Ohio Commission to Reform Medicaid

Recommendations List – Condensed

December 13, 2004

A. LONG-TERM CARE AND CARE MANAGEMENT

Recommendation 1: Balance the use of limited public resources to ensure access to a wide array of long-term care service and financing options in home and community-based settings or in institutions.

Action Step 1: Remove the nursing home reimbursement formula from Ohio statute, and give the executive branch authority to negotiate fair and reasonable rates that require nursing homes to achieve performance-based outcomes and objectives. This should happen in connection with the phase out of Certificate of Need.[1]

Action Step 2: Phase out the current Certificate of Need for Ohio's nursing homes.

Action Step 3: Offer assisted living as a Medicaid option.

Recommendation 2: Ensure that elderly and disabled Ohioans and their families/caregivers have easy and immediate access to needed information about long-term care service options, especially in a crisis situation.

Action Step 1: Create a more comprehensive preadmission screening process for any Ohioan in need of Medicaid–funded long-term care, especially nursing home care:

a. Require an in-person Pre-Admission Assessment for all consumers who will require Medicaid payment within six months; and/or
b. Expedite the eligibility determination process to allow Medicaid-funded providers to begin serving a consumer as quickly as a nursing facility could, regardless of whether the consumer's need is for NF or HCBS.

Action Step 2: Establish Long-Term Care Resources Centers in each Area Agency on Aging service area.

[1] See Action Step 2.

Within six months, establish at least one Long-term Care Resource Center in each AAA region in the state.[2] Require co-location of county eligibility determination workers to ensure speedy access to eligibility decisions and information. Develop comprehensive information on state and locally funded long-term care options in each service area. Provide care planning and family caregiver support to all who request such assistance. Provide comprehensive educational information and a coordinated state and local information campaign to educate health care professionals and other "gatekeepers" regarding new state policy and program initiatives and service options under development.

Recommendation 3: Encourage personal choice and responsibility.

Action Step 1: Modify Ohio's estate recovery process to align with federal Medicaid estate recovery law. In addition, use waivers to create incentives through an estate recovery model for consumers to select the lowest cost care options. Components include:

a. Expand the list of assets recoverable outside of state probate law, to include other real and personal property and other assets in which the individual had any legal title or interest at the time of death.
b. Restructure the estate recovery process to receive federal match for the legal administrative costs involved.
c. Consider establishing "tiered asset recovery policies" which give consumers and their heirs the opportunity to share in the benefits of cost containment when they choose alternatives that save the state money.

Action Step 2: Establish a long-term care "voucher system" (sometimes referred to as "Cash and Counseling") that would ensure that "money follows the person."

Action Step 3: Increase assets that may be retained by income-eligible Medicaid waiver applicants to avoid premature admission to an institutional setting.

Recommendation 4: Create a cost-efficient long-term care system with consolidated budgets, data collection and planning.

Action Step 1: Create a unified long-term care budget managed across all state funded service delivery agencies and service settings, and establish a

[2] If policy were to evolve to the point that services for younger persons with disabilities would be managed through the same state system as those for older persons, these centers would be called Aging and Disabilities Resource Centers.

single accountable head to provide leadership and direction for meeting the long-term care needs of Ohioans.

Action Step 2: Establish a long-term care policy coordinating body with authority that spans all state long-term care plans and programs.

Recommendation 5: Establish a statewide care management program for all Medicaid recipients.

Action Step 1: Expand care management in Ohio Medicaid to statewide enrollment of covered families and children and aged, blind and disabled adults who are not enrolled in Medicare. Strategies for managed care expansion may include a combination of expanded managed care enrollment, Enhanced Care Management (ECM), and expanded care management of older adults through Area Agencies on Aging (AAAs). In such expansion, risk-based payments to managed care organizations should be actuarially sound.

Action Step 2: Expand financial incentives in various Medicaid managed care capitation rates, including managed care plans, that develop and implement protocols specifically designed to improve outcomes through improved patient education and compliance, deployment of community health education and outreach workers, and coordination with public and private social service organizations to support adherence to those protocols. During the 2006-2007 biennium, these should include:

1. Prenatal care beginning during the first trimester;
2. Diabetes;
3. Asthma;
4. Chronic obstructive pulmonary disease;
5. Chronic heart failure; and,
6. Delaying or preventing nursing home admissions.

Action Step 4: Improve the management, quality review and financial strength of Medicaid managed care by:

- Increasing the level of coordination between the Ohio Department of Insurance, Ohio Department of Job and Family Services and the state contracted actuary in July 2005 to determine the capitation rates to be paid to the Medicaid Managed Care Plans to ensure actuarial soundness, as currently required under federal law.
- Adopting nationally recognized quality performance standards for Medicaid managed care.
- Requiring managed care entities to purchase surety bonds to further strengthen the risk-based capital and financial solvency requirements.
- Informing care management organizations doing or seeking to do business in Ohio about Ohio Medicaid's expenditure growth target,

and inviting initiatives that will enable them to support state government in meeting spending targets.

Action Step 5: Establish a Managed Care Working Group (MCWG) among representatives of Medicaid HMOs, major health care professional and trade associations, consumer advocates, and state agencies including the departments of Health, Insurance, Job and Family Services, Aging, Mental Health, Drug and Alcohol Addiction Services, Mental Retardation/Developmental Disabilities, and the Rehabilitation Services Commission. The purpose of the MCWG would be to increase consistency in, and better manage regulatory relationships and contractually related process issues between, the major parties in managed care systems.

B. PHARMACY

Recommendation 1: Secure the best prices for drugs (brand, generics and over-the counter prescribed medications) through expansion of buying power and creation of a more competitive market for price negotiation.

Action Step 1: Consolidate all drug purchasing by the state and other Ohio public entities with Ohio Medicaid for the purposes of negotiating rebates of individual drugs. At the same time, analyze the financial benefits of expanding the pool further through participation in newly emerging multi-state drug purchasing pools.

Action Step 2: Lift restrictions in the current rebate system which exclude certain Medicaid purchases from negotiated cost recovery: these include mental health and HIV/AIDS drugs, physician office purchases, and purchases in the Disability Assistance Medical program.

Action Step 3: Overhaul the current system of drug rebates and replace it with a system that allows for open, prospectively negotiated and publicly transparent individual drug discounts based on competitive pricing.

Recommendation 2: Restrict drugs eligible for payment under Medicaid program using a more limited formulary than currently in place, with preferred status going to similar, if not identical, lower cost drugs.

Action Step 1: Limit the number of preferred drugs to effective, lower cost products, and require documentation and prior authorization for off-formulary use.

Action Step 2: Regularly evaluate and promulgate evidence-based research on the use of prescription drug therapies, and utilize efforts such as prior-authorization to assure their practice.

Action Step 3: Set incremental time specific goals for increasing the use of generic as opposed to patented drugs as percent of all drug expenditures.

Recommendation 3: Reduce State expenditure at the point-of-purchase of Medicaid drugs.

Action Step 1: Bring Medicaid pharmacy reimbursement into parity with commercial insurers.

Action Step 2: Create a system of modest patient cost-sharing for all drug purchases to align with other states' Medicaid programs.

Action Step 3: Implement a mail-order program for Chronic Care Maintenance Medications.

Recommendation 4: Set up systems to monitor cost effective management of drugs by Medicaid reimbursed prescribing physicians and health plans.

Action Step 1: Initiate Medication Therapy Management.

Action Step 2: Provide incentives for physicians and hospitals to move to toward electronic prescribing supported by evidence-based research, practice guidelines and step therapy to improve health care quality and to reduce prescribing errors and cost.

Recommendation 5: Shift to the schedule of covered drug benefits under Medicare Part D in January 2006, without offering state subsidies for additional drugs not covered under that program.

C. ELIGIBILITY

Inherent in the recommendation: **The Commission believes that Medicaid eligibility standards for low-income families and children should be maintained by the Governor and General Assembly.**

Recommendation 1: Effective July 1, 2005, terminate the duplicative disability determination process administered by the ODJFS Office of County Medical Services, require ABD Medicaid applicants to first apply for federal Old Age, Survivors and Disability Insurance (OASDI) and Social Security Income (SSI), showing proof of such application, and base disability determination upon disability reviews conducted for the Social Security Administration (SSA) by the Bureau of Disability Determination Services at the Rehabilitation Services Commission (RSC).

Recommendation 2: Further develop data and policy alternatives for changing Ohio's Medicaid State Plan from 209(b) status to 1634 status. Such a change has the potential of (1) more closely aligning ABD eligibility with financial need; (2) modifying the service offerings for spend-down clients to provide greater consumer choice and reduce reliance on institutional long-term care services; and (3) reducing the rate of growth in Medicaid costs for ABD clients.

Recommendation 3: Expand health care coverage through a better-defined relationship between Medicaid and employer-based health plans. The Commission includes in this broad recommendation the following specifics:

Action Step 1: Collect premiums from persons receiving transitional Medicaid benefits.

Action Step 2: Require certain Medicaid recipients to enroll in private insurance.

Action Step 3: Establish a Medicaid Buy-In Program for People with Disabilities in tandem with Commission recommendations to control of the rapid growth in Medicaid spending.

D. FINANCE

<u>Recommendation 1</u>: Establish a firm annual spending target for Medicaid. Beginning with the 2006-07 biennium, annual appropriations to the Ohio Department of Job and Family Services' 525 account should be based upon actual spending for the most recent fiscal year for which data are available, adjusted for changes in the number of participants and health care costs.

<u>Recommendation 2</u>: Freeze at SFY 2005 levels fee-for-service payment rates for hospital inpatient services and decrease by 3 percent payment for nursing home services and intermediate care facility/mental retardation (ICF/MR services) – during the 2006 – 07 biennium.

<u>Recommendation 3:</u> Optimize payment and cash flow schedule. Establish a "just-in-time" program that pays all bills no sooner than the end of the month after receipt of valid invoice.

<u>Recommendation 4:</u> Identify areas in the federal government where recovery of monies can be maximized.

<u>Recommendation 5</u>: Ohio Medicaid should shift from a cost-plus basis to a prospective basis for reimbursing long-term acute care hospitals and rehabilitation hospitals.

E. STRUCTURE AND MANAGEMENT

Recommendation 1: Provide the Auditor of State with necessary statutory and budget authority to conduct both Medicaid provider audits in order to reduce fraud, waste and abuse, and program performance audits in order to improve overall effectiveness.

Design and implement a comprehensive program of fiscal compliance and performance audits to improve effectiveness and overall operation of Medicaid program.

Recommendation 2: Increase Medicaid's access to clinical and analytical resources for the improvement of health care delivery and financing through collaboration with Academic Medical Centers (AMC). The Commission recommends, during calendar year 2005, that Ohio Medicaid seek out and develop at least one multi-year collaborative relationship with one of Ohio's Academic Medical Centers.

Recommendation 3: Update Ohio's Medicaid information systems with current technology.

Recommendation 4: Restructure Ohio Medicaid through a multi-step process over the State Fiscal Year '06 and '07 biennial budget.

Action Step 1: Appoint a Medicaid Transition Council. The Commission recommends that the Governor, by January 2005 through Executive Order, appoint a Medicaid Transformation Council for a two-year period to oversee the process of transitioning and restructuring Ohio's Medicaid state organizational structure and system. The Council should focus first on establishing a Medicaid financing function within state government.

Action Step 2: Create an Ohio Department of Medicaid that will effectively streamline cabinet agencies and Medicaid services, and provide a more efficient platform for delivering care to Medicaid consumers.

Recommendation 5: Leverage Ohio Medicaid's buying power through greater use of care management, selective contracting, and pay for performance.

Action Step 1: Move from doing business with everyone ("any willing provider") to selective contracting, consistent with federal guidelines. Act upon what Ohio has authority to do in selective contracting, including laboratory services and medical devices. Expand capability to selectively contract for durable medical equipment, non-emergency transportation, specialty in-patient, and other services.

Action Step 2: Implement a Pay-for-Performance strategy for providers to maximize state return on investments.

F. Further Consideration

1. Medicaid in the local social service delivery system

2. Nursing Home admissions of people diagnosed with mental illness other than dementia and prescription rates for antianxiety, antidepressant and antipsychotic drugs in nursing homes:

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