintain their recovery, and stabilize the total cost of care. The Department is working to refine the program design to address the needs of multi-system children and youth with significant behavioral health challenges, and to ensure the most cost-effective design for the program. Implementation of BHCC is targeted for later this year. To implement BHCC in accordance with the care coordination requirement of the SUD Waiver, Ohio Medicaid will need to invest $338 million ($50.6 million State) over the biennium. It is important to note that under the Centers for Medicare and Medicaid Services Health Homes provision, this program will receive an enhanced federal match.

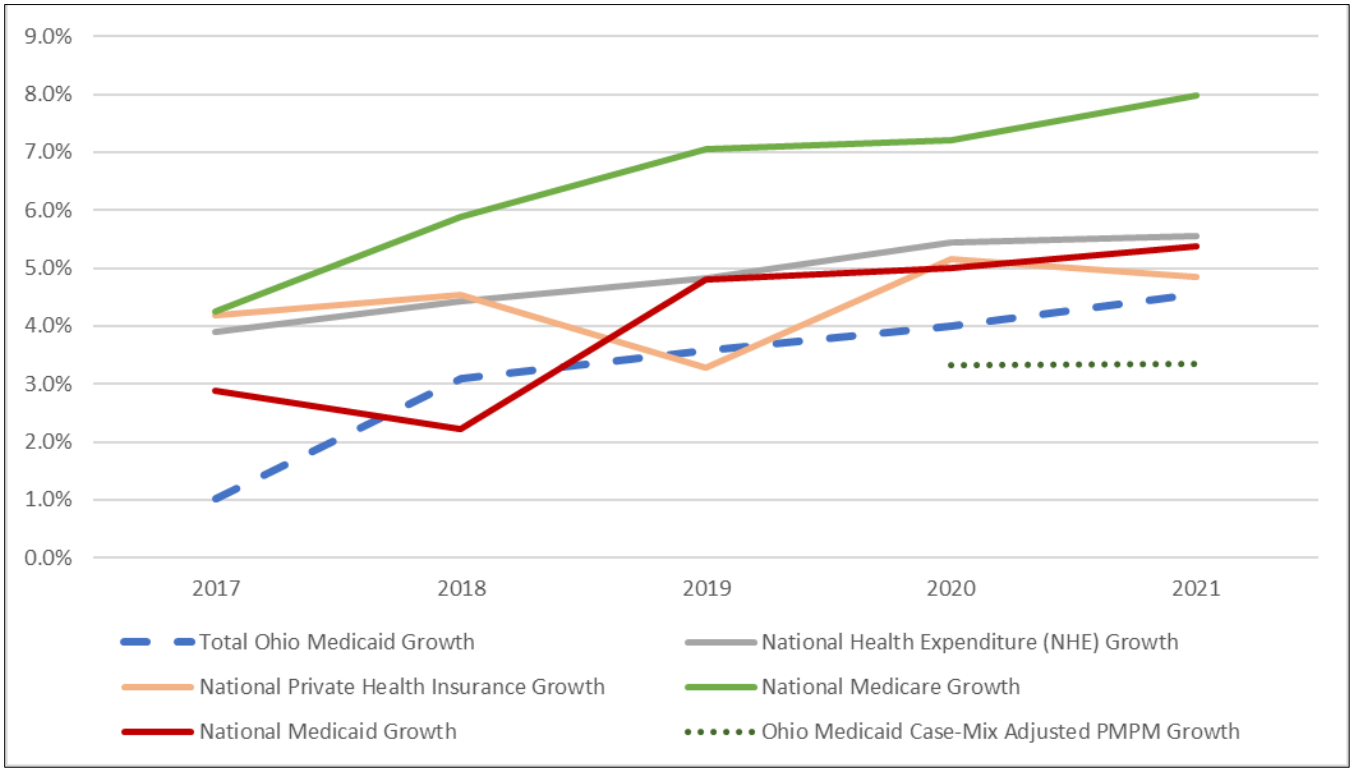
The 1115 waiver is presenting opportunities to improve clinical consistency while measuring service outcomes and performance, and it is a potential vehicle to improve care for pregnant women with opioid use disorder and their infants, some of whom may have neonatal abstinence syndrome (NAS). Mounting clinical evidence suggests that optimal care for a mother with opioid use disorder and/or a baby with NAS includes allowing moms and babies to stay together, but today, many moms in treatment are separated from their infants and many babies with NAS are taken into child protection custody. With this in mind, Ohio is proposing to design a new "dyad care" model to provide treatment and supports to co-located moms and infants. The Department also plans to request CMS approval to allow pregnant women in the Medicaid program to have 12 months of continuous eligibility following delivery, thereby guaranteeing coverage and access to care for moms and their infants. Together, these efforts will require a $30.6 million ($10.1 million State) investment over the biennium.

Closing Remarks

In closing, I appreciate the opportunity to present our executive budget proposal to you today. As you know, the Ohio Department of Medicaid has an enormous responsibility to provide health care for Ohio's most vulnerable individuals, maintain the highest levels of accountability to taxpayers, and ultimately, make a positive difference in our state. We respectfully ask for the legislature's support as we target investments toward our most pressing issues, and we look forward to an open and collaborative process with you as budget deliberations proceed. My staff and I welcome your feedback and ideas on how we can best work together to ensure all Ohioans have an opportunity to achieve the positive health outcomes they deserve. I welcome your questions and comments.

Appendix 1: Measures of Health Expenditure Growth, Including Ohio Medicaid Historical and Projected Growth

Measures of Health Expenditure Growth (2017 - Projected 2021)[10]



[10] Ohio Department of Medicaid and Centers for Medicaid and Medicare Services. Available at: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata

Appendix 2: ODM Baseline Medicaid Forecast Comparison To LSC

Process and Findings

ODM and LSC both independently forecast Medicaid services provided by the Ohio Department of Medicaid prior to introduction of the budget bill. Because it is current law (HB49) Ohio Medicaid's forecast included the cost of the nursing facility market basket increase in the baseline. It is our understanding that LSC did not include this cost. To make a direct comparison, Medicaid added the cost of the nursing facility increase into LSC's baseline forecast in the tables below.

- Overall, the forecasts are about 1% different in terms of overall expenditures and caseload for FY20/21.
- Variance for the Biennium is 0.9% (all funds) with ODM's baseline forecast $383M lower than the LSC forecast over a total of $42B in services expenditures forecasted.
    - State share variance is slightly closer, only 0.8% variance over the biennium with the ODM baseline forecast $103M lower than LSC. (See Table 1)
    - The caseload variance is one percent, with LSC having a slightly higher caseload. (See Table 2)

Table 1: Expenditure Variance – ODM Medicaid Services

	ODM Baseline	LSC	Difference	% Variance
SFY20				
All Funds	$20,529,679,911	$20,857,807,789	($328,127,878)	-1.6%
State Share	$6,202,933,031	$6,299,678,731	($96,745,700)	-1.6%
SFY21				
All Funds	$21,605,617,166	$21,660,467,363	($54,850,197)	-0.3%
State Share	$6,648,696,663	$6,654,915,725	($6,219,062)	-0.1%
Biennium				
All Funds	$42,135,297,077	$42,518,275,152	($382,978,075)	-0.9%
State Share	$12,851,629,694	$12,954,594,456	($102,964,762)	-0.8%

Note: Dollars are baseline only and include only ODM claims and capitation payments. The amounts exclude programs such HCAP, Medicare premium assistance payments and program administration.

Table 2: Caseload Variance – Average Monthly Caseload

	ODM Baseline	LSC	Difference	% Variance
SFY20				
Total	2,787,352	2,831,807	(44,455)	-1.6%
SFY21			-	
Total	2,782,751	2,799,822	(17,071)	-0.6%
Biennium			-	
Average	2,785,052	2,815,815	(30,763)	-1.1%

Appendix 3: Diversity and Inclusion at the Ohio Department of Medicaid

In-step with Governor DeWine's priority to promote diversity, the Ohio Department of Medicaid is committed to fostering a diverse workforce. Recently awarded the State's Diversity and Inclusion Award for a diverse, equitable and inclusive work environment, we value our employees and realize it is our differences that allow us to better serve Ohio.

All employee breakdown by gender and ethnicity (604 total employees)

All Employees	
Gender	
Female	416
Male	188
Ethnicity	
Asian/Pacific Islander	34
Black or African American	162
Hispanic	6
Two or More Races	2
White	400

All Employees		
Ethnicity	**Gender**	
Asian/Pacific Islander	Female	20
Asian/Pacific Islander	Male	14
Black or African American	Female	127
Black or African American	Male	35
Hispanic	Female	3
Hispanic	Male	3
Two or More Races	Female	2
White	Female	264
White	Male	136

Supervisor breakdown by gender and ethnicity (135 total supervisors)

Supervisors	
Gender	
Female	89
Male	46
Ethnicity	
Asian/Pacific Islander	11
Black or African American	20
Hispanic	2
White	102

Supervisors		
Ethnicity	**Gender**	
Asian/Pacific Islander	Female	7
Asian/Pacific Islander	Male	4
Black or African American	Female	14
Black or African American	Male	6
Hispanic	Male	2
White	Female	68
White	Male	34

Appendix 4: Optumas Projected Growth Rates

Overall Projection – Without Nursing Facility Market Basket

	PMPM		Trend	
SFY	Lower Bound	Upper Bound	Lower Bound	Upper Bound
2020	$655	$673	2.4%	4.0%
2021	$671	$701	2.5%	4.2%
2019 - 2021			2.5%	4.1%

Overall Projection – With Nursing Facility Market Basket

	Projection PMPM		Annualized Trend	
SFY	Lower Bound	Upper Bound	Lower Bound	Upper Bound
2020	$657	$675	2.8%	4.4%
2021	$677	$707	2.9%	4.6%
2019 - 2021			2.9%	4.5%

Appendix 5: SFY 2020-2021 Executive Budget Proposed Policy Changes

			FY20			FY21		
Category	Description	Start Date	All Funds	GRF Total	GRF State	All Funds	GRF Total	GRF State
Kids, Recovery	Home visiting	1-Jan-20	$ 13.4	$ 13.4	$ 4.0	$ 33.7	$ 33.7	$ 10.1
Kids, Recovery	Linking pregnant moms to services	1-Jul-20	$ -	$ -	$ -	$ 10.0	$ -	$ -
Kids, Recovery	12-month enhanced postpartum care	1-Jul-20	$ -	$ -	$ -	$ 15.0	$ 15.0	$ 5.4
Kids, Recovery	Mother/baby dyad care for women with OUD	1-Jan-20	$ 5.2	$ 5.2	$ 1.6	$ 10.4	$ 10.4	$ 3.1
Kids, Recovery	Behavioral health in schools	1-Jan-20	$ 5.0	$ 5.0	$ 1.5	$ 10.0	$ 10.0	$ 3.0
Kids, Recovery	Expand telehealth	1-Jan-20	$ 5.0	$ 5.0	$ 1.5	$ 10.0	$ 10.0	$ 3.0
Kids, Recovery	Establish Multi-System Youth and Innovation	1-Jul-19	$ 10.0	$ -	$ -	$ 10.0	$ -	$ -
Kids, Recovery	Access to autism services	1-Jul-20	$ -	$ -	$ -	$ 28.1	$ 28.1	$ 10.4
Kids	Wellness for kids: pediatric CPC	1-Jan-20	$ 4.0	$ 4.0	$ 1.2	$ 8.0	$ 8.0	$ 2.4
Kids	Lead testing and hazard control	1-Jul-19	$ 5.0	$ 5.0	$ 0.6	$ 5.0	$ 5.0	$ 1.2
Recovery	1115 SUD waiver authorization/evaluation	1-Jan-20	$ 2.5	$ 0.6	$ 0.6	$ 5.0	$ 1.3	$ 1.3
Recovery	Add Behavioral Health Care Coordination	1-Jan-20	$ 204.9	$ 204.9	$ 22.3	$ 133.1	$ 133.1	$ 28.3
SQA	Procuring managed care value	1-Jul-19	$ 3.5	$ 1.8	$ 1.8	$ 3.5	$ 1.8	$ 1.8
SQA	Modernizing pharmacy program	1-Jul-20	$ -	$ -	$ -	$ 35.0	$ (35.1)	$ (10.5)
SQA	Up and out (work requirement)	1-Jul-19	$ 15.5	$ 5.1	$ 5.1	$ 12.5	$ 4.4	$ 4.4
SQA	Eliminate automatic NF rate inflator	1-Jul-19	$ (74.8)	$ (74.8)	$ (27.7)	$ (164.8)	$ (164.8)	$ (61.0)
SQA	Ensuring access to community support-	1-Jul-19	$ 10.2	$ 10.2	$ 3.1	$ 20.4	$ 20.4	$ 6.1
SQA	Ensuring access to community support-DODD	1-Jan-20	$ 58.7	$ 18.5	$ 18.5	$ 138.8	$ 12.9	$ 12.9
SQA	Increase managed care performance	1-Jan-20	$ (67.1)	$ (67.1)	$ (20.1)	$ (141.3)	$ (141.3)	$ (42.4)
SQA	Managed care lower bound trend assumption	1-Jan-20	$ (80.4)	$ (80.3)	$ (24.1)	$ (251.0)	$ (251.0)	$ (75.5)
SQA	Billing of retroactive member months	1-Jul-19	$ -	$ (74.7)	$ (22.4)	$ -	$ (38.3)	$ (11.5)
SQA	Program integrity	1-Jan-20	$ (5.0)	$ (5.0)	$ (1.5)	$ (10.0)	$ (10.0)	$ (3.0)
SQA	Hospital Franchise Fee Alignment	1-Jul-19	$ 383.3	$ (53.4)	$ (16.0)	$ 502.8	$ (54.2)	$ (16.3)
		Total	**$ 498.8**	**$ (76.7)**	**$ (50.1)**	**$ 424.1**	**$ (400.8)**	**$ (127.0)**

Appendix 6: Example of Managed Care Plan Performance

Ohio Department of Medicaid

Managed Care Financial Dashboard

Cost Reports through December 31, 2018

Summary of Cost Report Income Statements: Medicaid Only

Claims Incurred During Calendar Year (CY) 2018 and Paid through December 2018

Medicaid Managed Care (MMC)	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Composite
% Market Share							
Gross Revenue							
Net Medical Expense							
Care Management							
Administrative Expense							
Taxes, Fees, and Add-On Programs							
Net Underwriting Gain							
Net Underwriting Gain %							
Medical Loss Ratio (MLR)							

MyCare Ohio	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Composite
% Market Share							
Gross Revenue							
Net Medical Expense							
Care Management							
Administrative Expense							
Taxes, Fees, and Add-On Programs							
Net Underwriting Gain							
Net Underwriting Gain %							
Medical Loss Ratio (MLR)							

Total	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Composite
% Market Share							
Gross Revenue							
Net Medical Expense							
Care Management							
Administrative Expense							
Taxes, Fees, and Add-On Programs							
Net Underwriting Gain							
Net Underwriting Gain %							
Medical Loss Ratio (MLR)							

Note: All dollar values are displayed on a PMPM (per member per month of eligibility) basis.

Note: All dollar values are displayed on a PMPM (per member per month of eligibility) basis.

Ohio Department of Medicaid

Managed Care Financial Dashboard

Cost Reports through December 31, 2018

Definitions

Actual Experience - From the cost reports, total dollar amount divided by the total number of member months for the State.

Administrative Expense Ratio - The portion of the capitation payment that is spent on operating expenses necessary to administer the program.

Care Management - MCP/MCOP expenses attributable to Case Management, Healthcare Information Technology, and Medical Management. Consistent with Healthcare Quality Improvement (HCQI).

Gross Revenues - Total revenue received, including capitation, delivery payments, reimbursement for add-on programs, quality withhold return along with other taxes, fees, and income.

Medical Loss Ratio (MLR) - The portion of the capitation payment that is spent on all medical services eligible under the program. For the purposes of this dashboard, MLR is calculated as the ratio of the sum of Net Medical Expense and Care Management compared to Gross revenue less Taxes, Fees, and Add-On Programs.

Net Medical Expense - The total of paid and incurred but not paid medical expense, less post-payment recoveries and rebates.

Taxes, Fees, and Add-On Programs - HIC Tax, HIC Franchise Fee, Other Taxes and Fees, Health Insurance Providers Fee, MCP/Hospital Incentive, Enhanced Maternal Program, and CICIP Program.

Underwriting Gain Ratio - The ratio of the capitation payment that is over or under calculated costs for medical services and administration for the MCP. Includes consideration for revenue from quality withhold returns. Note that no other revenue items are considered in this ratio unless otherwise noted.

Acronyms and Abbreviations

ABD - Aged, Blind, and Disabled

AFK - Adoption and Foster Kids

CFC - Covered Families and Children

CICIP - Care Innovation and Community Improvement Program

COS - Category of Service

EXT - Extension

HIC - Health Insuring Corporation

HCQI - Healthcare Quality Improvement

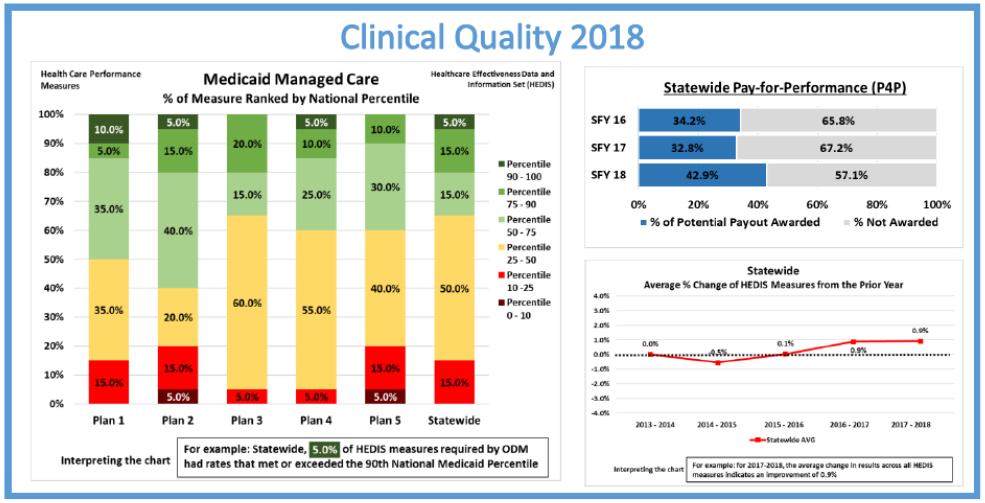
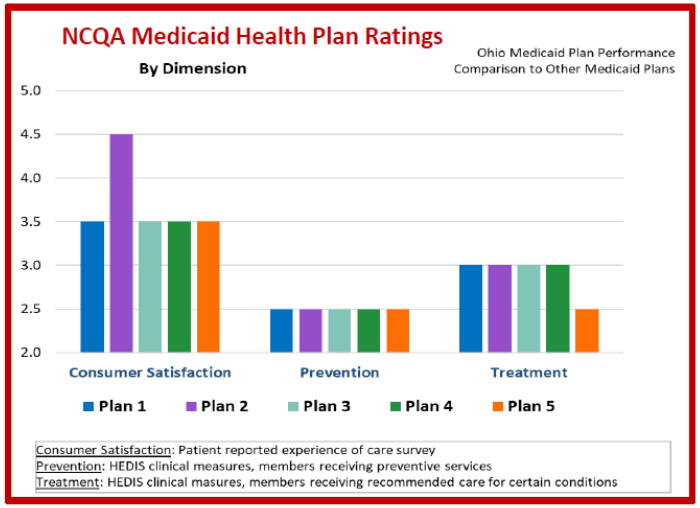
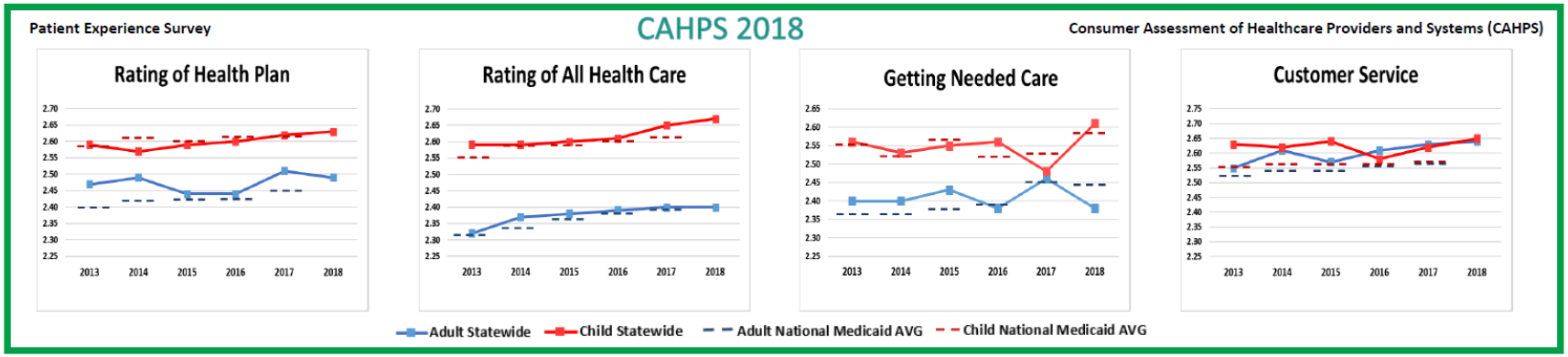
MCP - Managed Care Plan

MCOP - Managed Care Ohio Plan

MLR - Medical Loss Ratio

NFLOC - Nursing Facility Level of Care

PMPM - Per Member Per Month

Rad/Path/Lab - Radiology, Pathology, and Laboratory

Appendix 7: Medicaid Consumer Dashboard March 2019