BRT State Budget Initiative

November 10, 2010

DRAFT

OHIO BUSINESS ROUNDTABLE

Executive Summary- Ohio Business Roundtable Budget Work

- At the request of its membership, the **Ohio Business Roundtable has undertaken an overarching review of the budget**, analyzing the overall state of Ohio's budget and it's looming $8 billion budget gap as well as **potential opportunities for improvement**
- The review looked deeply into **Ohio' Medicaid program** and identified potential savings **levers worth roughly $2 billion** in state dollars over the biennium
- The review also took a deep look into **Ohio's K-12 education spend**, analyzing the system for efficiency and operational improvements that could save money. The review identified savings **levers worth $2-4 billion** in state dollars over the biennium
- Other areas of **light review included prisons/corrections, higher education, state benefits and pensions, and overarching government structure**, with additional savings identified in the **range of $1-2 billion** in state dollars
- While we acknowledge that closing the budget gap represents a massive challenge for the state, we believe the need to **set Ohio back on the path to prosperity** outweighs the shorter-term discomfort that will no doubt arise from making difficult choices. The time to act is now, and we respectfully submit our work as a **potential source of insight and menu of opportunities** to resolve Ohio's budget gap.

Team charter and objectives

Ohio Business Roundtable Executive Committee

Project objective: to conduct an independent review of Ohio's budget situation and develop a menu of potential options for improvement

- Considering all options through the lens of what is best for the state of Ohio
- Develop perspective on current budget gap, including overall sizing, benchmarking of Ohio vs. other states, identification of range of levers to close gap
- Conduct deep dives into 1) Medicaid and HealthCare Financing and 2) Education
  - Build factbase on current spend
  - Develop range of options of cost savings measures with lens of what is best for Ohio
- Conduct "light touch" analyses on other areas of interest to BRT membership

Team structure

Steering Committee
- John Barrett, Chair, (EC member)
- Mike Connelly
- Erin Hoeflinger
- Steve Steinour
- Frank Sullivan (EC member)
- Tim Timken (EC member)
- George Vincent
- Tom Zenty

Project leadership
- Richard Stoff
- John Warner, McKinsey
- Brandon Carrus, McKinsey
- Brendan Buescher, McKinsey

Team leads
- Jennifer Carlson (on loan to the BRT from OSU Medical Center)
- Aaron Flohrs, McKinsey

Working team
- Arvind Sohoni, McKinsey
- Ken Harbaugh, McKinsey
- Budget, Medicaid, and Education experts as needed

Topics of discussion for today

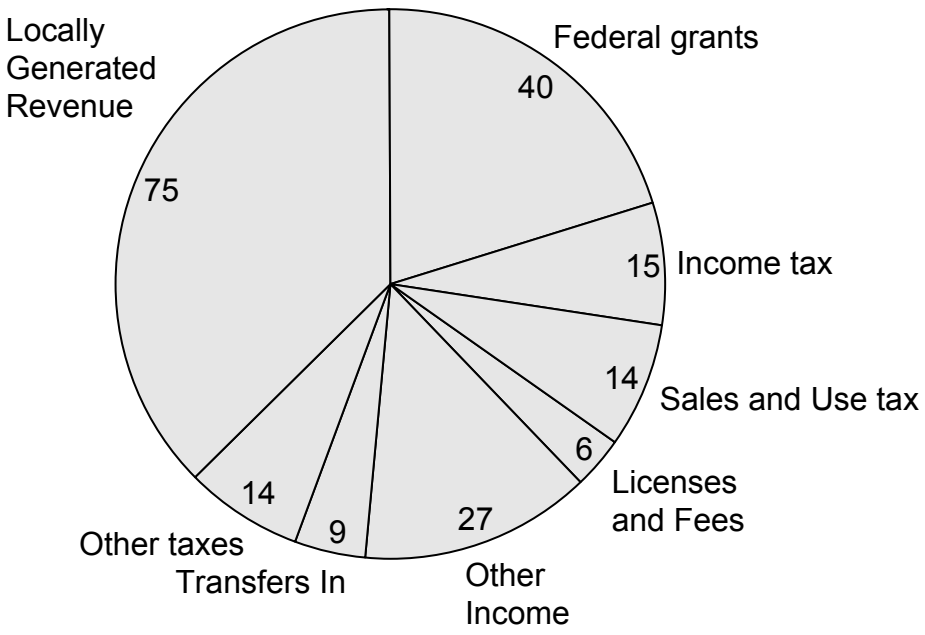
- **General budget and the upcoming gap**
- **Medicaid / Healthcare Financing**
- **K-12 Education**
- **Other opportunities**

Ohio total revenue and expenditure picture- a $200 billion business

ROUGH ESTIMATES

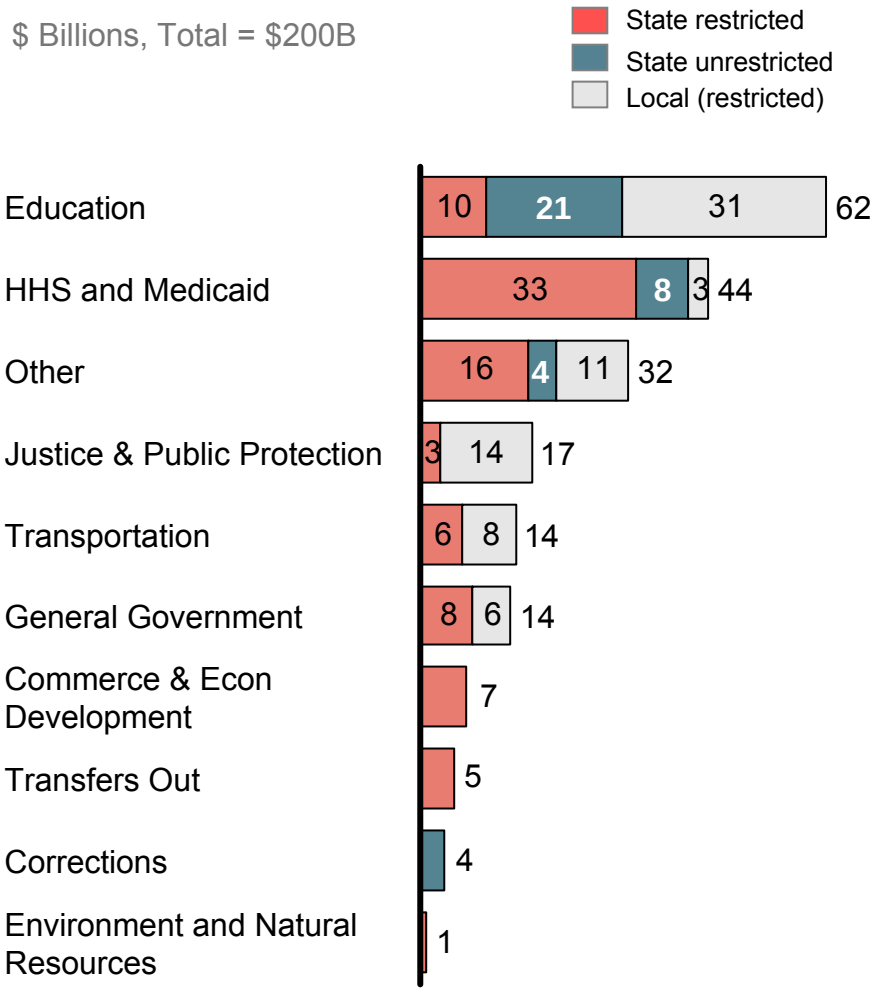
Total Ohio state and local revenue, FYs 10-11

$ Billions, Total = $200B



Expenditures, FYs 10-11

$ Billions, Total = $200B



SOURCE: Ohio Office of Budget and Management, Ohio Legislative Services Commission, McKinsey analysis

Ohio's projected budget gap ranges from $5-$11 billion based on varying growth and spending projections

Most likely

Inputs	Scenario		
	Negative	Baseline	Positive
Economic growth in 2012-2013	0%	1.1%, 1.5%	2.2%, 3.1%
Federal grant-making levels	Keep constant with economic growth in 2012-2013		
Increase in state spending in 2012-2013*	2.6%	2.6%	0%
Loss of one-time funding (e.g., stimulus)**	$8B	$8B	$8B
Additional political expenditure impacts***	$2.8B	0	0
Total size of budget gap	$11B	$8B	$5B

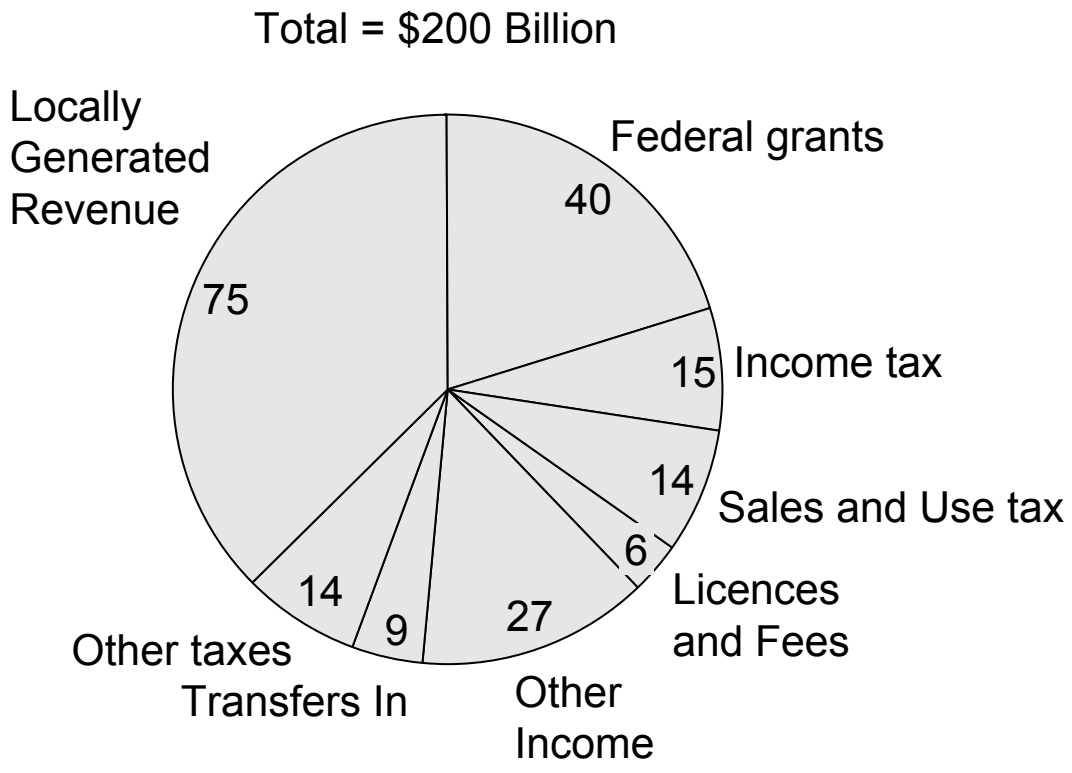
* Ohio Legislative Service Commission (2.6% = compound annual growth in spending, 2001-2011)
** Ohio OBM, Ohio Legislative Service Commission
*** Includes possible expiration of HMO and bed taxes, declines in FMAP percentage, Interest on Unemployment Compensation Debt, GRF subsidy for CAT shortfall

Ohio total revenue (state and local) derives from multiple sources

ROUGH ESTIMATES

Total Ohio state and local revenue, FYs 10-11

$ Billions



- Major revenue sources for Ohio are local revenue, federal grants and two major buckets of tax- personal income and sales/use tax
- Personal income and sales tax generally considered as major sources of state's general spending- most other sources of revenue are placed in restricted funds and appropriated accordingly (see next page)

SOURCE: Ohio Office of Budget and Management, Ohio Legislative Services Commission, McKinsey analysis

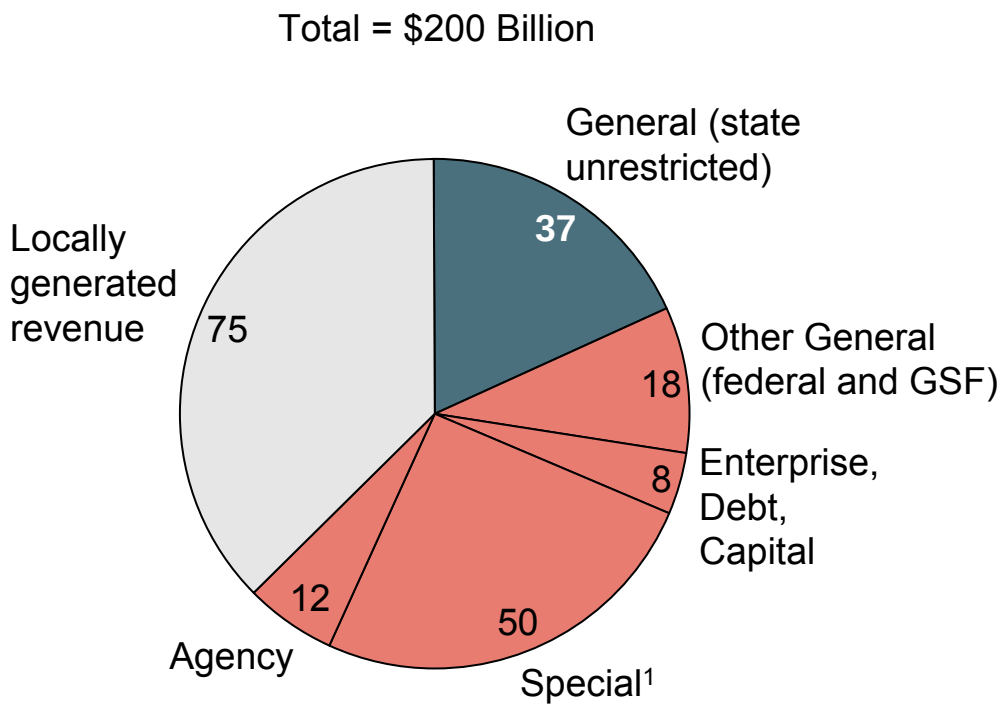
Depending on source, revenue flows into restricted and unrestricted funds

ROUGH ESTIMATES

- Local restricted
- State restricted
- State unrestricted

Revenue funds, FYs 10-11

$ Billions

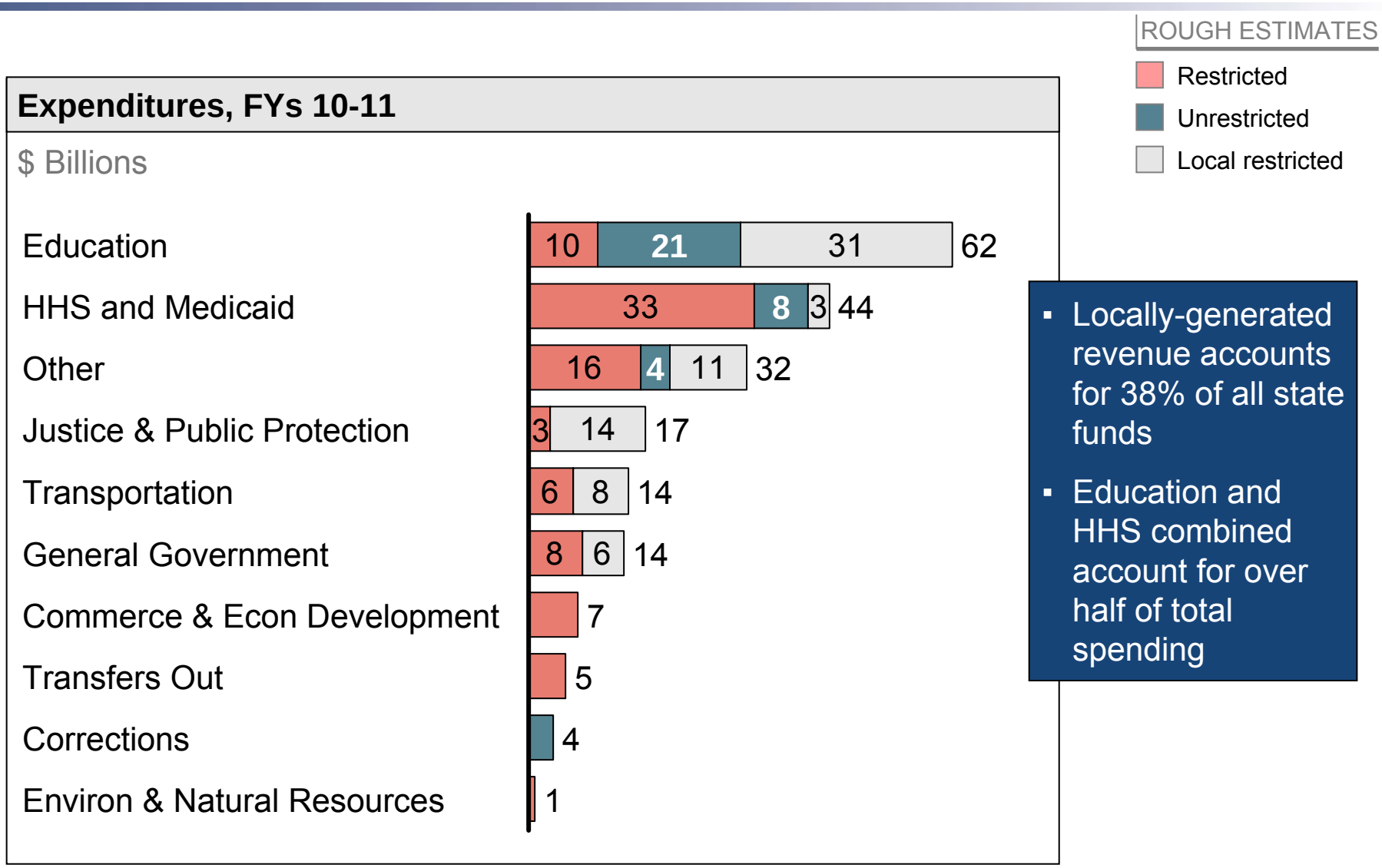


- $37 billion in "General Revenue Fund" is unrestricted and can be spent and re-appropriated as government sees fit
- Other revenue, including federal money placed in the general fund, is tied to specific expenditures
- Of restricted state funding, only $48B is constitutionally or federally protected- the remainder can be reallocated through law for other purposes or moved to general fund

1 Special revenue includes Highway Operating Fund, Federal Grants, Revenue Distribution Fund, Waterways Safety Fund, etc.

SOURCE: Ohio Office of Budget and Management, Ohio Legislative Services Commission, McKinsey analysis

Ohio then draws from state restricted and unrestricted funds to meet expenditure obligations

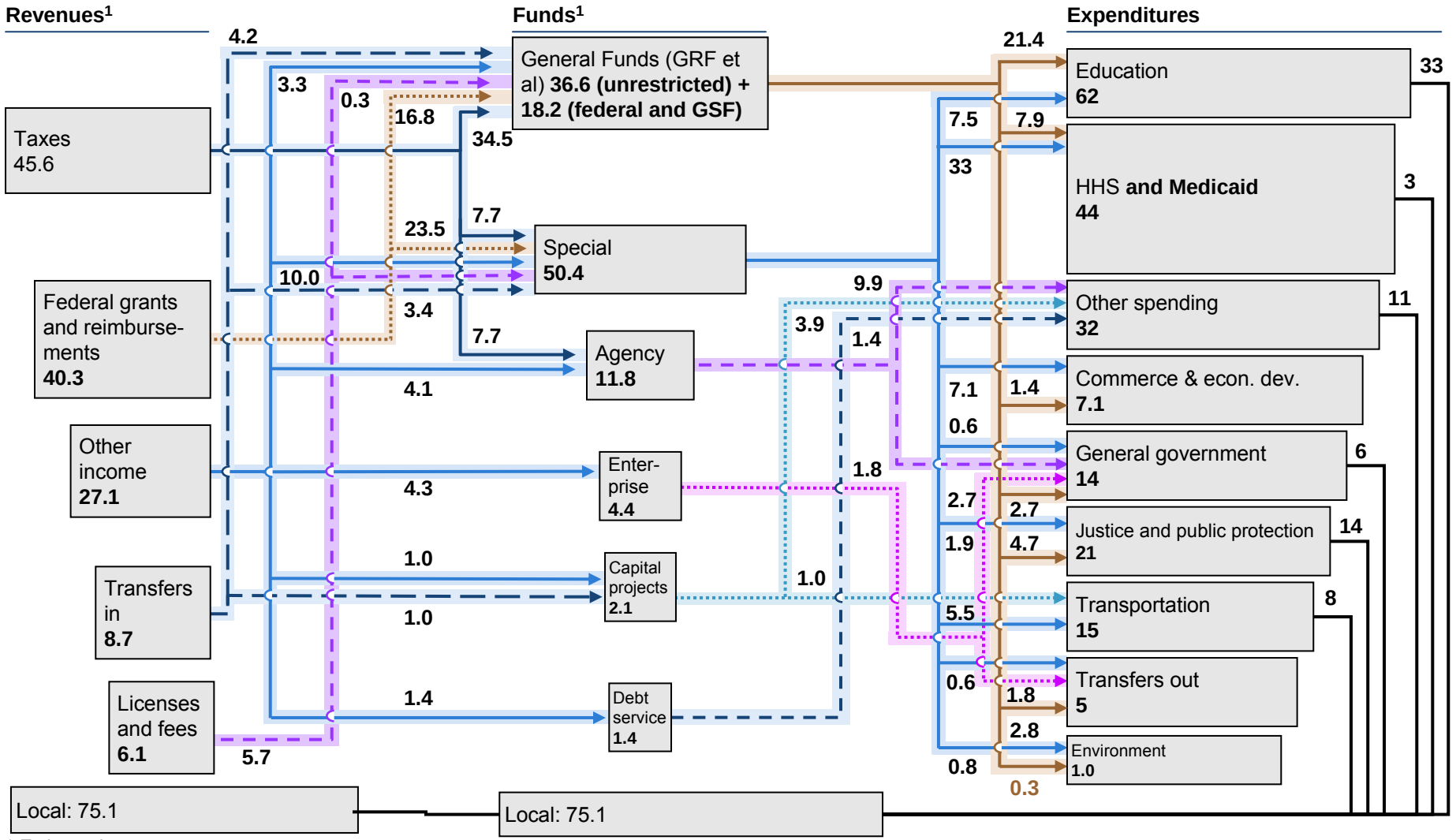


- Locally-generated revenue accounts for 38% of all state funds
- Education and HHS combined account for over half of total spending

SOURCE: Ohio Office of Budget and Management, Ohio Legislative Services Commission, U.S. Census Bureau

Revenue and expenditure flows (federal, state, and local), FYs 10-11

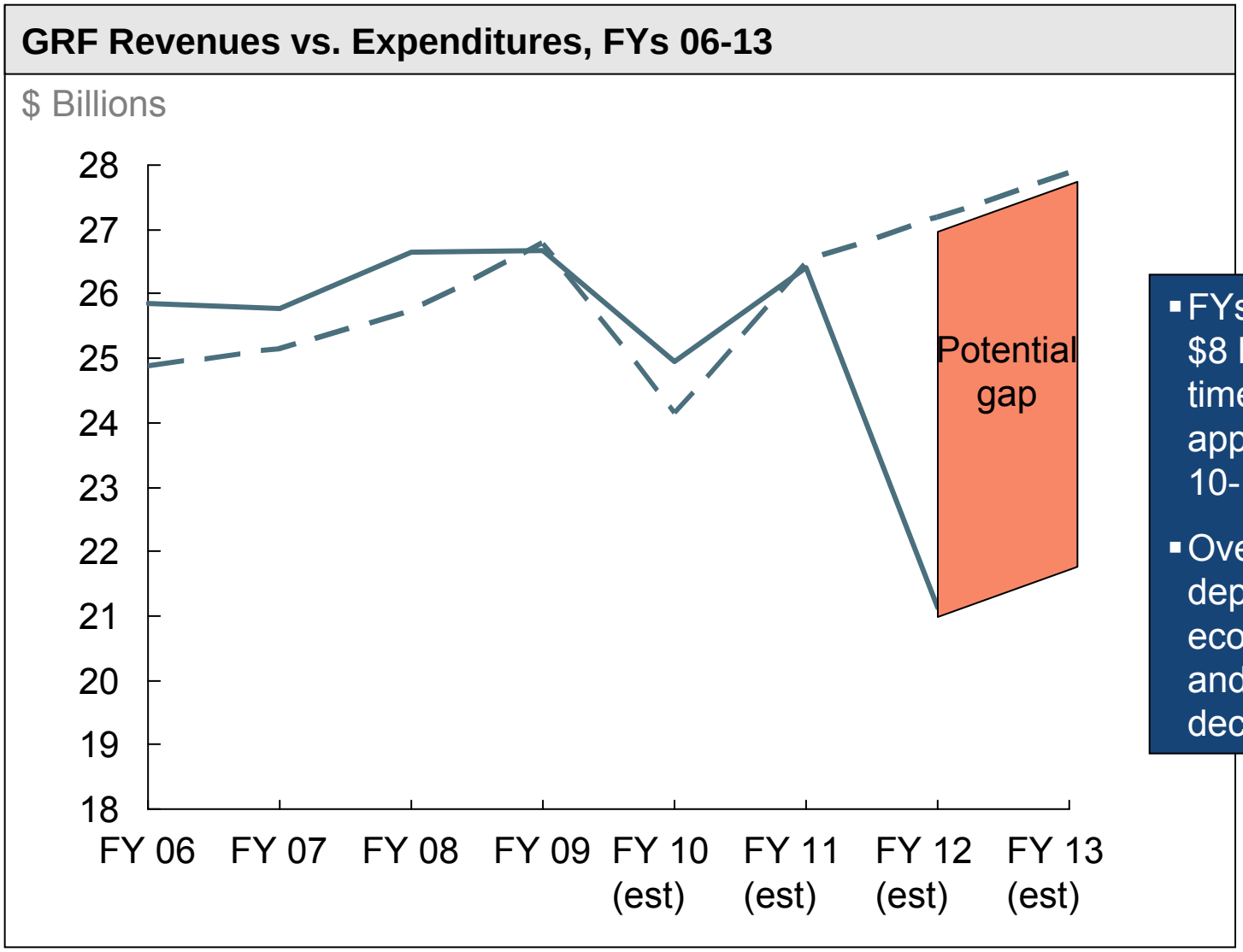
$ Billions



1 Estimated

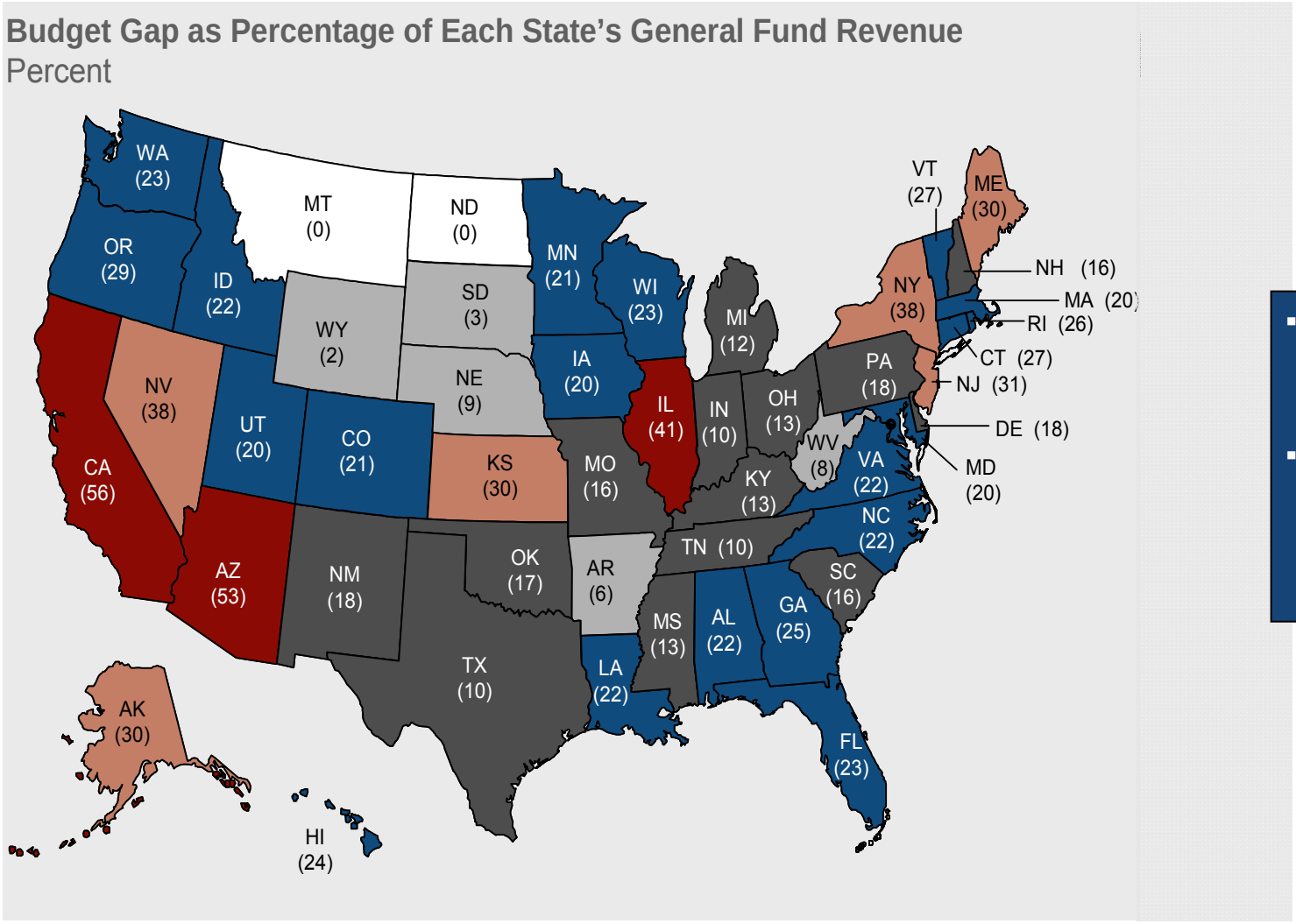
SOURCE: Ohio Office of Budget and Management, Ohio Legislative Services Commission

Use of one-time funding sources in FYs 10-11 will lead to significant budget gap in FYs 12-13



- FYs 12-13 will lack $8 billion in one-time funding applied during FYs 10-11
- Overall gap will depend on economic growth and spending decisions

Ohio's budget gap is comparable to its neighbors

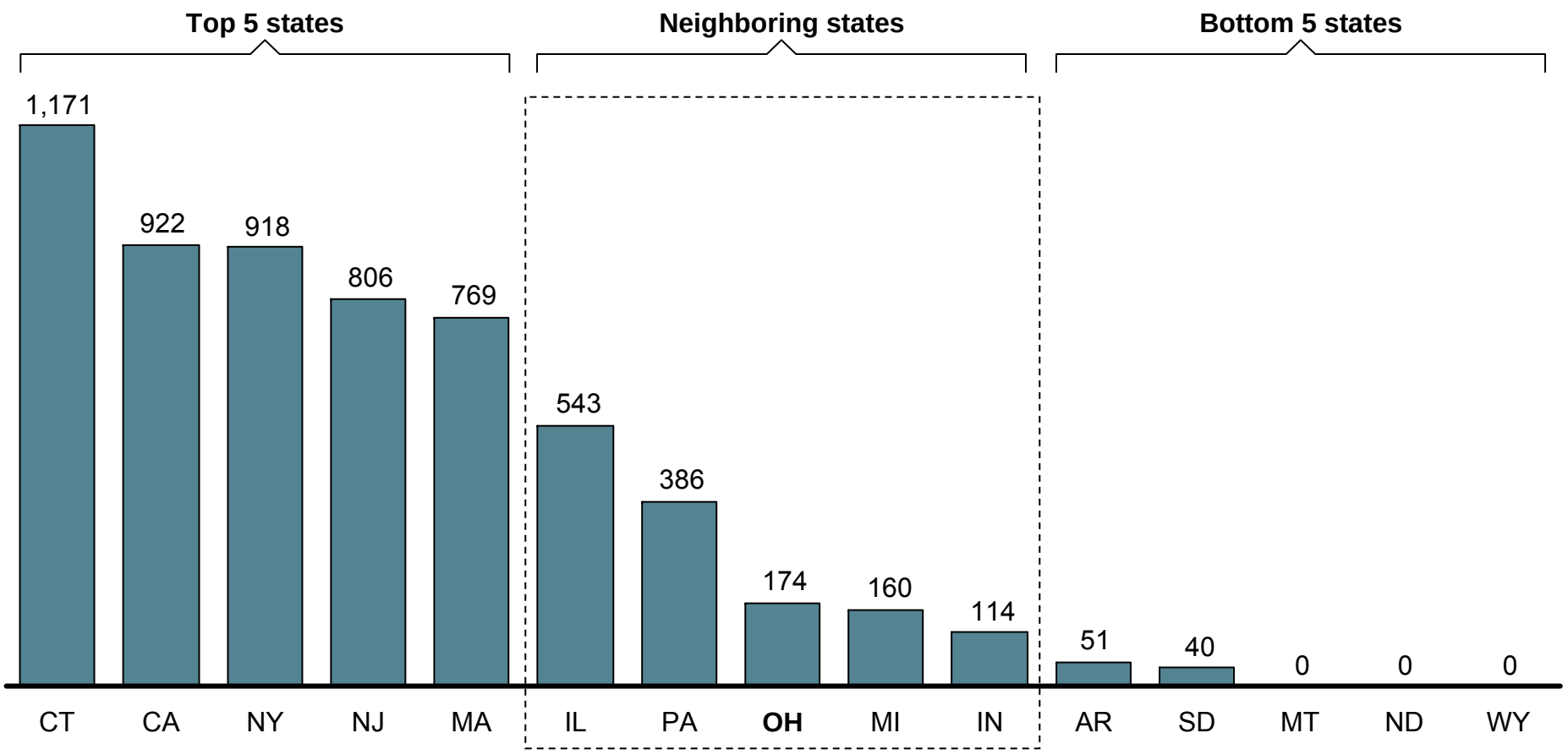


- Budget crisis is national in nature; Ohio's gap is not exceptional
- Problem is systemic – revenue growth alone cannot close the gap

SOURCE: Center on Budget and Policy Priorities (Nov 2009)

Ohio's per capita deficit ranks 32nd nationally

Total per capita deficit (estimate)*
$, 2010

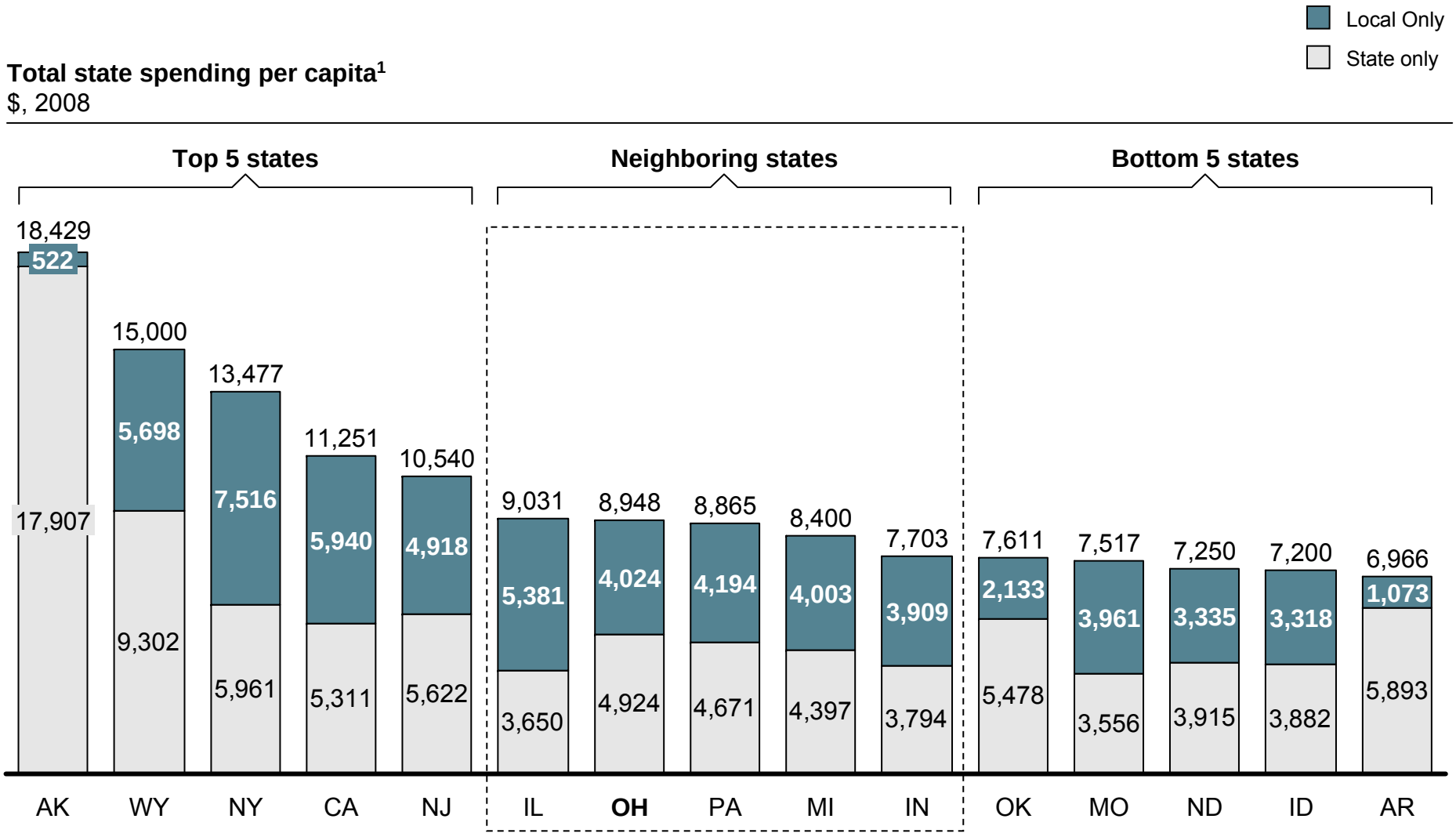


* To establish baseline comparison, this chart uses common data set for all states (deficit projections for Ohio vary depending on assumptions used; this comparison uses similar assumptions across all states)

SOURCE: U.S. Census Bureau, National Association of State Budget Officers, Team analysis

Ohio expenditure per capita is in line with neighboring states

Total state spending per capita[1]
$, 2008

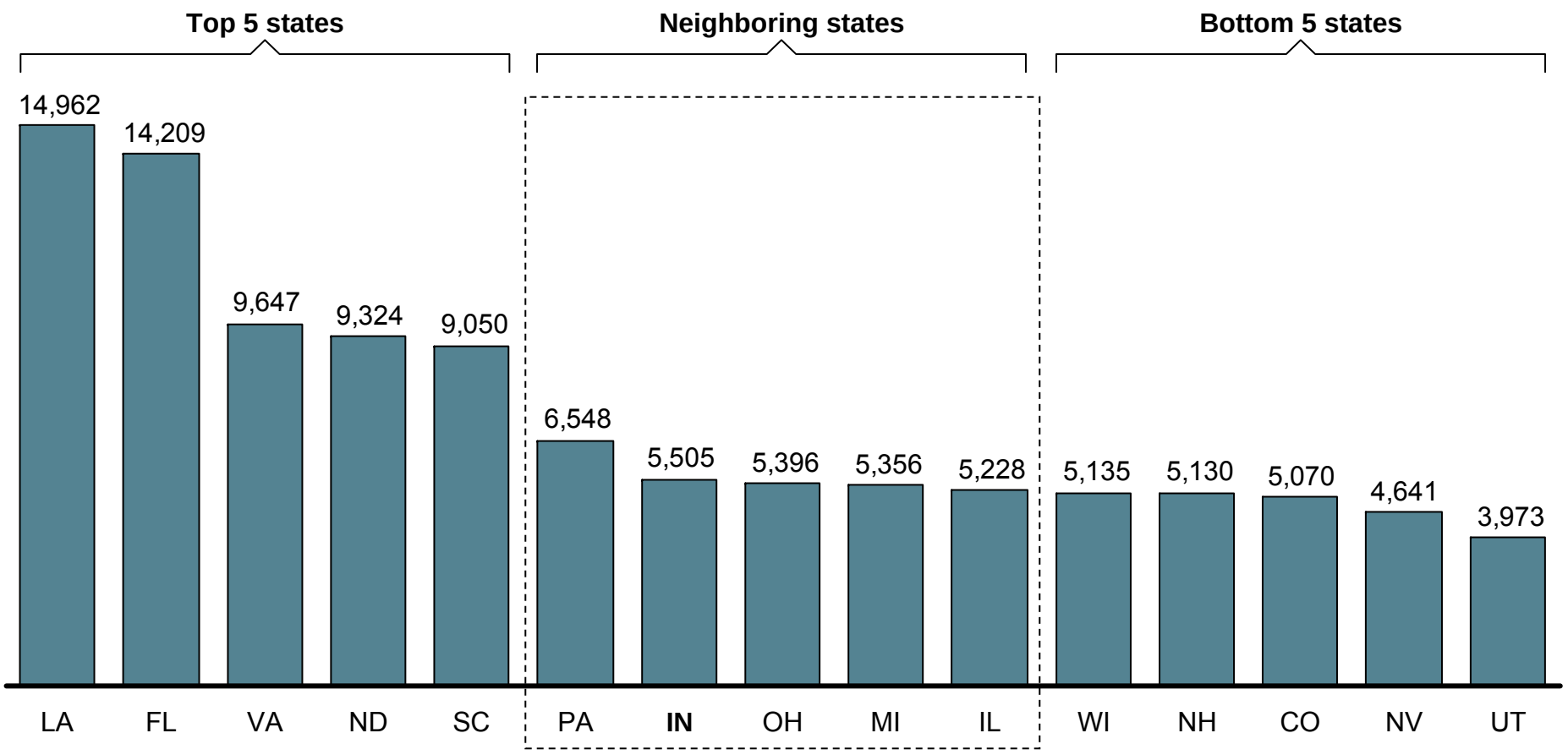


1 Includes all known sources of funding including state general fund, federal funding, other state funds, bonds

SOURCE: State expenditure report, National Association of state budget officers; team analysis

Federal per capita spending in Ohio ranks 41st nationally

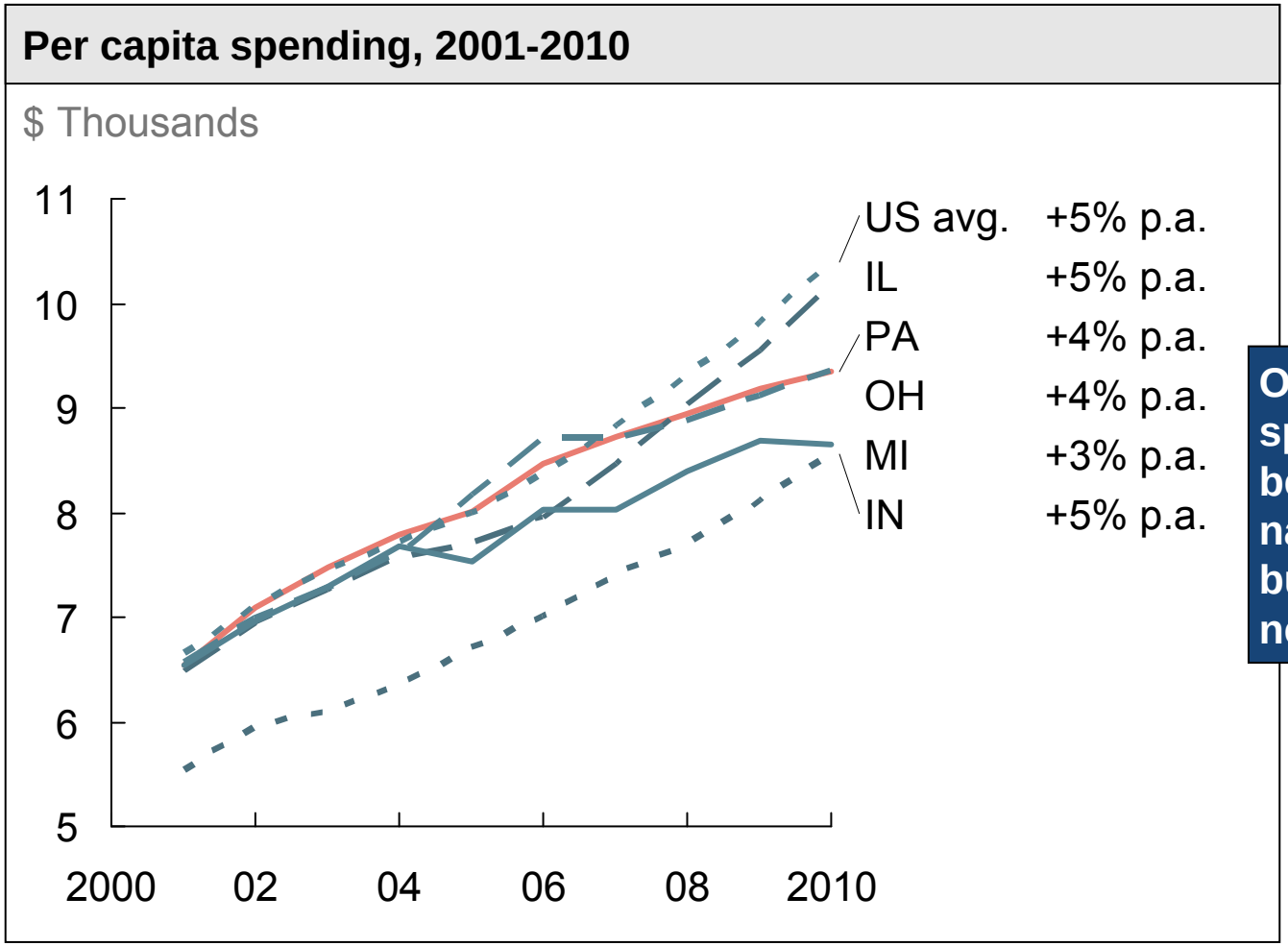
Federal per capita spending[1], 2001-2010 avg.
$, 2001-2010 (avg.)



1 Federal spending includes all **federal contract and assistance awards**

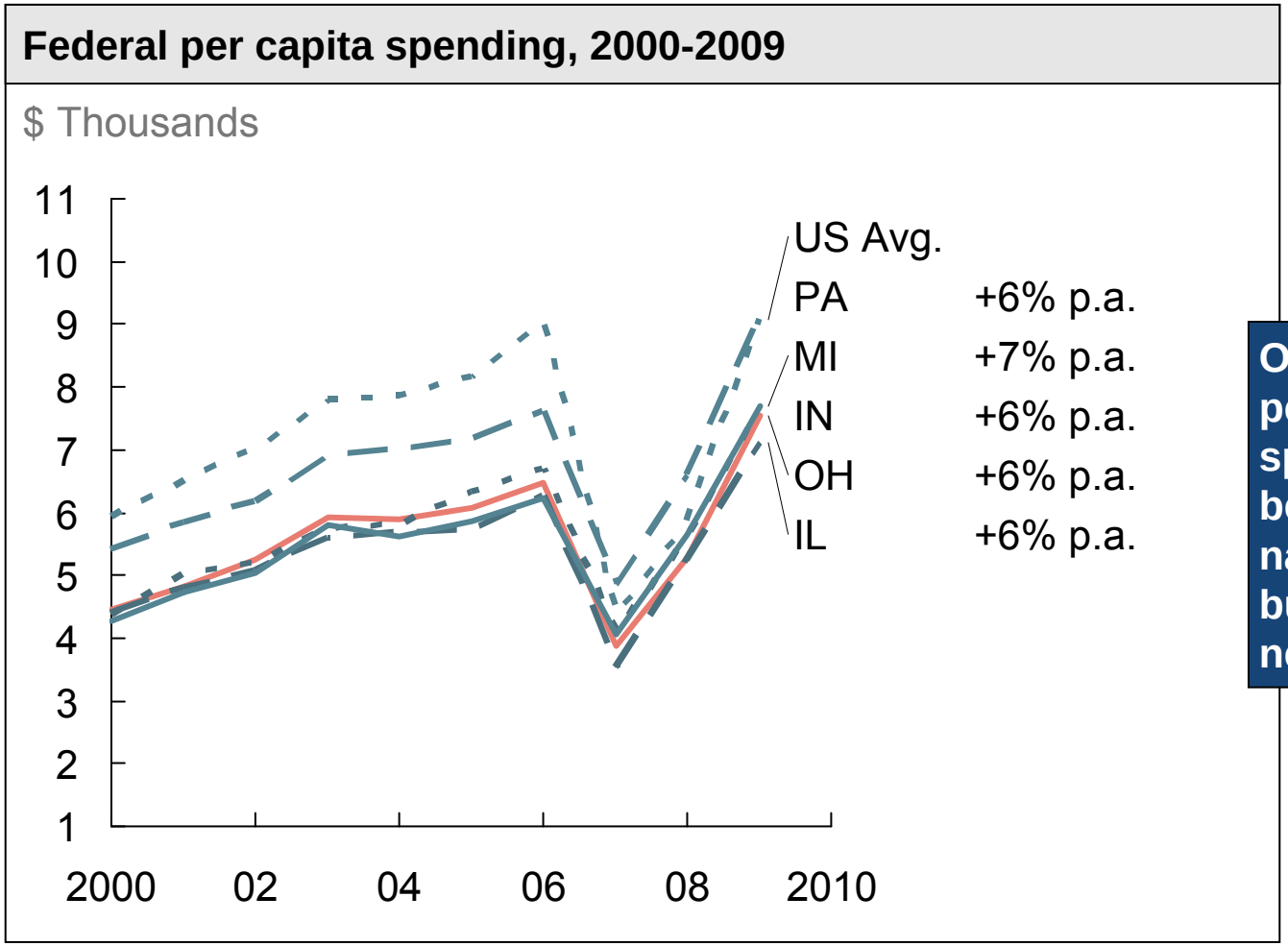
SOURCE: US Census Bureau, Moody's Analytics, USASpending.gov

Ohio's historic per capita spending is in line with neighboring states



Ohio's per capita spending is below the national average but in line with neighbors

Historic federal per capita spending in Ohio is in line with neighboring states



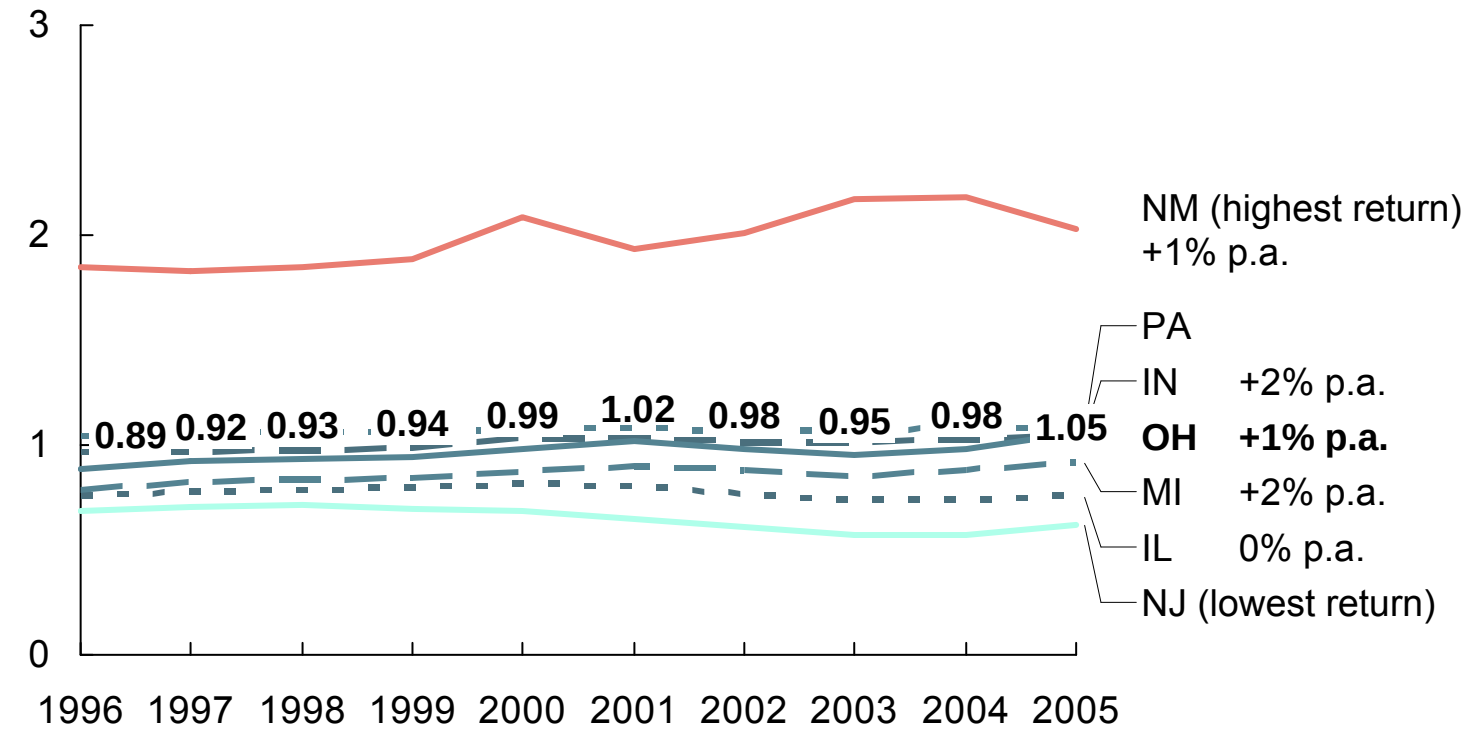
Ohio's federal per capita spending is below the national average but in line with neighbors

1 Federal spending includes all **federal contract and assistance awards**

SOURCE: US Census Bureau, Moody's Analytics, USASpending.gov

Ohio has historically received roughly the same amount in federal spending that it pays in federal taxes

Federal spending for every dollar paid in taxes, 1996-2005



Ohio's return on federal taxes is in line with neighbors

SOURCE: The Tax Foundation, Team Analysis

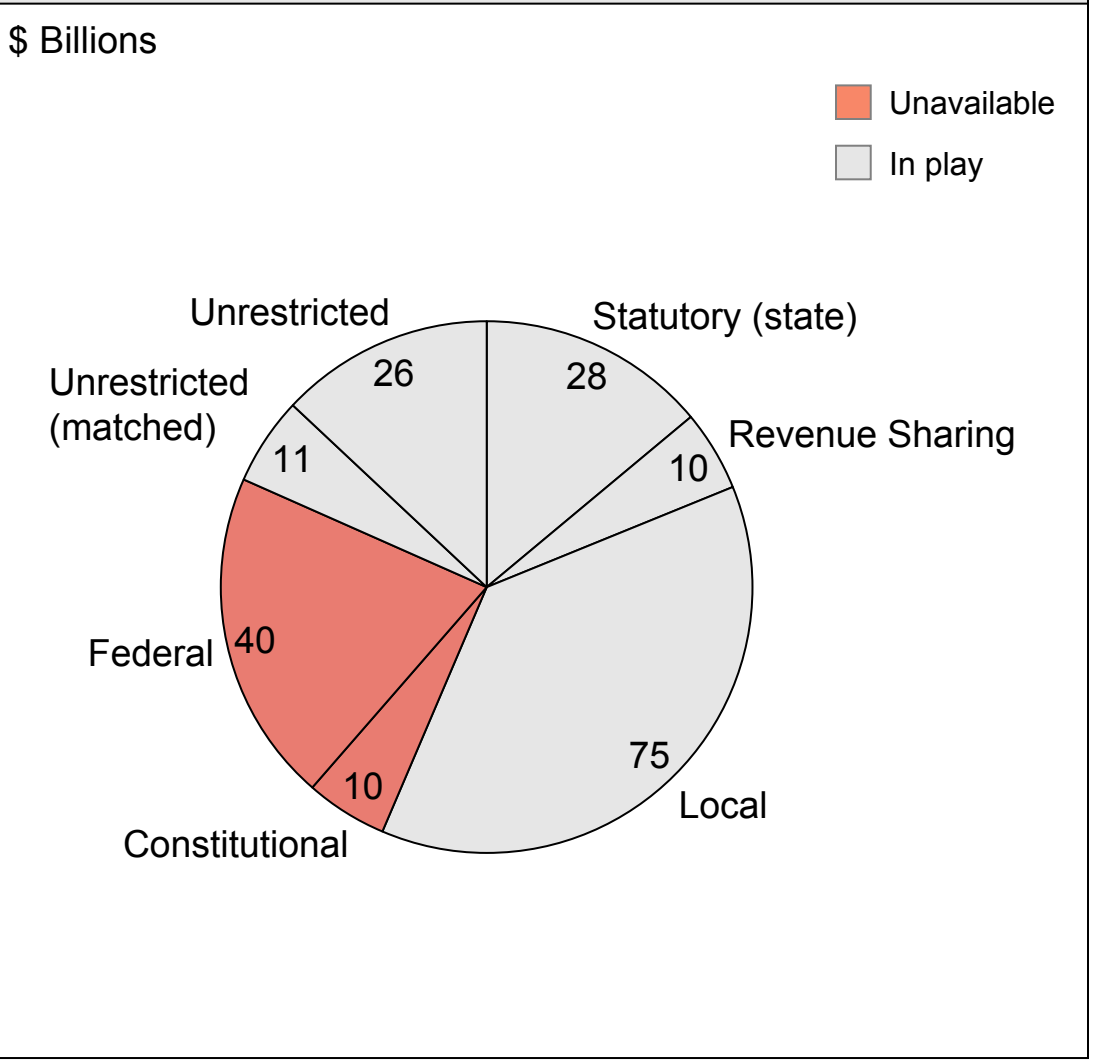
3/4 of total state funding should be considered "in-play" to address budget gap

ROUGH ESTIMATES

Types of restricted funding

- **Constitutional and federal:** Completely restricted and unavailable for addressing budget gap
- **Local:** Revenue generated at the local level is not controlled by the state, but local spending decisions can be influenced indirectly
- **Revenue Sharing:** Statutory agreements compel state to share funds with local governments, but these can be re-negotiated
- **Statutory:** Certain state-generated revenues are designated for specific purposes, but may be re-appropriated with changes in the law
- **Unrestricted**: Funds may be appropriated freely, though some are tied to federal matching funds

Categories of restricted and unrestricted funds, 2010-2011



Ohio restricted funds operate under different degrees of constraint

Low Potential
Medium Potential
High Potential

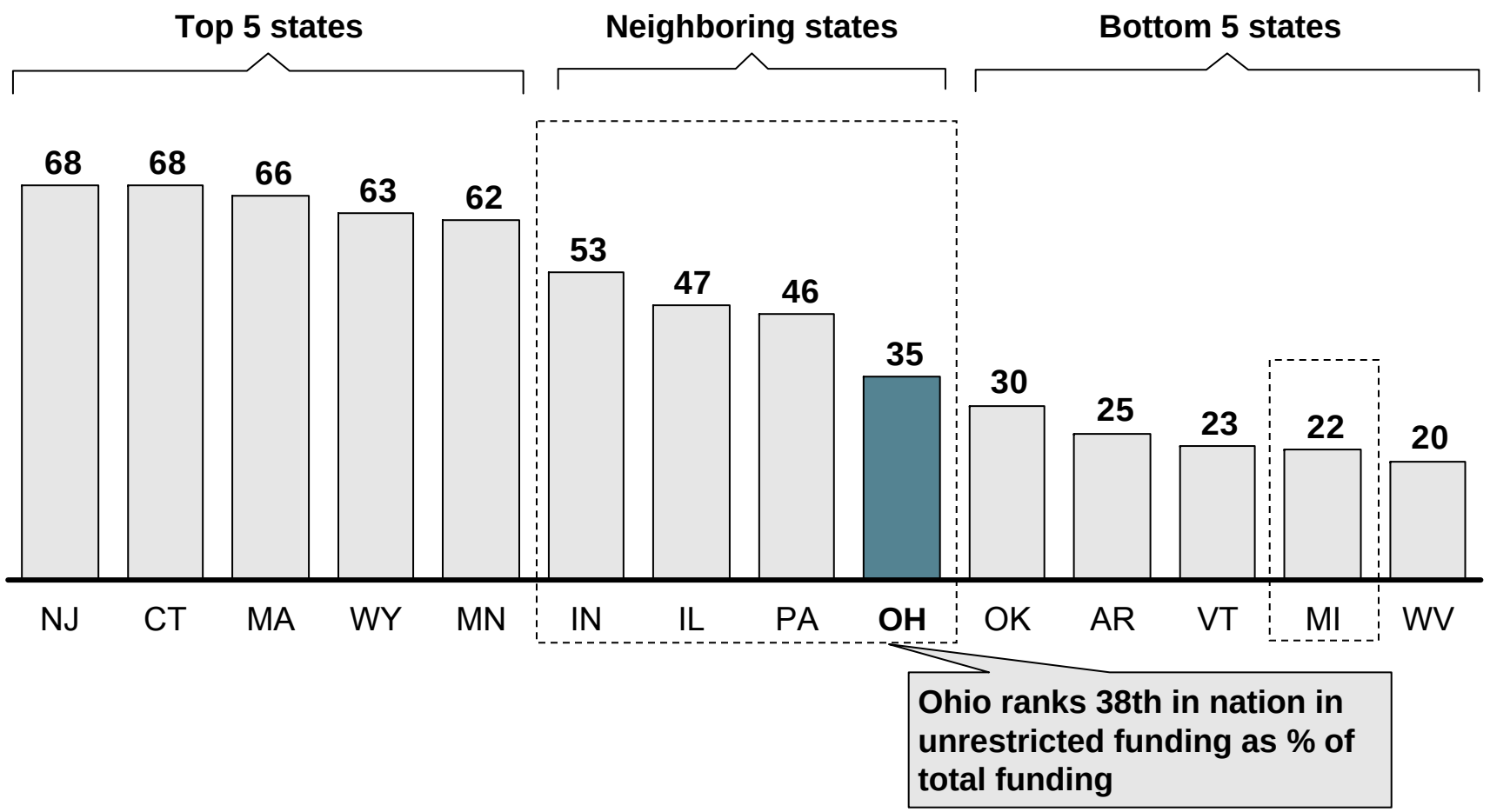
Type of constraint	Source of funds	Value (FYs 10-11)	Potential to re-designate
▪ Constitutional[1]	▪ Highway funds ▪ Debt service funds ▪ Lottery fund	$10 billion	○
▪ Statutory – state restricted	▪ Other non-GRF – Agency fees, lottery etc.	$28 billion	●
▪ Statutory – federally restricted	▪ Federal Grants – General revenue fund – Special revenue fund	$40.3 billion	○
▪ Local – state contribution	▪ Revenue distribution fund ▪ "Hold harmless" replacement funds	$10 billion	◐
▪ Local -- locally generated revenue	▪ Personal property tax, income and sales tax, local fees, etc.	$75.1 billion	○
▪ Unrestricted but federally matched	▪ GRF – HHS and Medicaid	$11 billion	= $36.6 billion ●
▪ Unrestricted	▪ GRF	$25.6 billion	

Re-designating funds does not necessarily lead to greater savings or efficiency

1 Ohio constitution requires that 50% of income/estate tax return to locality of origin. This requirement is more than satisfied through state-controlled spending at the local level

Ohio ranks 38th in nation in percent of funding that is unrestricted

Unrestricted funding as percentage of total funding (local excluded)
Percent, 2008



SOURCE: State expenditure report, National Association of state budget officers; team analysis

The team conducted an in-depth review of Ohio's Medicaid system to identify gaps and savings opportunities

Facts on Ohio Medicaid

- Ohio spends $13B per year on Medicaid; **$5B of which is true state spending** as the remaining $8B is federal match
- Federal match means that every **$1 in savings from the Medicaid program saves the state $0.30-0.40 on average,** with remainder attributing back to federal government
- Aged, blind and disabled (ABD) population of Medicaid equals roughly **20% of enrollees but 80% of the cost**, with $/ individual being disproportionately high compared to other states
- Children and families (CFC) population are placed into managed care and **largely fall within national benchmarks** for $/ individual
- Health care reform will bring about significant changes to Medicaid, including additional lives and costs, but will not impact state's bottom line until 2014

Critical challenges to address

- **Operational inefficiencies**, including an overly decentralized eligibility process and poorly coordinated claims systems
- Limited ability to impact **high use of expensive and/or unnecessary treatments, hospitalizations**
- **Poorly coordinated care of aged and disabled population**
- High cost and above-average use of **institutional care, particularly nursing homes**

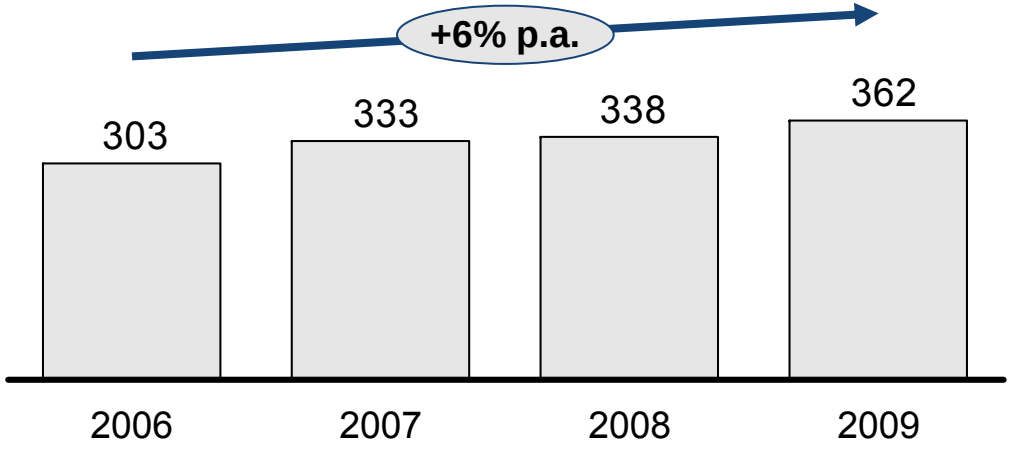
Topics of discussion for today

- General budget and the upcoming gap
- Medicaid / Healthcare Financing
- K-12 Education
- Other opportunities

What is Medicaid?

- Medicaid is a **federally-coordinated, state-administered program**, established in 1965 to provide **health care for the poorest Americans**
- Facilitates **payments to a variety of providers** of medical care; payments are matched by the federal government
- Covers families and children (CFC) as well as Aged, Blind, and Disabled (ABD) population
- Covers both **acute care** (shorter-term medical needs) and **long-term care**

Total US Medicaid expenses (Federal + State)
$ Billions

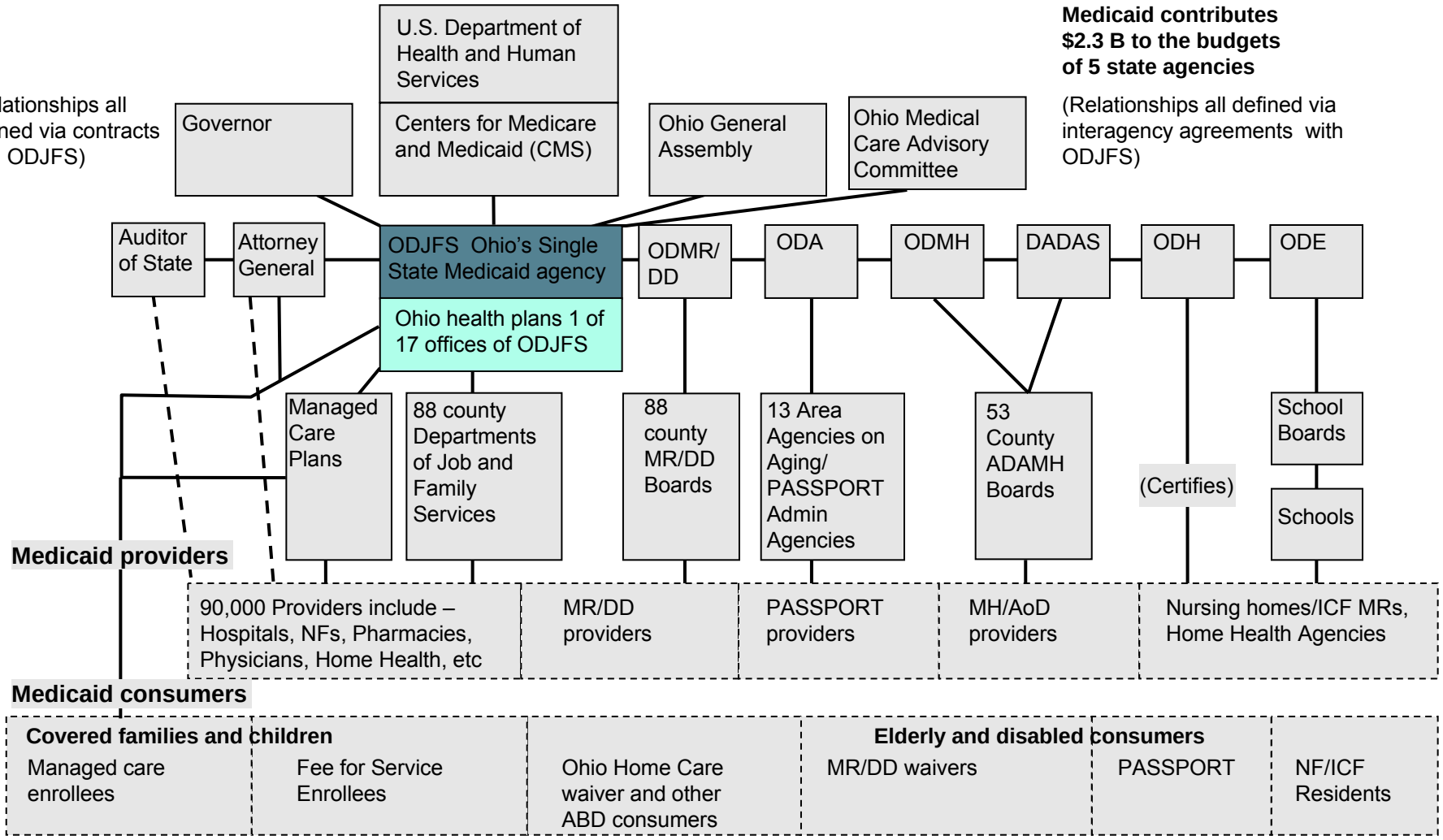


Top spending states (+DC) per capita

1. New York (~$2,400)
2. District of Columbia
3. Rhode Island
4. Maine
5. Massachusetts
6. Vermont
7. New Mexico
8. Louisiana
9. Minnesota
10. Pennsylvania
20. Ohio (~$1,140)

There are numerous Medicaid departments and entities that add additional layers of complexity

Major Organizational Relationships of Ohio's Medicaid Program



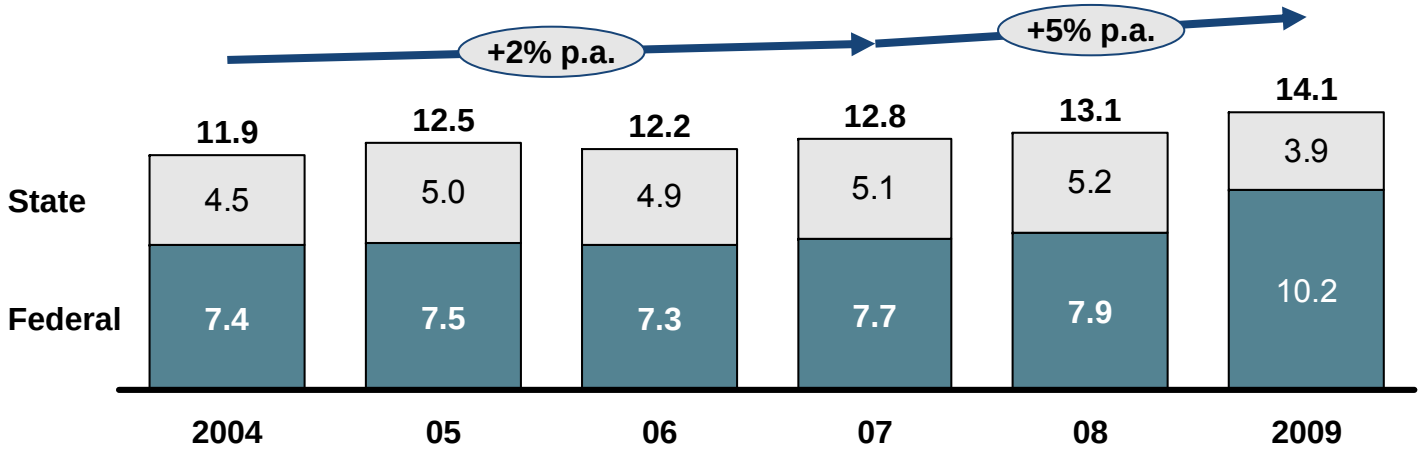
Note: ODJFS, Ohio Dept of Job and Family Services; ODMR/DD, Ohio Dept of Mental Retardation and Developmental Disabilities; ODA, Ohio Dept of Aging; ODMH, Ohio Dept of Mental Health; DADAS, Dept of Alcohol and Drug Addiction Services; ODH, Ohio Dept of Health; ODE, Ohio Dept of Education; ICF, Intermediate Care Facility ; AoD, Alcohol and other Drugs

Source: Ohio Medicaid Report 2005

Ohio's Medicaid spending continues to increase year over year, largely driven by an increasing number of enrollees

Using 2008 data going forward for state comparisons

Total Medicaid spend – Ohio
$ Billions



	2004	05	06	07	08	2009
Number of enrollees Millions	1.6	1.6	1.6	1.6	1.7	1.8
Average cost per enrollee USD $	7,672	7,832	7,687	7,985	7,643	7,815

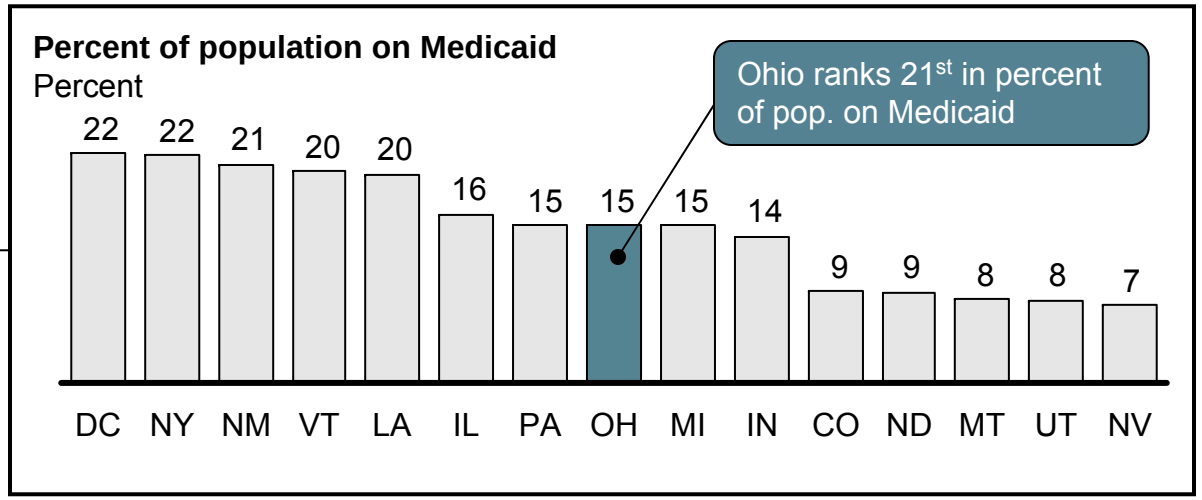
The 2007-2009 increase is **driven more by an increase in the number of total enrollees** rather than an increase in the cost per enrollee

SOURCE: CMS, Kaiser State Health Facts

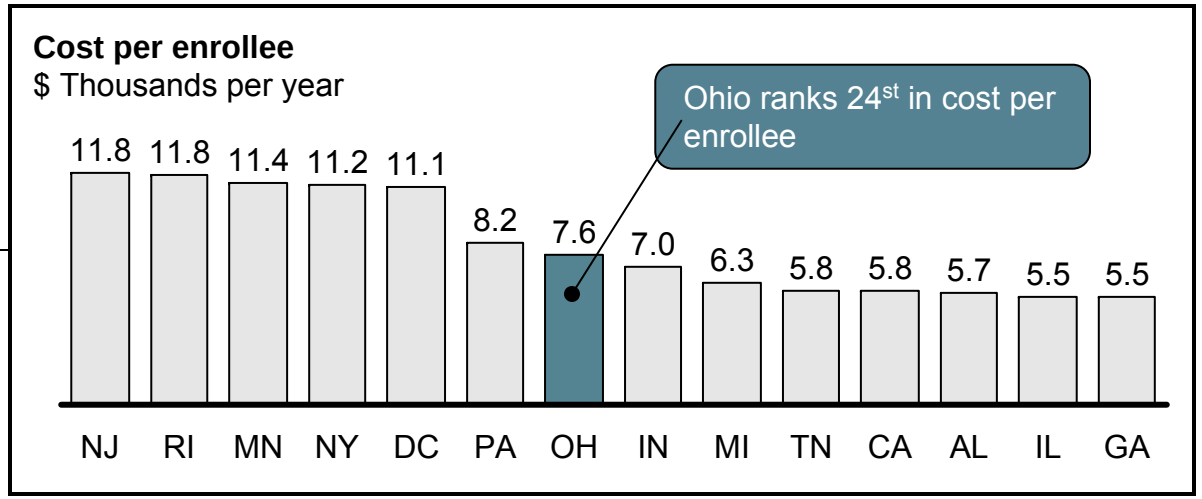
Ohio is an average state in terms of the size of its Medicaid population and overall cost per enrollee

Medicaid costs
$ Billions

Demographics
# of people



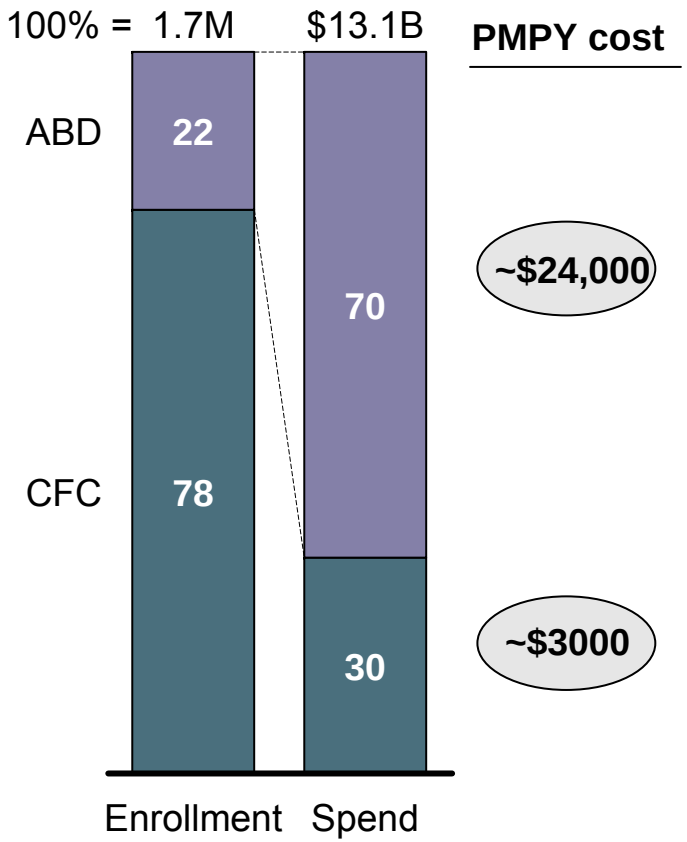
Cost of care
$ per person



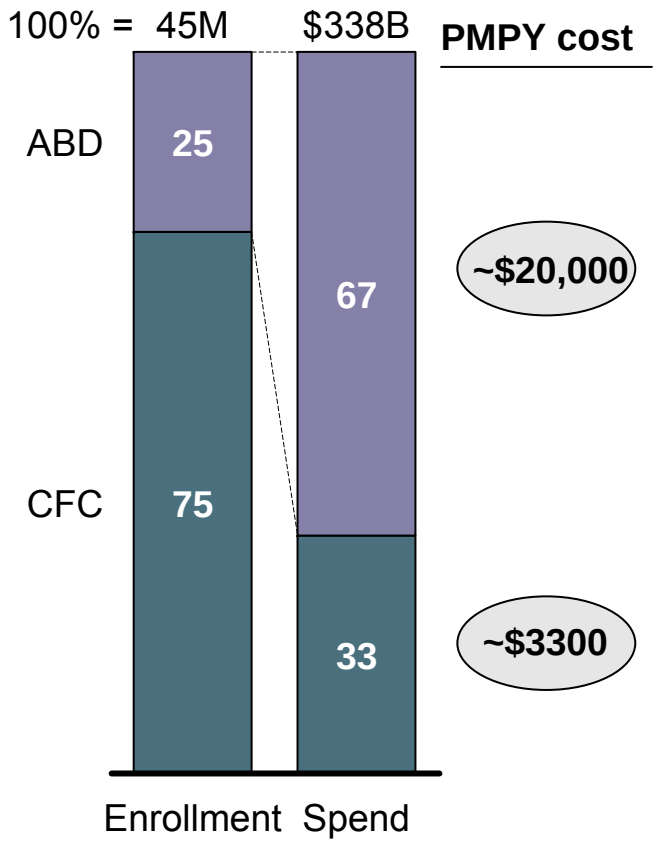
SOURCE: Kaiser State Health Facts

Ohio's Covered Families and Children (CFC) per member costs are below the national average, but Aged/ Blind/ Disabled are 20% higher

Ohio Medicaid breakdown by demographics
Percent, $; 2008



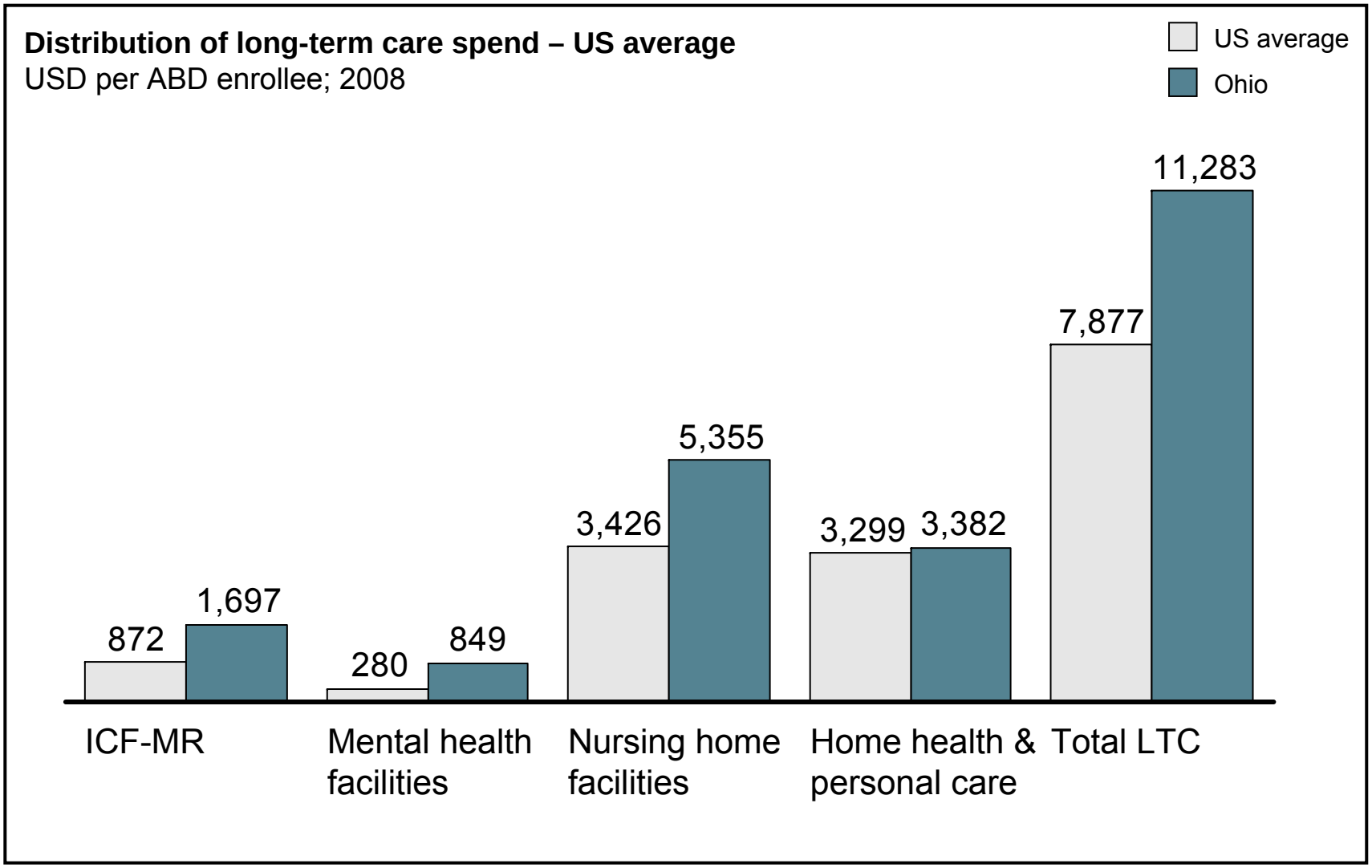
US Medicaid breakdown by demographics
Percent, $; 2008



While Ohio performs under national average cost for the CFC population, the state **spends 20% more per year on ABDs**

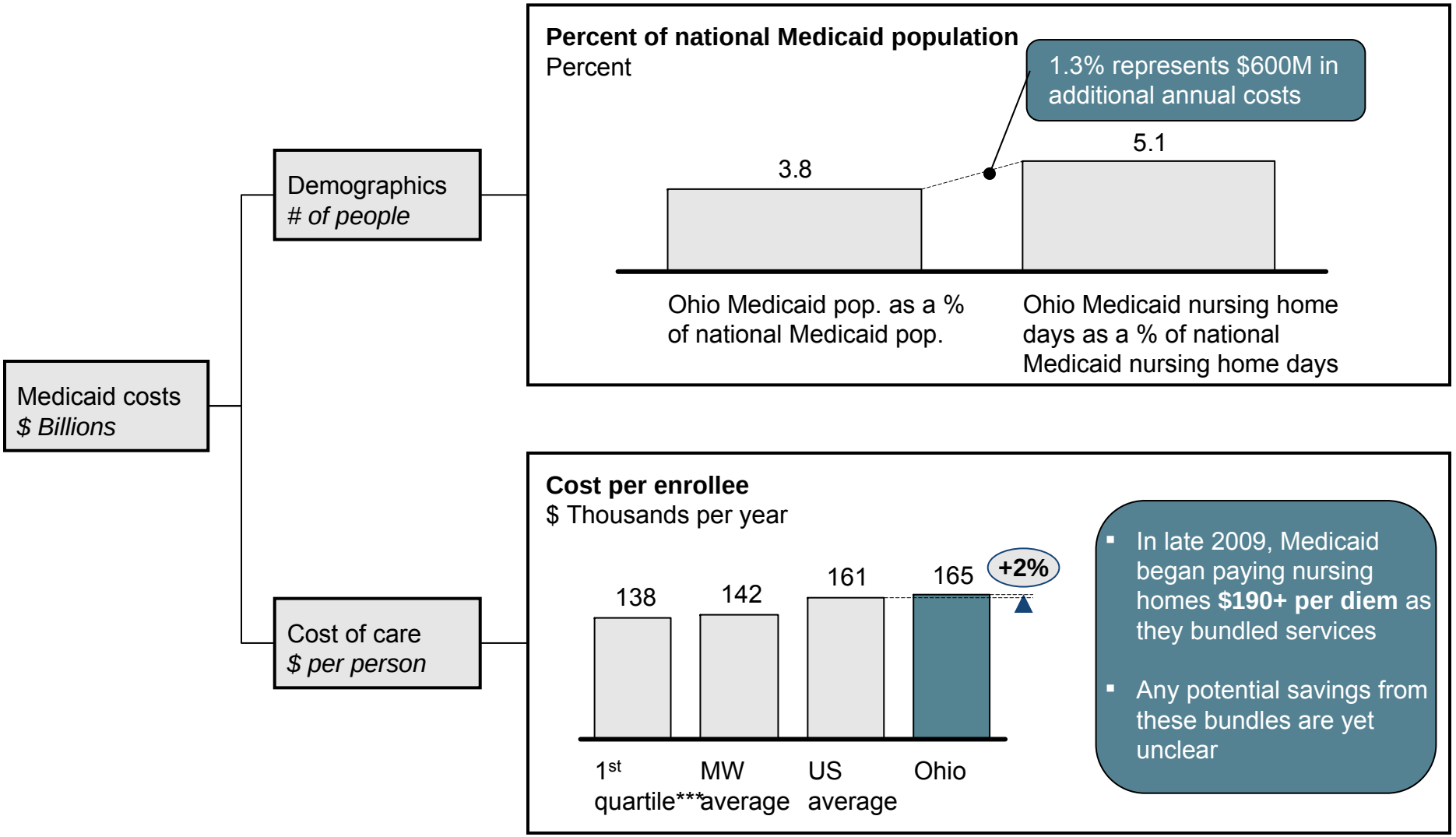
Ohio has a disproportionate spend on long term care, especially for institutional care settings

PRELIMINARY



SOURCE: statehealthfacts.org

Ohio spends more per bed day on nursing homes, and has tendency to move more people to institutional care



SOURCE: Kaiser State Health Facts

Health care reform will increase the state's Medicaid burden, but will supply additional federal funds to cover new enrollees

	Effective date	Description	Who pays?	$ impact
Uniform 133% FPL eligibility	2014	▪ New federal minimum eligibility of 133% FPL; will add additional people to the state Medicaid rolls;	▪ Federal govt. covers 100% of 2014-2016, 95% in 2017, 94% in 2018, 93% in 2019 and 90% for 2020+	~$300M
Elimination of cost-sharing	2011	▪ No more cost sharing of preventative services between Medicaid and Medicare for patients that are dually-eligible	▪ Unclear whether burden falls on Medicare or Medicaid systems	TBD
Reduced DSH payments	2011	▪ Reduced DSH payments by 50%; 25% once uninsured rate decreased by 45% or more	▪ If states wish to compensate hospitals, they will be forced to assume the cost burden	TBD
Reduced readmit payments	2012	▪ Reduced payments to hospitals to avoid unnecessary hospital readmissions	▪ Cost of readmissions may be borne by the hospitals themselves	TBD
Increase in fed. Rx pricing disc.	2013	▪ Disallows states from negotiating additional savings on top of federal best pricing	▪ State transfer to federal government	<$100M

SOURCE: HR 3590; Team Analysis

We have identified three groups of opportunities in Medicaid – operational levers, changes to the delivery system, and limits or reductions in coverage

State savings

Operational levers

Simple changes to Medicaid's business processes

- Reducing fraud, waste, and abuse within the system
- Effective utilization of prior authorizations and edits
- Improving financing mechanisms

$230-390M

Changes to care delivery system

More complicated changes to the medical offering

- Improving eligibility determination processes
- Providing a spectrum of options to long term care patients
- Reducing the nursing home per diem rate
- Effective care coordination efforts, including an ACO model

$325-580M

Limits or reductions in coverage

Reduces overall level of care by cutting services

- Reduced coverage of optional services
- Reductions in reimbursement rates for providers

$150M-1B

Operational levers could have immediate savings impact of up to $390M annually

	Description	Estimated impact (state)
1 Reducing fraud, waste, and abuse in system	▪ Independent claims auditing mechanism will identify and prevent undue overspending within the system ▪ Claims IT system upgrades required to track spending patterns and outlier costs	▪ **$100-160M**
2 Using prior authorizations and edits to change outlier behavior	▪ Reduce misuse of prescription drugs and medical services through clinical safeguards (with IT support) ▪ "Lock-in" program provides more visibility into individual's spending behavior	▪ **$100-175M**
3 Improving financing mechanisms (purchasing, float)	▪ Delaying Medicaid payments 30 days to capture paid interest ▪ State-wide purchasing of drugs and durable medical equipment will produce savings through economies of scale	▪ **$30-55M**

1 Reduced fraud, waste, and abuse through increased auditing can lead to an annual savings of $100-160M in state savings

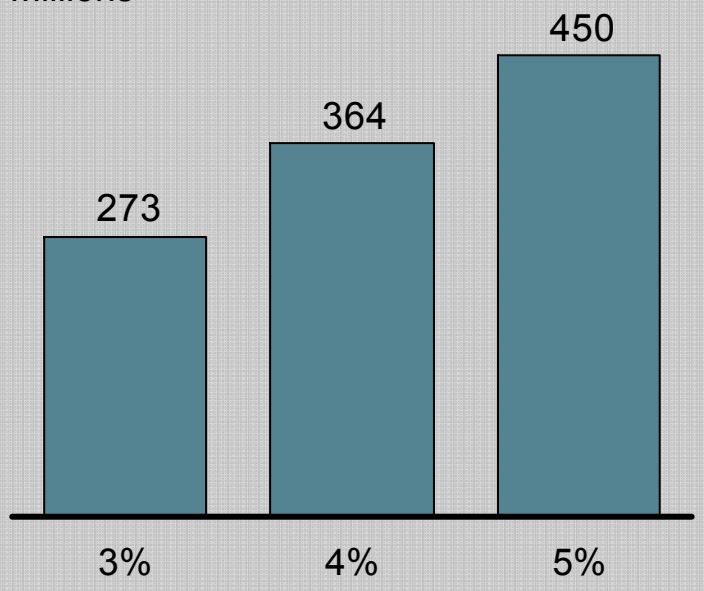
ESTIMATES

Background/Approach

- Increasing oversight capabilities – including unique **patient tracking** (debit card), **third party auditors**, and **enhanced IT**, all lead to a reduction in fraud, waste, and abuse
- Conservative estimates of fraud, waste, and abuse in the system range from 3% to 5% of total FFS spending
- While fraud, waste, and abuse may be as high as 15%, it is **unlikely that any single lever or combination of levers will completely eradicate misuse of the system**

Opportunity

Potential savings from auditing
$ Millions



Our estimates assume 3-5% capture of all FFS Medicaid fraud, waste, and abuse

Impact

Increasing auditing capabilities can result in **$275-450M** of annual cost savings; **$100-$160** in state savings

SOURCE: OCRM report; Team analysis

2 Using prior authorization and edits to alter patient behavior can contribute an additional $100-$175M in annual state savings

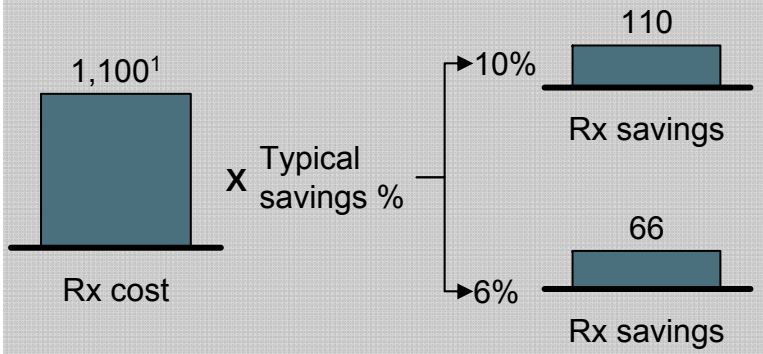
ESTIMATES

Background/Approach

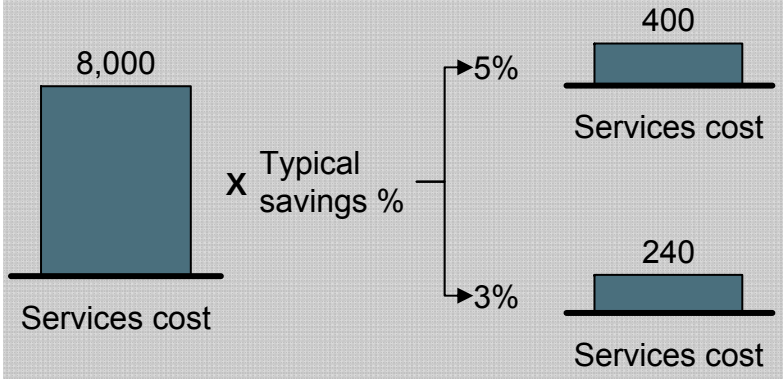
- More stringent use of the **preferred drug list**, along with an additional emphasis on **pre-authorization**, can provide some Rx savings
- A 2009 Government Accountability Office (GAO) report suggested that states need **multiple layers of preventative controls** and extensive data sharing to effectively curtail high utilization
- Prior-authorization for all other medical services can also have a **3-5% savings effect** as utilization rates fall
- The **2005 OCRM report identified $69M** in duplicate claims paid to pharmacies

Opportunity

Pre-authorizations on Rx



Prior-authorizations on services



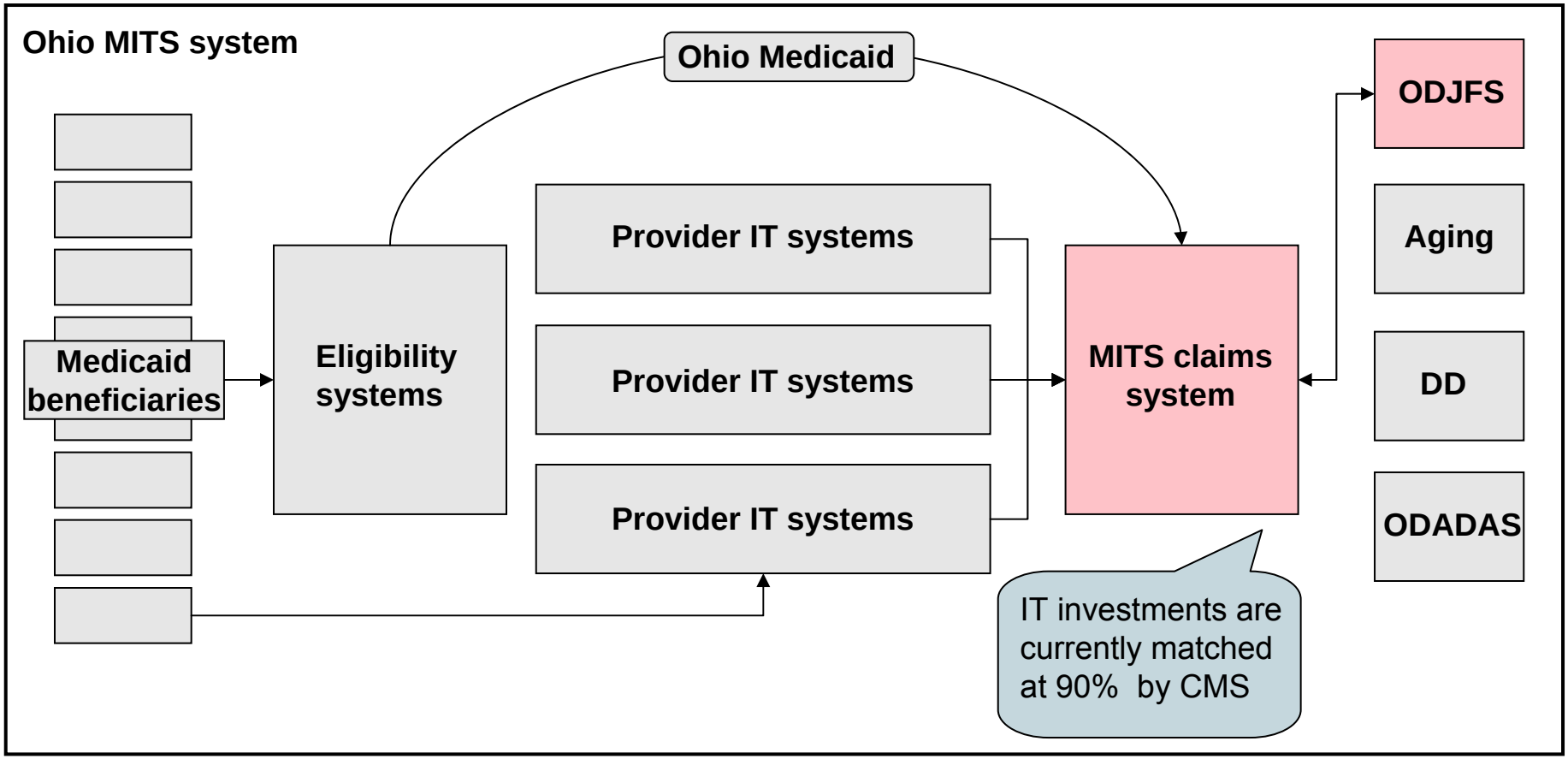
Impact

3-10% savings through stricter use of prior-authorizations and edits can lead to **$305-510M** in savings; **$100-175M** in state savings

1 Given recent carveout, this assumes Rx costs at pre-MCO totals

SOURCE: Kaiser Family Foundation; GAO; Oregon State University; Team analysis

2 As planned, the state's new Medicaid IT claims systems (MITS), is not the ideal system to handle the state's auditing mechanism



Beneficiaries enroll with **JFS at the county level**	Front-end systems are still complicated and **disaggregated across counties**; other JFS programs have siloed systems	Provider IT systems are all different, making it **difficult for inter-provider communication** for a single patient	MITS, scheduled to launch in December, is a **back-end claims system** – it does not address eligibility issues nor does it communicate with all relevant agencies

SOURCE: ODJFS, ODA, Expert interviews, Team analysis

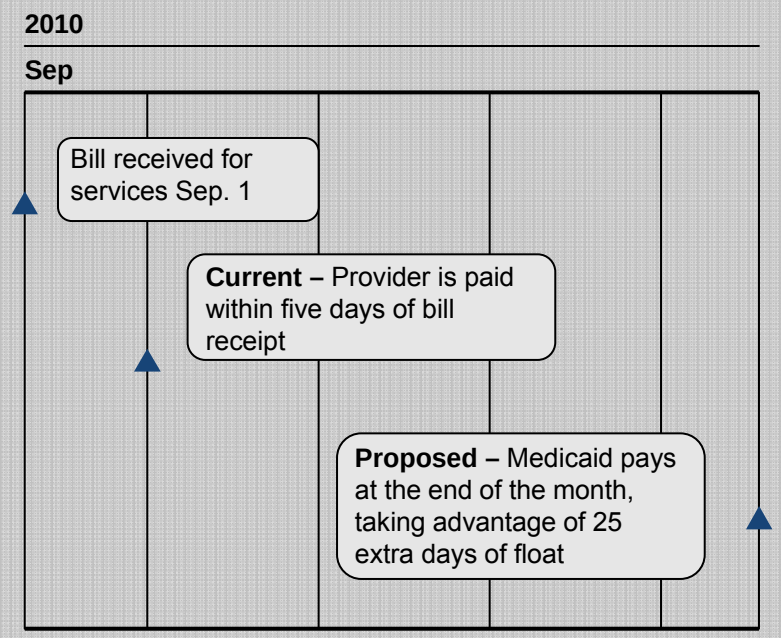
3a Extending payment terms can provide an extra $15-20M in liquidity to the state's Medicaid system

ESTIMATES

Background/Approach

- Ohio Medicaid is currently **paying most providers within five days of billing**, and the MITS system is designed to further speed that process up
- However, by pushing payments out to 30 days, the **state can collect the interest on the cash balance** instead of transferring it to providers immediately
- **Does not apply to MCO payments** – MCOs are paid prospectively; JFS delayed payments in 2010, but only to avoid paying the 12th monthly capitation this year

Opportunity



~ $0.75B in monthly Medicaid spending

X

3% interest rate x 1/12 (monthly rate)

X

25/30 days

=

$1.6 Million per month

Impact

Capturing the interest float on delayed Medicaid payments can result in **~$15-20M in additional revenue**

SOURCE: Team analysis

3b Centralized purchasing will produce savings as the state's large buying power is better leveraged

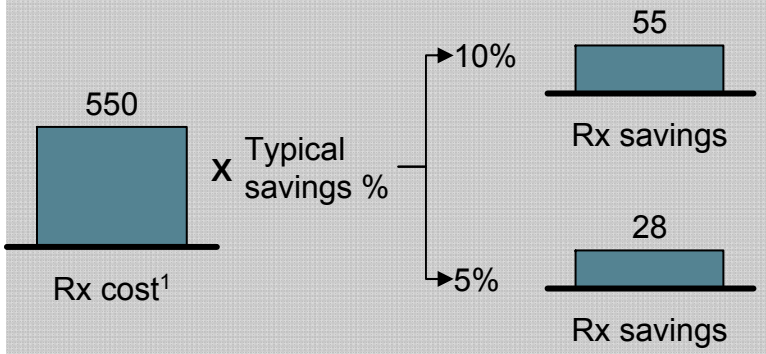
ESTIMATES

Background/Approach

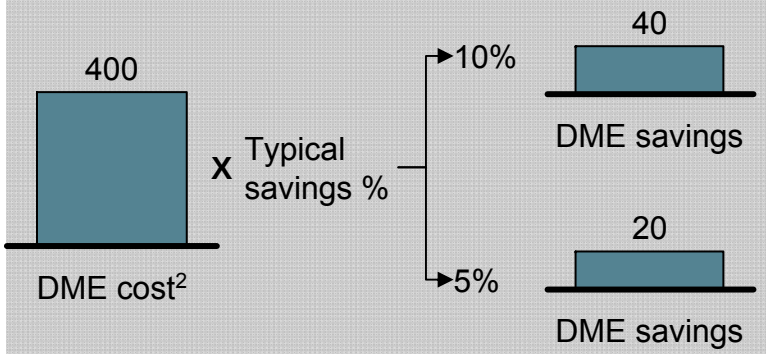
- Ohio's pharmaceutical and DME purchasing is spread across multiple different agencies, resulting in **diminished buying power**
- The statewide Rock program has saved **~7% on pharmaceutical purchases** for its health plans
- Some complication due to Medicaid drug rebate programs
- Centralized purchasing **only applies to purchases made directly by the state**
  - For example, a prescription filled at Walgreens will not be any cheaper to the state as that purchase is not controlled by Medicaid

Opportunity

Pharmacy



Durable medical equipment



Impact

Centralized purchasing can provide **$50-100M** in overall savings; **$15-35M in state savings**

1 Assumes 50% of pharmaceutical spend is driven by institutions or other state-influenced settings
2 Assumes 10% of NHF costs are DME, in addition to non-NHF DMF spend reported by JFS

SOURCE: ODJFS, Team analysis; Expert interviews

Changes to the Medicaid care delivery system could have savings impact of up to $580M annually

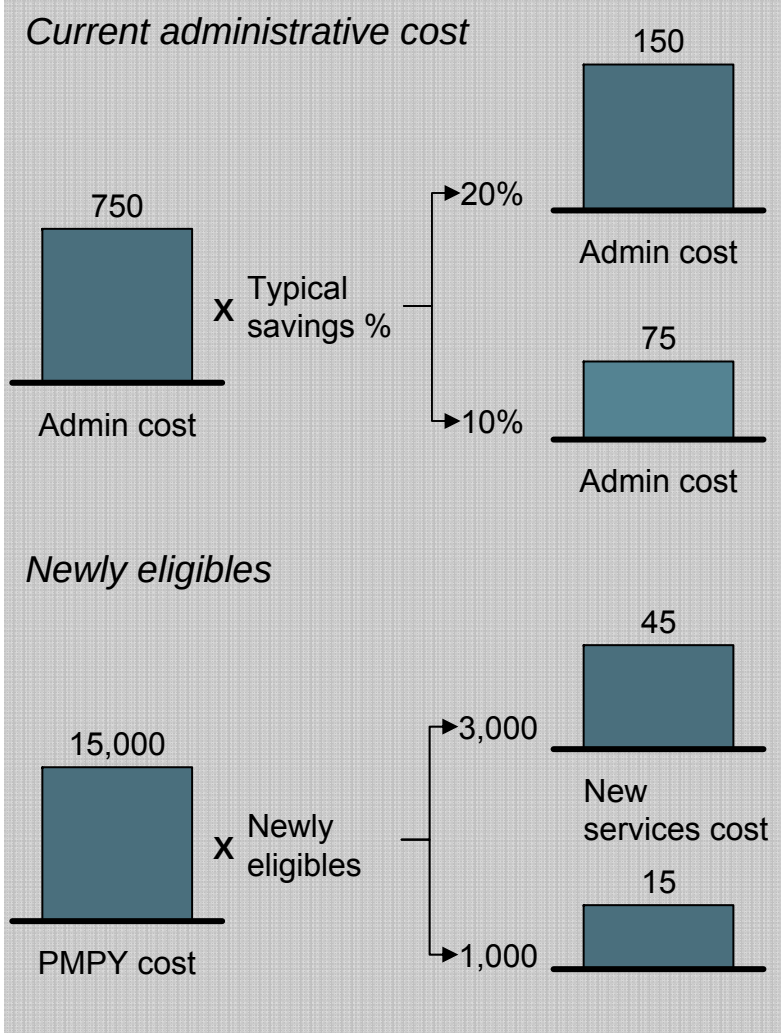
	Description	Estimated impact (state)
3 **Improving eligibility procedures for Medicaid**	▪ Shifting from a 209(B) to 1634 statute will streamline eligibility determinations, reducing the state's administrative burden and reducing wait times ▪ Likely to increase enrollment	▪ **$20-40M**
5 **Providing a wider spectrum of options to LTC patients**	▪ Provides a full spectrum of options rather than defaulting to nursing homes for long term care patients ▪ Establishes a "front door" mechanism to direct and place individuals in the proper type of care	▪ **$130-215M**
6 **Lowering Medicaid reimbursement to institutional care**	▪ Medicaid is largely financing the nursing home industry, as Medicaid per diems underwrite the business functions (including legal expenses) of nursing home facilities	▪ **$105-175M**
7 **Enhanced care coordination for ABD population**	▪ Reduces overall utilization and improve outcomes as patients have a better understanding of what they need for their specific circumstance ▪ Bundle payments in an ACO structure to realize joint savings across the system	▪ **$70-150M**

4 Converting from a 209 (B) eligibility system to a 1634 system can provide additional incremental savings

Background/Approach

- Currently, eligibility is determined at the county level through a complicated process derived from the state's decision to operate as a 209(B) state, allowing it to set separate eligibility criteria
- Shifting to a 1634 system will **streamline eligibility determination** and reduce overall administrative costs
- However, streamlining this process will **likely increase the overall size of the Medicaid rolls** as individuals are cleared onto the rolls faster
- Converting to a 1634 may not be a large savings lever in the short term, but will help avoid costs as Medicaid becomes larger and larger under reform

Opportunity

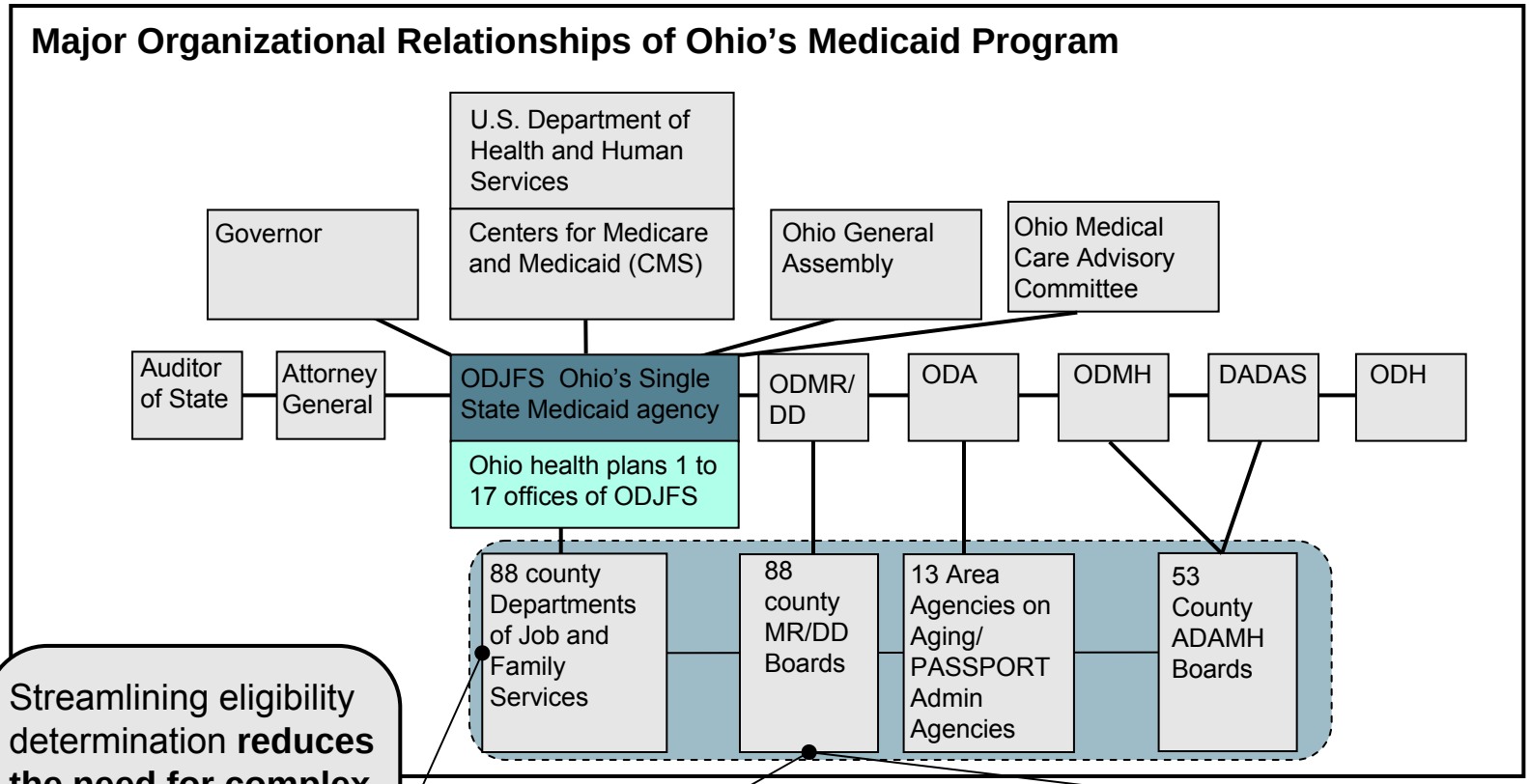


Impact

Streamlining eligibility can provide $60-105M; **$20-40M in state savings**

SOURCE: Kaiser Family Foundation; Team analysis

4 Streamlining the eligibility determination process allows for potential consolidation at the state and county level



Streamlining eligibility determination **reduces the need for complex county JFS structures** to handle front-end eligibility and on-boarding

Even without the 1634 determination process, there is an opportunity to **consolidate functions across the county structure**

Privatization is also a key enabler of reducing costs at the state and county level – creating quasi-governmental orgs to administer Medicaid can save state funds while drawing federal match

SOURCE: Ohio Commission to Reform Medicaid

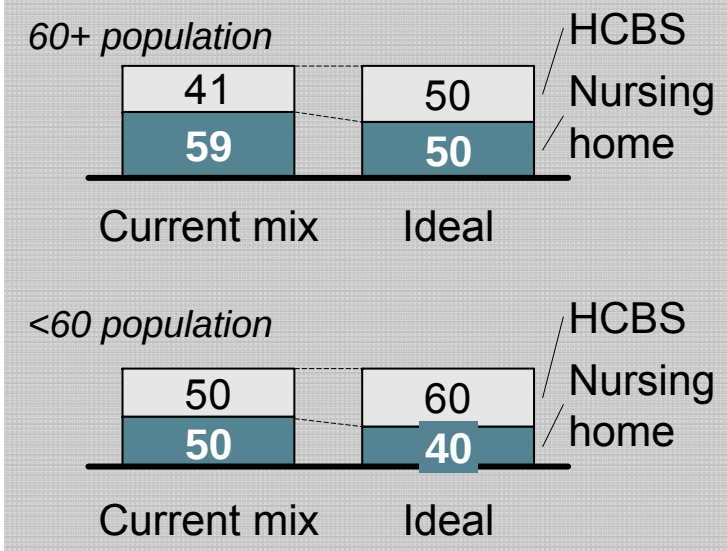
5 Converting some of the current nursing home population to HCBS or assisted living facilities can provide significant savings

Background/Approach

- Ohio's Medicaid system is **predisposed to sending a large number of its patient population into nursing homes**, rather than more appropriate and less expensive options
- Converting patients who do not require nursing home to HCBS or assisted living facilities can **reduce annual per-person expenses from $75K down to $25-50K**
- Shifting a large percentage of the nursing home population into home care will likely require **new waivers or additional capacity within existing waivers**

Opportunity

Percent of LTC patients in different settings



- Assumes ~400 open assisted living beds are filled first (@25K in annual savings)
- Remaining individuals are placed in HCBS (@50K in annual savings)

Impact

This series of nursing home levers can result in **$365-615M** in overall savings; **$130-215M** in state savings

SOURCE: Kaiser Family Foundation; Team analysis

5 There are six key issues that are hindering Ohio's efforts to reduce long term care spend

	Description of issue	Other states/solution space	Importance
Post-acute pathway funnels patients to NF	• Patients (pts) are pushed from acute care to NF as they transition out of hospital care • Medical evidence supportive of homecare	• Create coordinated HCBS offering to better support discharges • Ensure efficient provision of HCBS care	
Limited transition back into community	• Once in Nursing Facility, transition back into community is hampered as patients may fail to qualify for HCBS – Interviewee estimated up to 5% of Ohio NF pts	• Ease eligibility criteria for patients wishing to return home after nursing home stay • Primary focus of MFP* programs – Ohio to receive $100 MM over 5 years	
Incentives and policy favor NF use	• Nursing facilities have high bed capacity • Strong financial incentive to fill beds • Few incentives to coordinate care or manage utilization under current model	• Move away from cost-plus reimbursement • Tighten criteria for NF eligibility • Increase focus on LTC managed care to align incentives and improve utilization (VA)	
Enrollee incentives favor NF use	• Members are responsible for room and board in assisted living facilities • Dual eligible members responsible for drug co-pays and deductibles in assisted living facilities	• Provide assistance to members to compensate for any additional costs • Education and LTC insurance/savings can delay need for Medicare in long term	
Tough AL eligibility criteria	• Current rules require a member to be a resident in a nursing home or pay for oneself for 6 months before he / she can be moved to an assisted living facility	• Consider use of ADL criteria to determine appropriate site of care (AL vs. NF) • Consider room & board subsidies • Allow informed consent agreements (PA)	
Limited assisted living capacity	• Limited Medicaid capacity in existing facilities • Facilities that could potentially be accredited for Medicaid used for private pay individuals • Other supported living sites not currently eligible for Medicare	• Adjust incentives to encourage conversion or creation of beds in AL or AL-like settings (e.g. adapting subsidized housing or Adult Foster Care models with additional su)	

* MFP- Money Follows the Person is a federal program created through the Deficit Reduction Act of 2005. Approximately $100 million has been allocated to Ohio over 2007-2012

** LTC Partnership Program provide asset protection for patients entering LTC

Source: OBRT analysis

5 Nursing homes also have the largest capacity of any setting and have the easiest enrollment criteria

	Distribution of capacity	Annual price tag	Enrollment detail
Assisted living facility	1%	$50k	▪ Assisted living facilities only available if doctor puts into discharge plan ▪ Limited availability in state, not in all locations ▪ Reimbursement rate less from Medicaid so limited incentive to build
Nursing home	68%	$75k	▪ Easiest and most familiar options for docs ▪ High capacity, no challenge in placement ▪ Full Medicaid reimbursement and nursing home tax
Home health care	31%	$25k	▪ Challenging to have Medicaid pay for coverage except under waiver program (need to apply, additional work by family) ▪ Limited capacity for state to provide services today

In Ohio, nursing homes and home health care are required to have the **same level of care**, adding an additional constraint to Ohio Medicaid

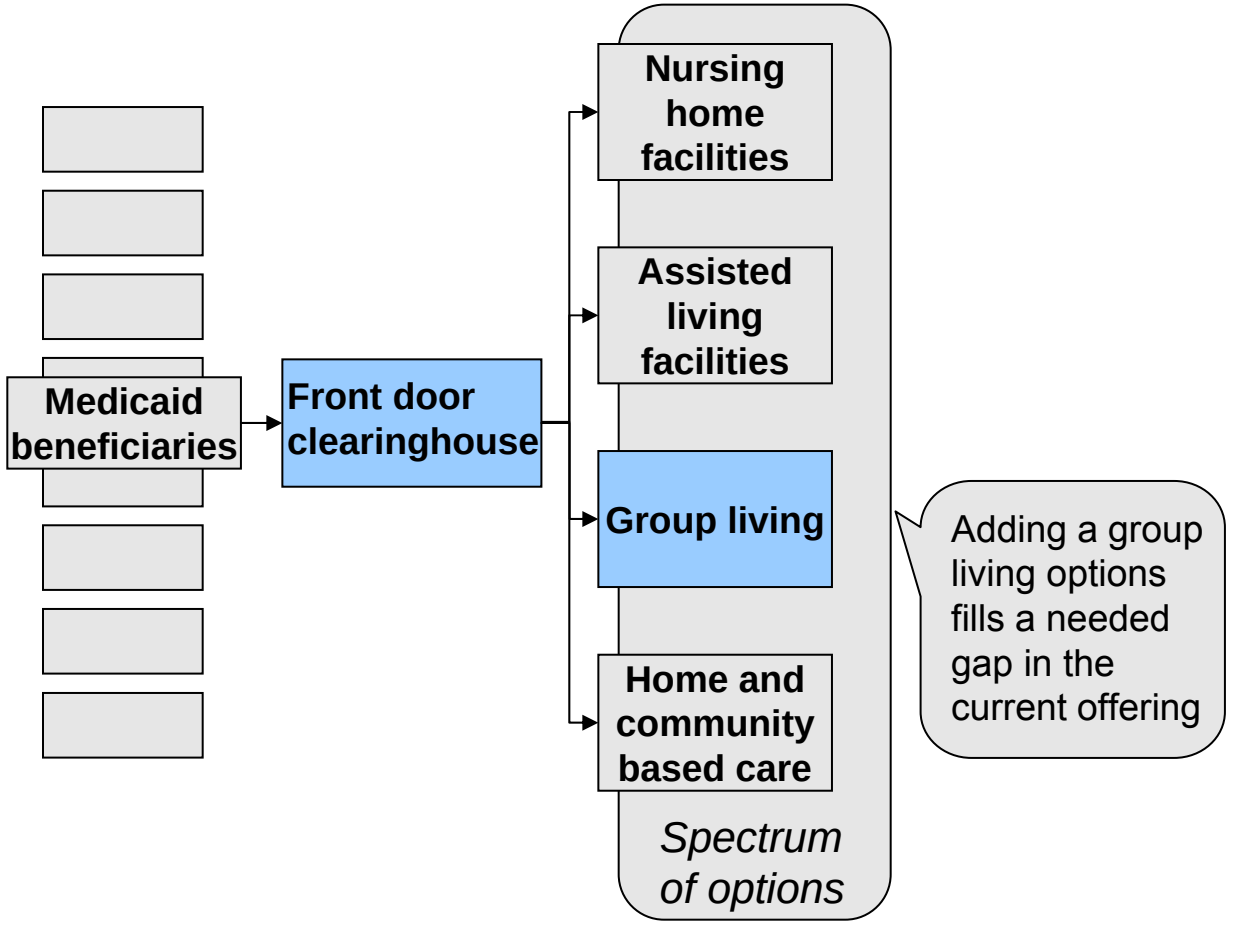
SOURCE: Department of aging; team analysis

5 Rather than nursing homes as a default, Ohio should provide beneficiaries with a spectrum of options specific to their level of care

Long term care strategies

- **Unified long term care budget –** specific allocation for long term care rather than separate allocations for nursing homes, ICF-MRs, HCBS, etc.
- **Money follows the person –** financing moves with the beneficiary to the most appropriate and preferred setting
- **Offering parity –** actively increasing HCBS capacity while drawing down nursing home capacity

Potential redesign



SOURCE: Ohio Department of Aging; Team Analysis

6 Currently, Ohio Medicaid is funding 70% of the nursing home industry – including their end-to-end business functions

Ohio Medicaid nursing home formula

Direct care price
- Covers the **cost of medical services** rendered and pharmaceuticals dispensed in the facility

+

Ancillary services price
- Covers the nursing home's **entire end-to-end business costs**, including legal, accounting, and admin salaries

+

Capital price
- Covers the **cost of ownership** including new construction projects

+

Other price
- Covers various taxes as well as the **quality incentive** and nursing home franchise fee

What is covered by ancillary services

- Accounting services
- Legal services
- Management and consulting services
- Travel and entertainment
- Data services
- Insurance
- Housekeeping
- Marketing and advertising
- Interest payments

SOURCE: Ohio Department of Aging; Team analysis

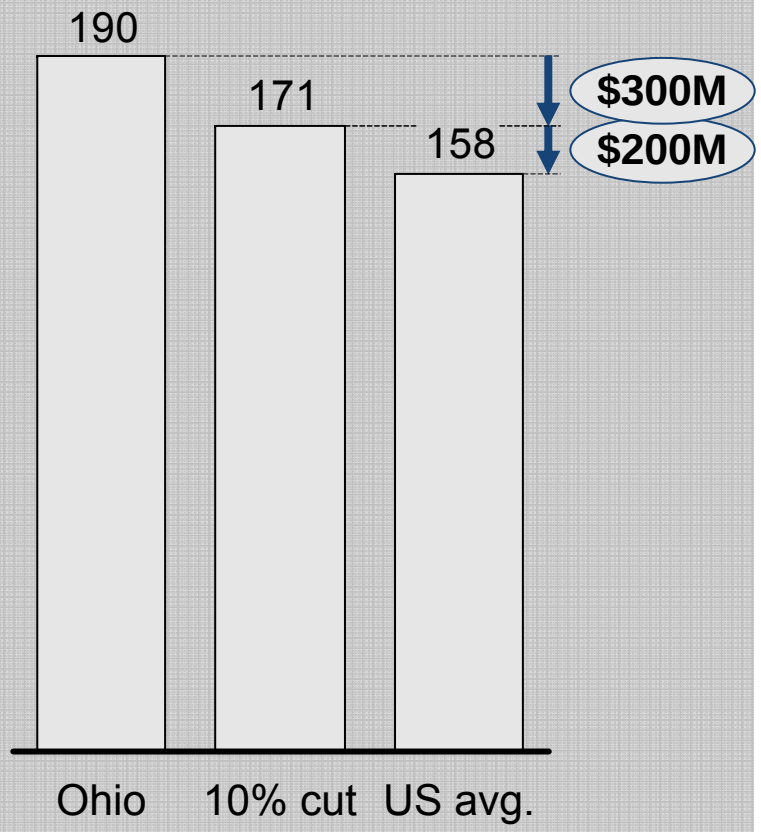
6 Cutting 10% from the current nursing home per diem will provide significant savings, as the industry should be able to absorb the reduction

Background/Approach

- **Ohio Medicaid is paying over $190 per bed per day** to the nursing homes
- Reducing this by $10-20 per bed per day will **produce significant savings**, given the scale of the NHF operation, while still **providing enough revenue for the homes to stay afloat**
- In 2007 (last year with reliable data), **Ohio had the 7th highest Medicaid per diem of any state**
- Shifting to a pure pay-for-performance model can also reduce average per diems within the system

Opportunity

Savings from ABD care management
$ Millions



Impact

This series of nursing home levers can result in **$300-500M** in total savings; **$105-175M** in state savings

SOURCE: AARP; Team analysis

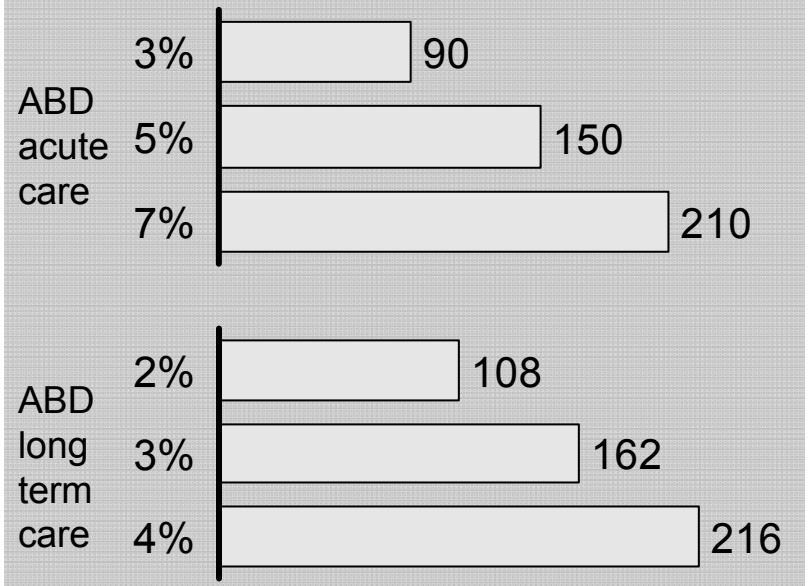
7 Enhanced care coordination of the ABD population can lead to across the board cost savings within fee for service

Background/Approach

- Employing better care coordination within Medicaid for the ABD fee-for-service population
- The most expensive Medicaid enrollees can have **medical costs upwards of $2-3 million per year** (e.g. hemophiliacs)
- Other **states have had success** in reducing overall ABD spend by implementing comprehensive care management strategies
- In the short term, implementing **care coordination programs for the most expensive users** of Medicaid will have more immediate payoffs

Opportunity

Savings from ABD care management
$ Millions



- Assumes 5% average savings on acute care (Carolina case study)
- Lower savings (2-4%) on long term care given other levers (NHF to HCBS, etc.)

Impact

This series of nursing home levers can result in **$200-425M** in total savings; **$70-150M** in state savings

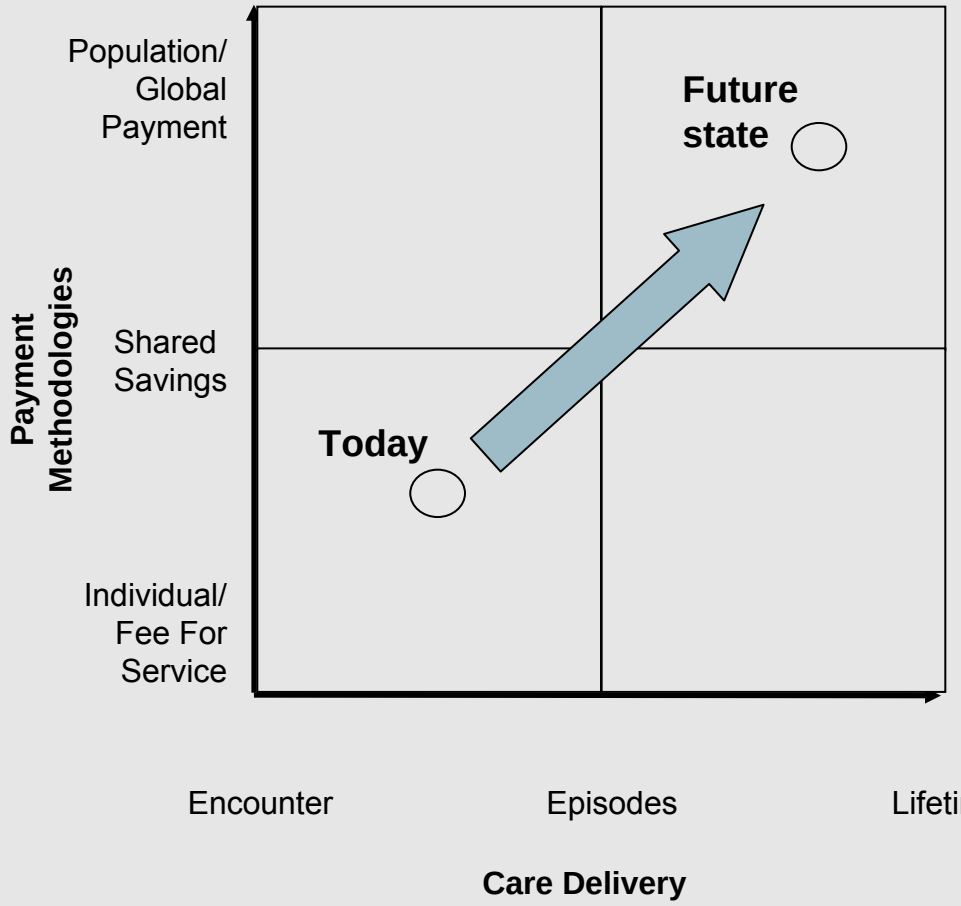
SOURCE: Kaiser Family Foundation; Team analysis

7 Accountable care organizations (ACOs) are one possible delivery mechanism for enhanced care coordination

What are ACOs?

- Accountable care organizations **assume the risk of a patient population** while streamlining end-to-end care for each patient
- In the context of Medicaid, ACOs have **incentives to improve outcomes and reduce costs**, leading to shared savings for both the ACO and the state
- ACOs can **reduce unnecessary hospital readmissions and reduce overall utilization** due to the focus on lifetime care, rather than encounter-specific care

Medicaid's path to ACOs



SOURCE: Team analysis

7 In addition to lowering Medicaid costs, ACOs also represent an important mindset shift – paying for "health care" instead of "sick care"

Current system	ACO system
▪ Care is paid for on a **retrospective** manner – once a person is sick, their services and prescription drugs are covered by fee-for-service payments	▪ Care is paid for on a **prospective** basis – ACOs receive bundled payments to treat the patient as a whole
▪ No incentives to view the individual as a holistic consumer of health care – **each encounter is treated as a discrete event**	▪ Incentives to treat the patient as a holistic consumer – **encounters are treated as part of the larger pattern in the individual's care**
▪ Incentives and ability to improve outcomes are scattered across a wide array of providers – **no single entity assumes the risk** of outcome for patient	▪ **ACOs assume the entire risk** of a patient population
	▪ **Shared savings between the state and the ACOs** – as outcomes improve, both entities see savings

SOURCE: Ohio Pharmacy Association, Ohio Hospital Association, Institute of Medicine, Team Analysis

7 ACOs can also affect consumer change by focusing on personal responsibility and wellness strategies

How ACOs affect consumer change

- Wellness programs that address the biggest drivers of Medicaid spending (diabetes, smoking, obesity) are easily implemented in the context of an ACO
- Given ACOs role as a holistic view of an individual's health care, these organizations have a unique ability to control consumer behavior through continuity of care
- ACOs have incentives to maintain wellness programs as they share in any savings gained from a healthier Medicaid population

Types of potential wellness programs

Smoking cessation program

Healthy habits nutrition program

Exercise and physical fitness program

SOURCE: Team analysis, Expert interviews,

7 Changing workforce scope of practice regulations can provide savings to the Medicaid program and offer more care in rural areas

Ohio scope of practice laws

- Nurse practitioners are **required to have MD collaboration** for most decisions
- 44 states provide **explicit authority for nurse practitioners to diagnose** – Ohio is one of the other six states
- Some advance practice nurses are authorized to prescribe drugs
- Ohio's **scope of practice for pharmacists is also limited** – providing medical therapy management is difficult due to statute

What you gain by changing them

- **Reduced overall costs** as physicians are no longer required for a host of procedures
- **Better health outcomes** as care is managed at a more local level – medical therapy management with pharmacists and primary care with non-physicians
- **Increased access to services in rural Ohio** – Medicaid beneficiaries no longer need to go to the nearest ER for basic services
- **Encourage nurses and pharmacists to stay in state –** those educated at state universities currently have incentives to leave the state and practice elsewhere, resulting in a "brain drain" of sorts

SOURCE: Ohio Pharmacy Association, Ohio Hospital Association, Institute of Medicine, Team Analysis

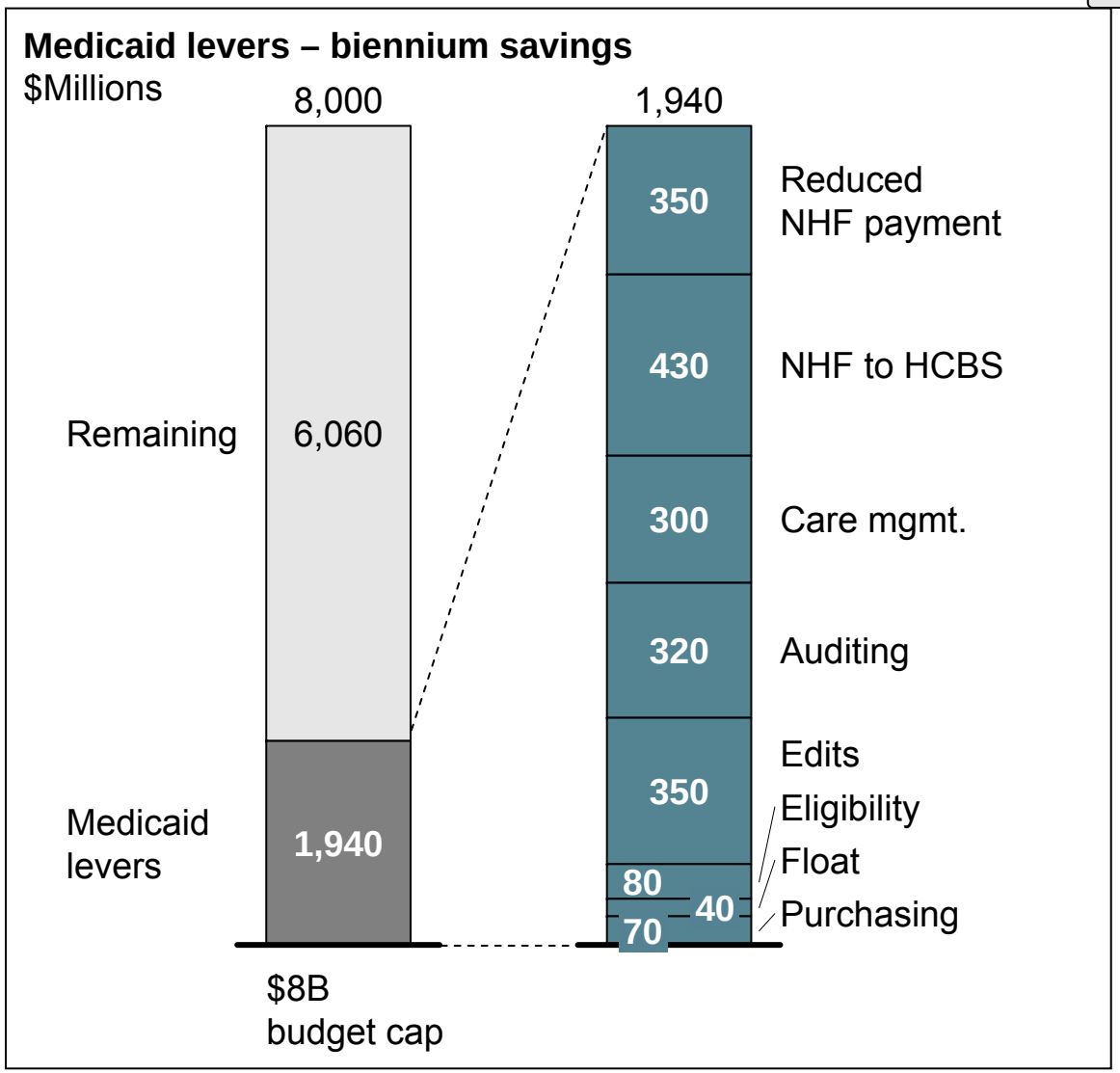
There is an additional set of less palatable levers that can also reduce state Medicaid spending

	Description	Estimated impact
Reduced coverage of optional services	▪ Medicaid has a set of "required" services and a set of "optional services" ▪ Reducing coverage of optional services, include dental and pharmaceuticals, can provide dramatic savings	▪ **$50M – $1.5B** (varies widely depending on how many services are to be cut)
Reimbursement reductions for providers	▪ Medicaid has discretion in setting reimbursement rates for providers ▪ Setting rates too low, however, can lower overall level of care and have detrimental effects on the large health care industry	▪ **$100M- $?** (depends directly on reimbursement cuts)

Upper bound of savings would be shutting down program- $5B saved- clearly not politically viable or in best interest of Ohio

On an annual basis, these levers can save roughly $2 billion in Medicaid spending over the biennium, nearly 1/4 of the budget gap

Not including reductions in coverage here



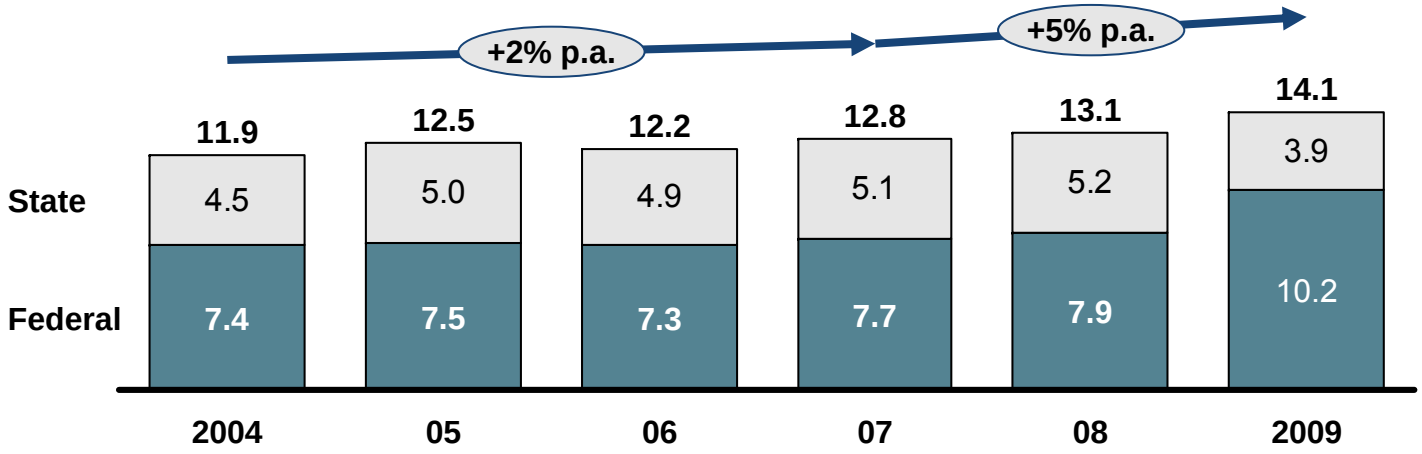
Lever descriptions

Reduced NHF payment – reduction in NHF per diems
NHF to HCBS – moving more enrollees to home care and away from nursing homes
Care mgmt. – ABD care management
Auditing – enhanced mechanisms to track fraud, waste, and abuse
Edits – increased use of prior authorizations and edits to reduce overall utilization
Eligibility – streamlines eligibility process
Float – delayed payments to capture interest
Purchasing – leveraging the state's buying power

Most of these levers could have impact on state's broader HCF spend as well- TBD

Medicaid: Ohio's Medicaid spending continues to increase year over year, largely driven by an increasing number of enrollees

Total Medicaid spend – Ohio
$ Billions

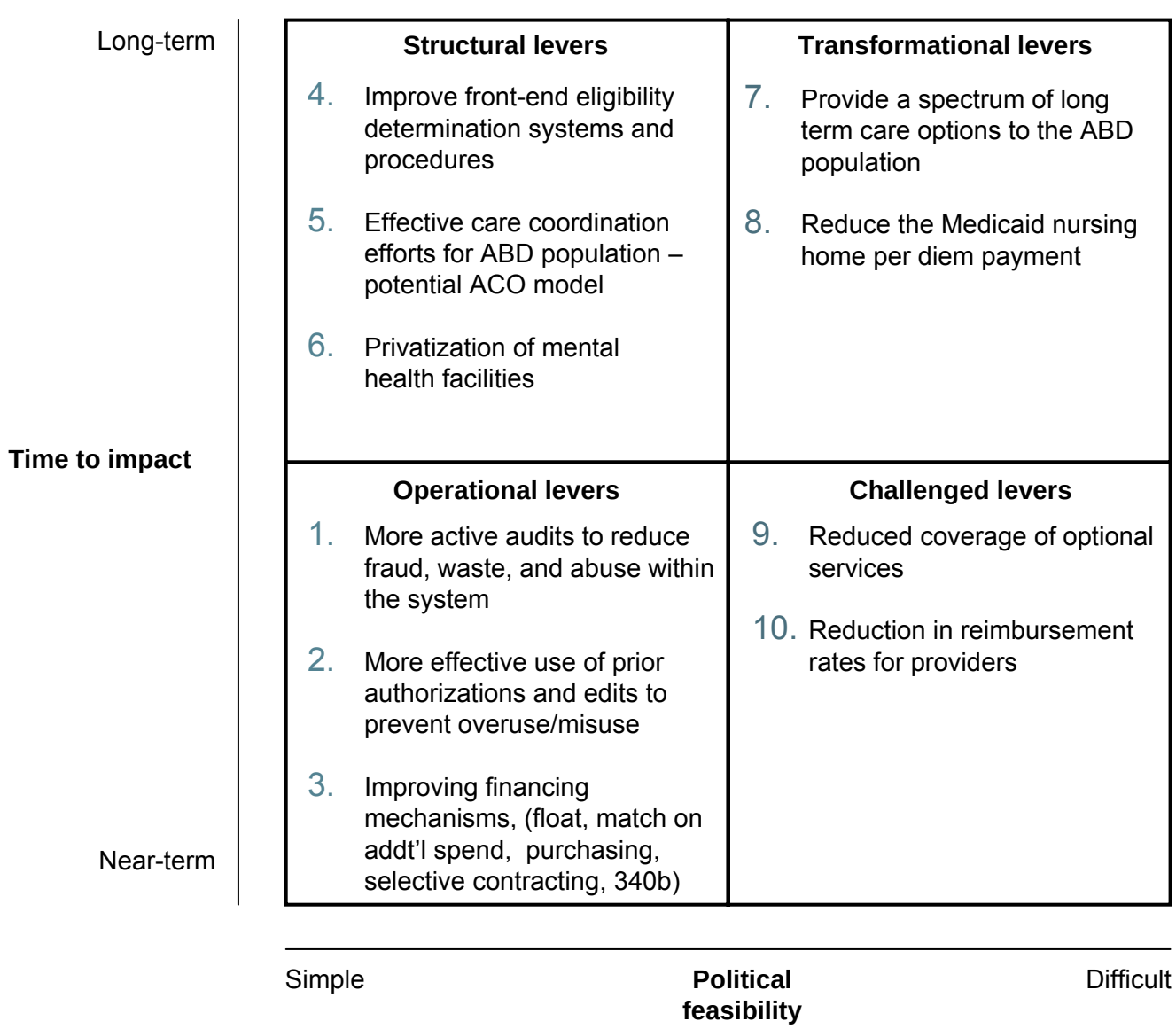


	2004	05	06	07	08	2009
Number of enrollees Millions	1.6	1.6	1.6	1.6	1.7	1.8
Average cost per enrollee USD $	7,672	7,832	7,687	7,985	7,643	7,815

The 2007-2009 increase is **driven more by an increase in the number of total enrollees** rather than an increase in the cost per enrollee

SOURCE: CMS, Kaiser State Health Facts

Medicaid: We have identified three groups of opportunities in Medicaid – operational levers, changes to the delivery system, and limiting coverage



Estimated annual savings
Millions

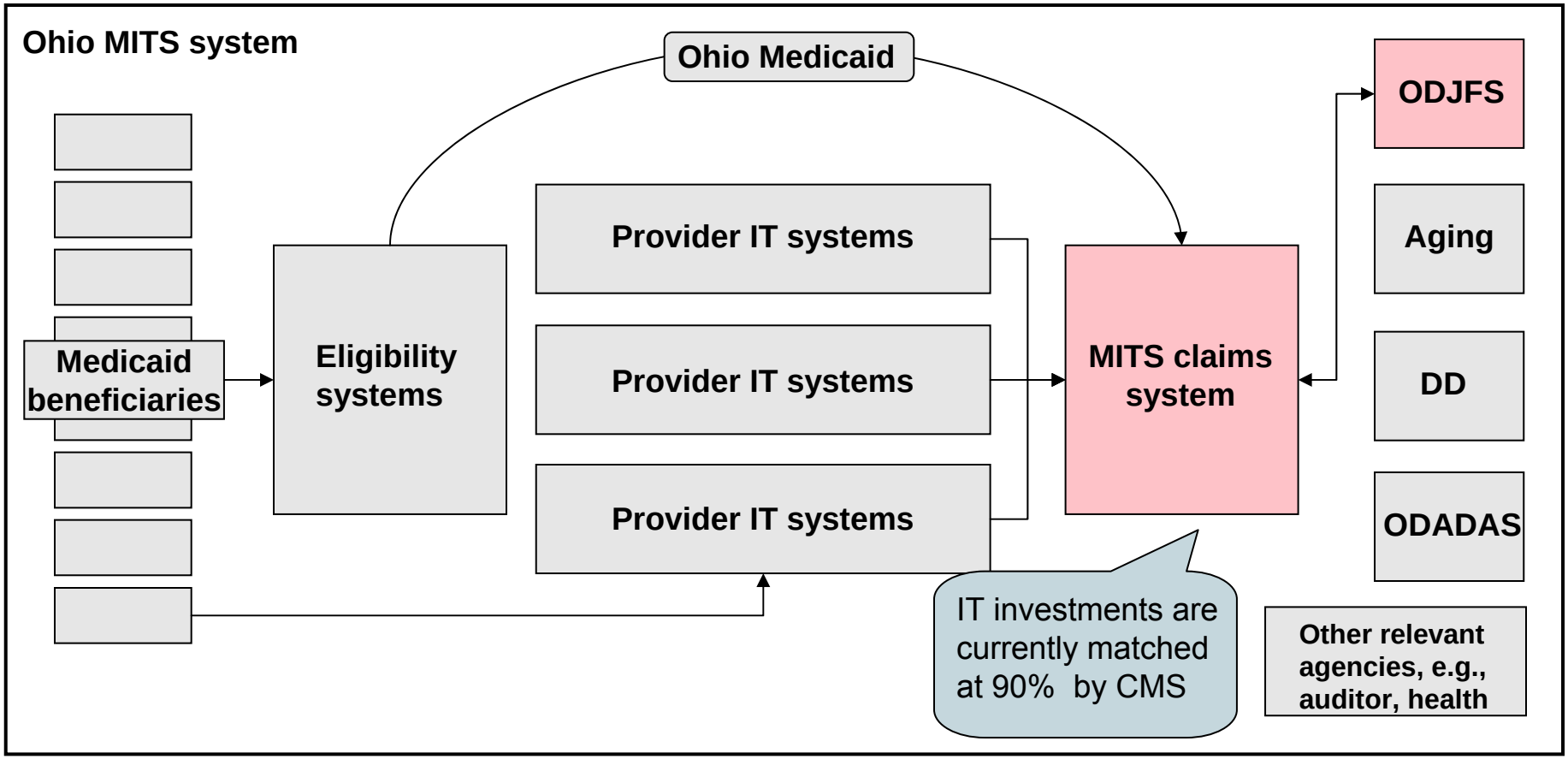
1	$100-160
2	$100-175
3	$100-175
4	$20-40
5	$70-150
6	$20-40
7	$130-215
8	$105-175
9	$50-1,500
10	$100-?

Not included in overall sizing

Total annual: $575-1,010

Total biennial: $1,150-2,020

Medicaid: As planned, the state's new Medicaid IT claims systems (MITS), is not the ideal system to handle the state's auditing mechanism



Beneficiaries enroll with **JFS at the county level**	Front-end systems are still complicated and **disaggregated across counties**; other JFS programs have siloed systems	Provider IT systems are all different, making it **difficult for inter-provider communication** for a single patient	MITS, scheduled to launch in December, is a **back-end claims system** – it does not address eligibility issues nor does it communicate with all relevant agencies

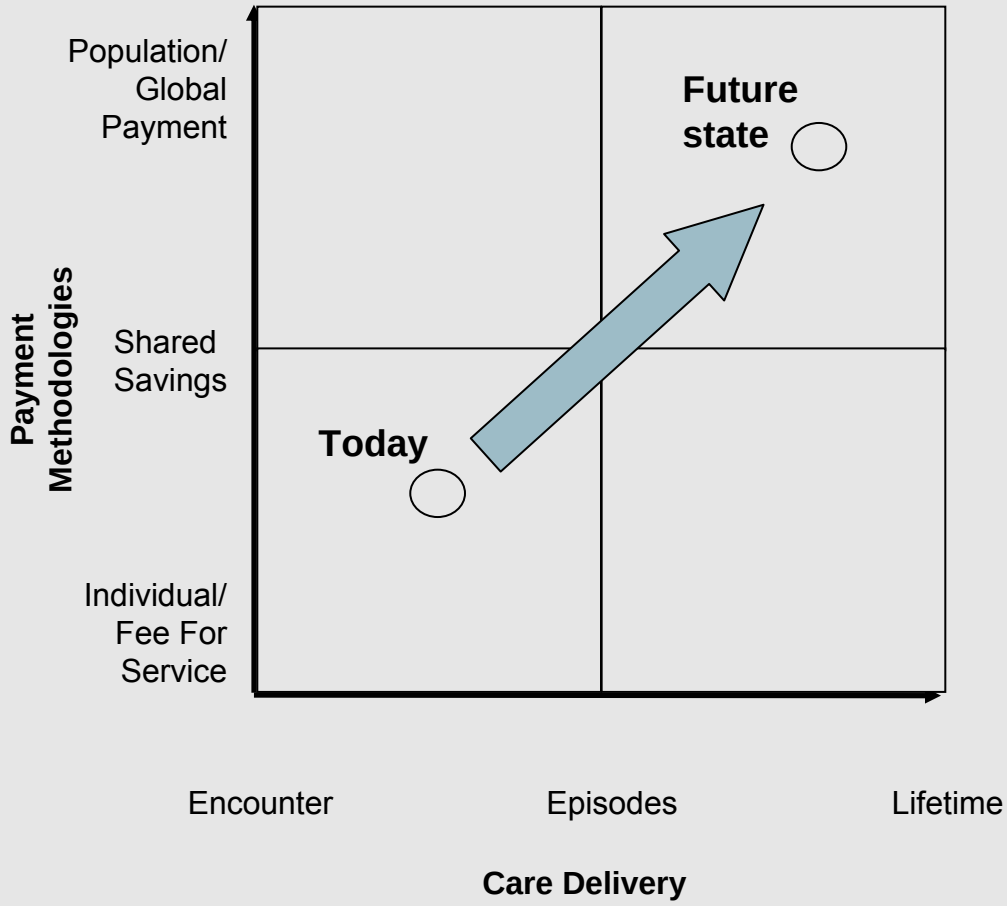
SOURCE: ODJFS, ODA, Expert interviews, Team analysis

Medicaid: Care management set-ups like accountable care organizations (ACOs) could deliver enhanced care coordination

What are ACOs?

- Accountable care organizations **assume the risk of a patient population** while streamlining end-to-end care for each patient
- In the context of Medicaid, ACOs have **incentives to improve outcomes and reduce costs**, leading to shared savings for both the ACO and the state
- ACOs can **reduce unnecessary hospital readmissions and reduce overall utilization** due to the focus on lifetime care, rather than encounter-specific care

Medicaid's path to great care management



SOURCE: Team analysis

Topics of discussion for today

- General budget and the upcoming gap
- Medicaid / Healthcare Financing
- K-12 Education
- Other opportunities

The team conducted an in-depth review of Ohio's K-12 education system to identify gaps and savings opportunities

Facts on Ohio K-12 education

- Ohio's K-12 education system is a $50 billion/ biennium program, and is the largest user of state and local funds in the budget
- Ohio's K-12 education system is responsible for 612 school districts and 1.9 million students, primarily educated through traditional public schools but with growing charter participation
- Ohio schools receive varied amounts of state and local funding, dependent on their ability to use levies for local dollars; funding levels vary from ~$6900/ student at low end to ~$20,000 at high end
- Due to the structure of funding, savings in K-12 education will need to be captured at local level, as districts have majority of control in how dollars are spent and saved

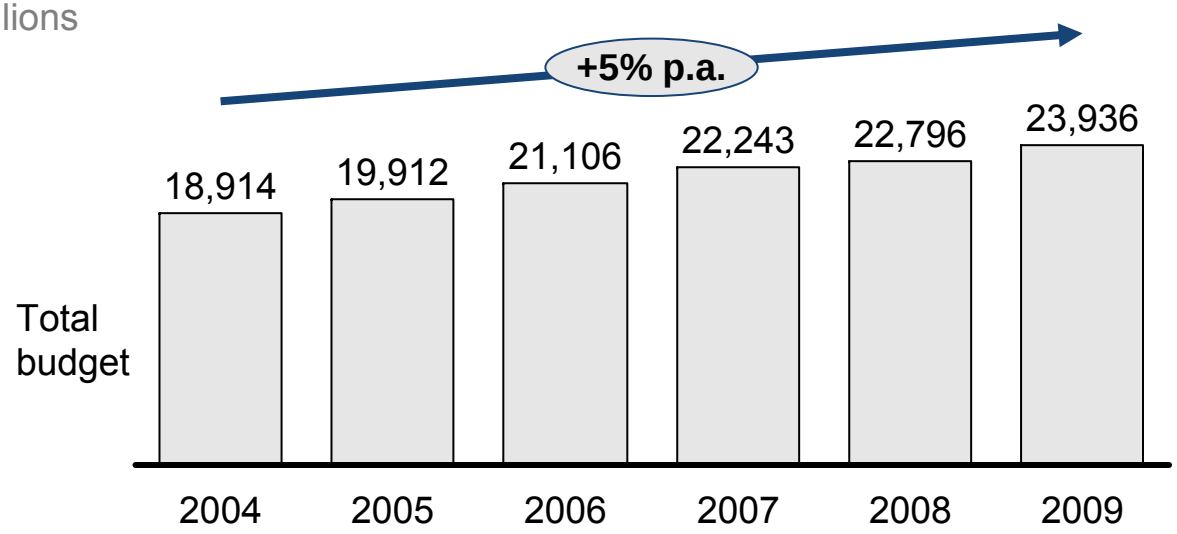
Critical challenges to address

- **Administrative bloat- Ohio** ranks 47th in nation in % of spending in classroom and 49th in ratio of teacher comp to total comp
- **Undersized districts-** districts significantly smaller than neighboring states, with disproportionate per pupil expenditures on support and operations
- **Rules around teacher pay and employment**
  - Collective bargaining increases pay at unsustainable rate
  - Last-in first-out lay-offs eliminate performance as a key consideration

Education: Ohio's K-12 education budget has steadily increased, while the student population has remained flat

K-12 education budget (all sources), 2004-2009

$ Millions



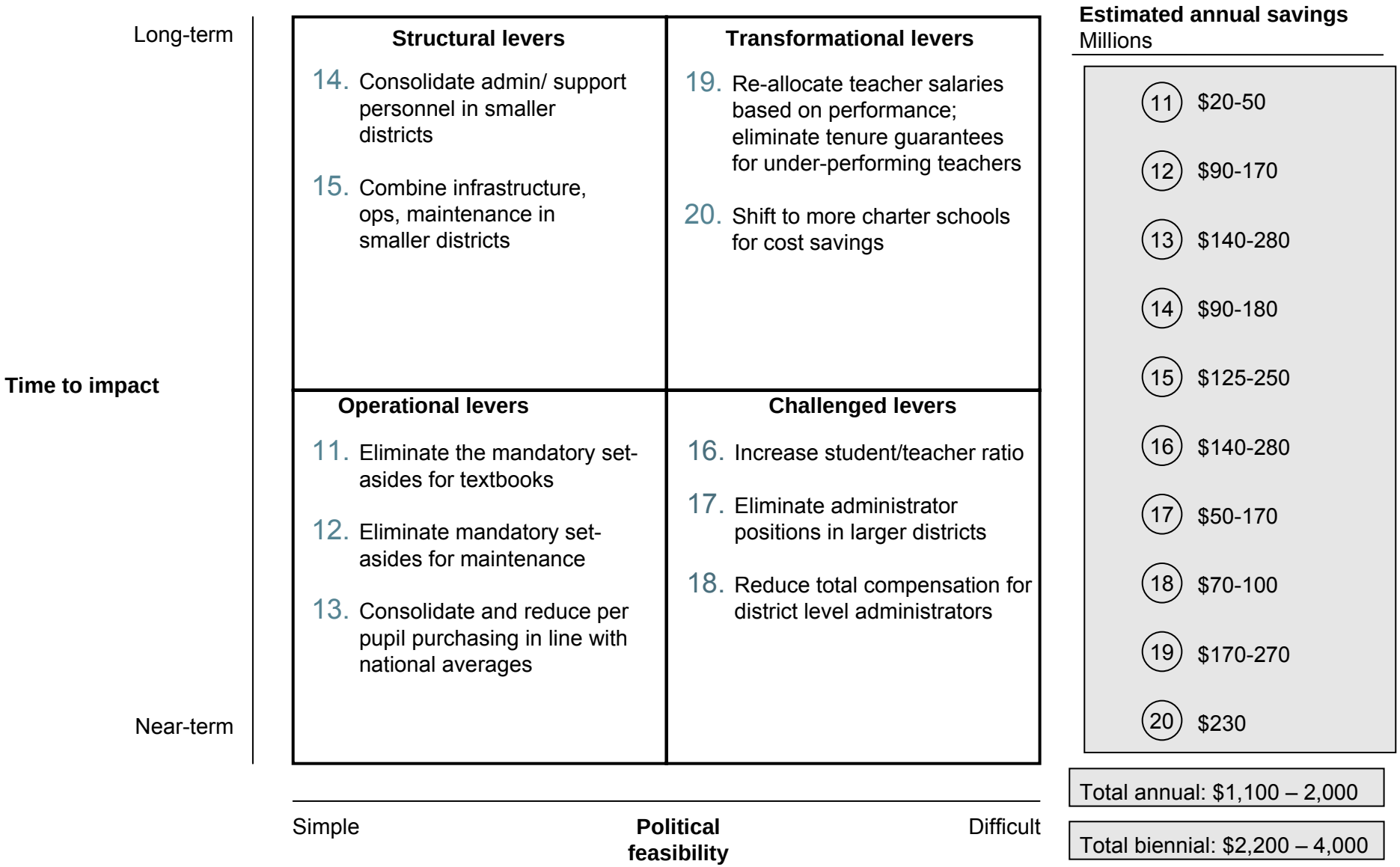
	2004	2005	2006	2007	2008	2009	CAGR Percent
# of students	1,845,428	1,840,032	1,839,683	1,836,722	1,827,184	1,817,163	**0**
Spending per student Dollars[1]	9,029	9,330	9,692	9,937	9,995	10,495	**5**

- 5% growth from 2004-2009 is in line with other states
- Ohio expects growth to continue for FYs 10 and 11
- A few states (e.g. New Jersey, Indiana) have curbed this trend for FY 10

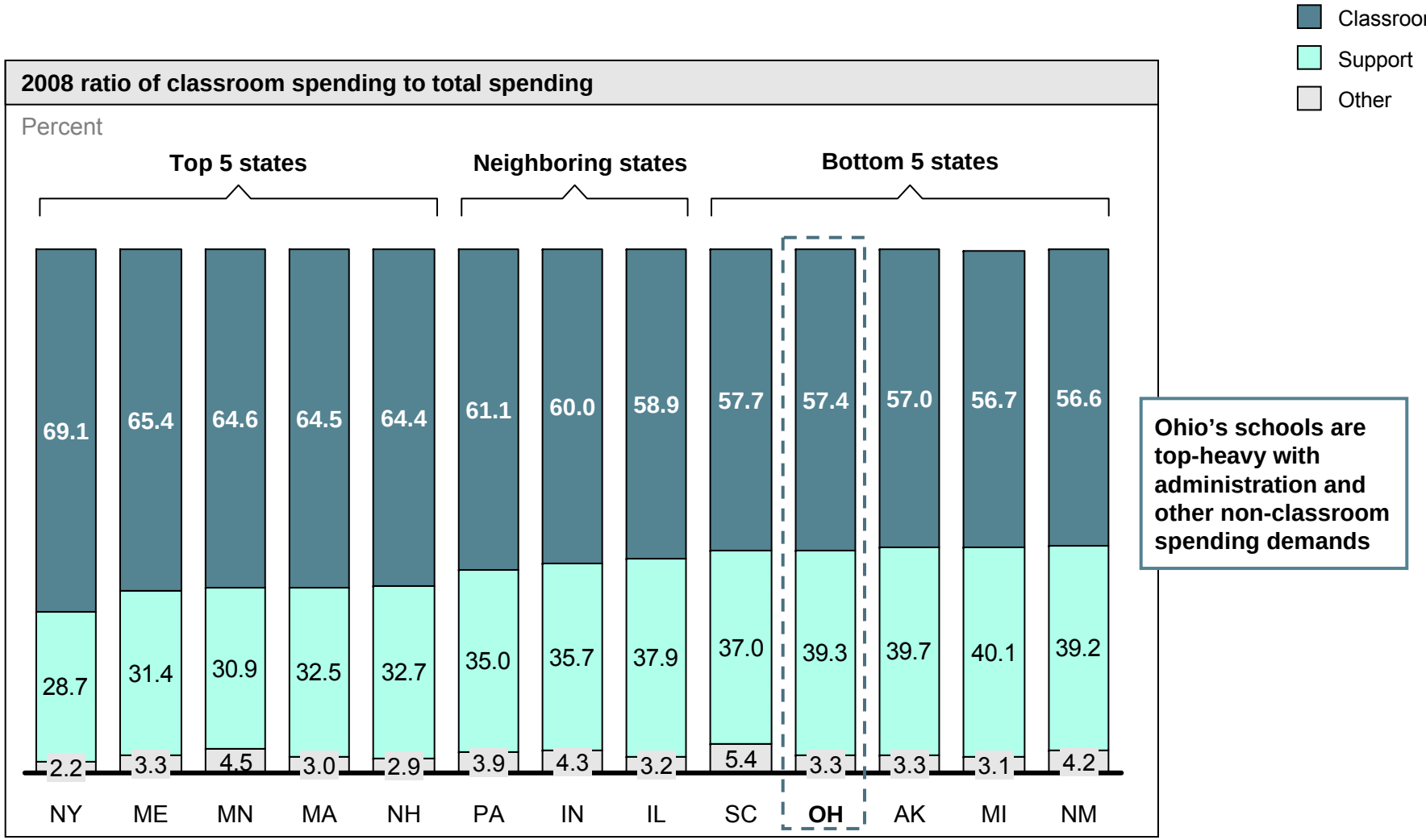
1 Data does not include certain expenditures (i.e. interest on debt, some capital outlays) in "per student" calculations

SOURCE: US Census; NCES; team analysis

Education: We have identified and grouped a set of levers that can help the state and local districts capture savings



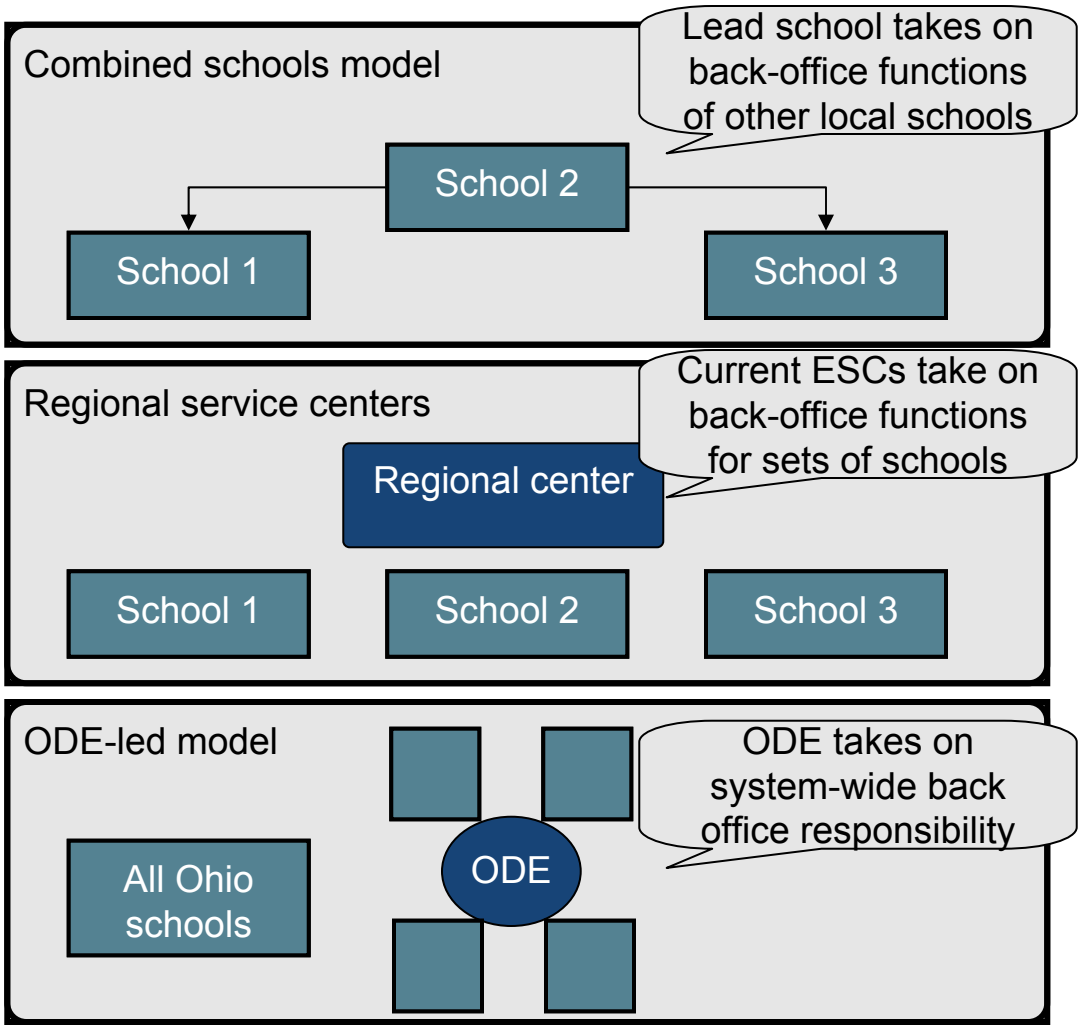
Education: Ohio ranks 47th nationally in total classroom spending ratio



SOURCE: NCES

Implementation approach for consolidation could vary dependent on depth of consolidation

Consolidation options



- **While combined schools model is easiest to implement,** likely will result in less efficiency and standardization gains
- Regional service centers are attractive as **Educational Service Centers** already exist at regional level, bring deeper integration
- **ODE-led model** would represent greatest cost savings in theory and represent transformational change, but actual ability to implement has been called into question

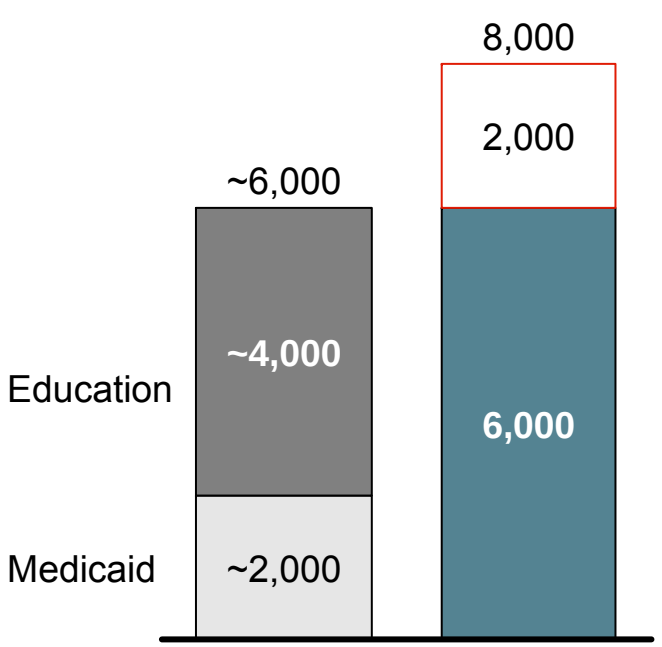
SOURCE: Interviews; Press reports; team analysis

Topics of discussion for today

- General budget and the upcoming gap
- Medicaid / Healthcare Financing
- K-12 Education
- Other opportunities

Other areas: We also investigated other opportunities for savings

Total annual budget gap
Millions



Savings measures to consider

Medicaid levers

- Administrative savings
- Utilization reduction
- Broader care mgmt
- Reductions in eligibility and coverage

Total savings= $2,000M

Education levers

- Services and administrative savings
- Operations improvement
- Teacher ratio reduction and performance pay

Total savings ~4,000M

Other program levers

- Corrections savings
- Higher education
- Other program areas

Total savings= $1,000M+

Cross-cutting levers

- Gov't salary and benefits reductions
- Local/ state government overlap

Total savings= $1,000M+

There are five primary levers within the pension and benefits space

	Description	National benchmark	Potential savings
Reduce pension multiplier that determines annuity	▪ Ohio has a defined benefit plan, that multiplies years of service by final salary and a formula multiplier to determine the annuity	▪ Ohio – 2.2-2.5% ▪ Nat. Avg - 2%	*$200-400M*
Reduce state contribution to pension system	▪ Every state provides a certain level of contribution into their retiree's pension benefit plan	▪ Ohio – 14% ▪ Nat. Avg. – 10-12%	*$400M*
Reduce health care coverage premiums	▪ Ohio's average state employee health care coverage requires a total monthly premium of $326 for an individual plan	▪ Ohio – $327 ind.; $897 family ▪ Nat. Avg - $475 ind; $1,062 family	*$40-50M*[1]
More active audits of pension funds	▪ Many states have found millions in fraud, waste, and abuse within their pension funds	▪ 0.5-1.5% in savings across the $10B in annual payouts	*$50-150M*
Lower average salaries for state workers	▪ Ohio has a total (state and local) personnel cost of over $28 billion annually across 750,000 employees	▪ 0.5-1% across-the-board cuts to state and local employee salaries	*$140-280M*

Max opportunity roughly $1,200M

1 Accounts of only state portion of savings; potential for additional $600M at the local level

Prisons: Savings opportunities exist through reducing cost of operations as well as through reducing overall population

		Detail	Savings
Reductions in total cost of operating prisons	**Reducing marginal per prisoner cost**	▪ Privatization of non-core elements of prisons operations- staffing, food service, etc ▪ Reduction in medical costs through joint purchasing, leveraging Medicaid for expenses outside of prison system	$22M
	Reducing fixed cost of prisons	▪ Full closure of one medium-sized prison (with concurrent decline in population) ▪ Reduction in non-productive measures in collective bargaining contracts up during this biennium	$47M
Reductions in total prison population	**Limit prison admissions**	▪ Divert low-level offenders to cheaper, non-prison facilities ▪ Require judiciary to utilize standardized risk assessments	$35-100M
	Shorten length of stay	▪ Implement sentencing reform through modification of statute	$200-225M

Max opportunity roughly $400M (with additional opportunity as more prisons close)

SOURCE: Interviews, Higher education literature review; team analysis

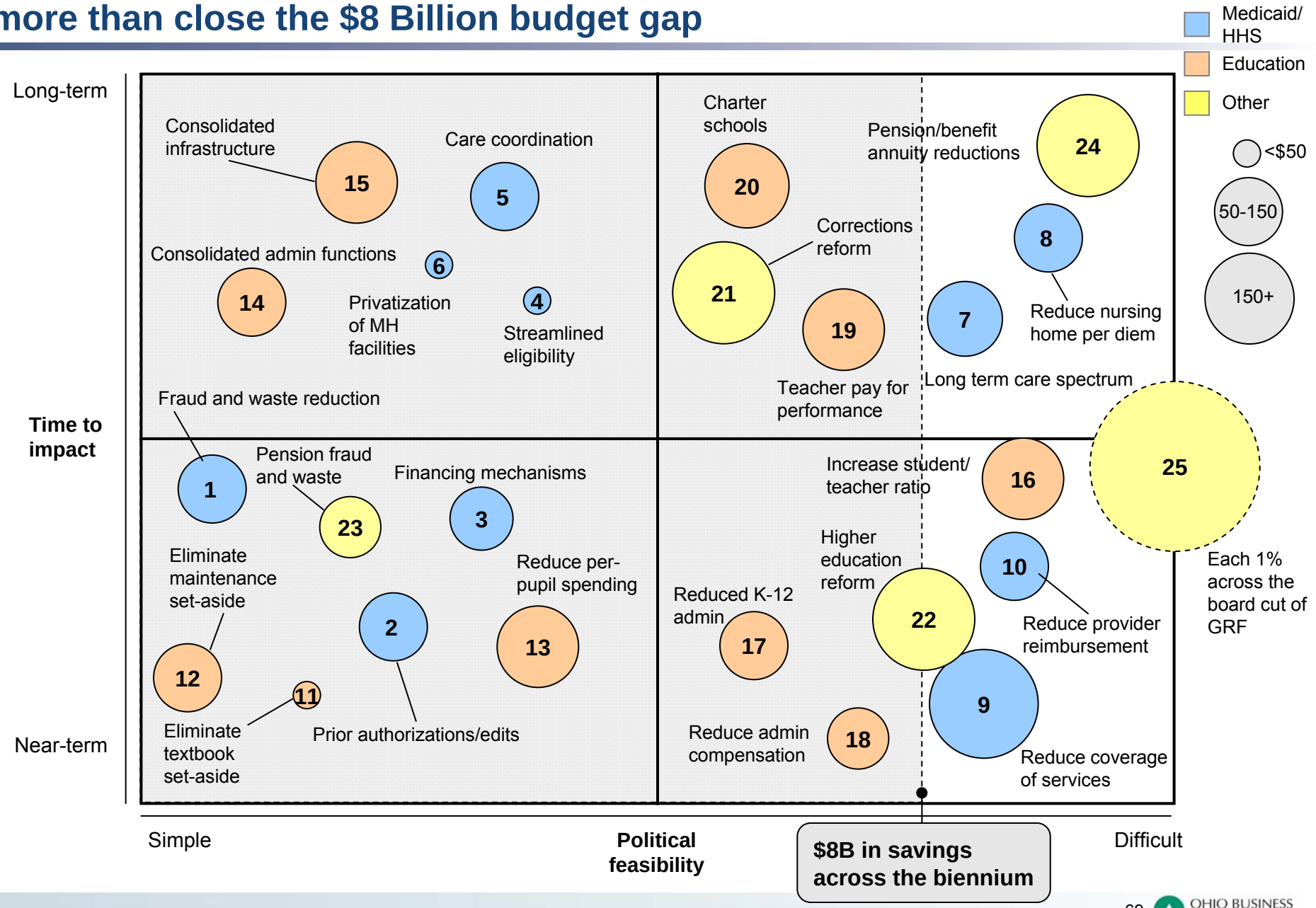
Higher education: While state savings require cuts, we have identified a set of levers by which the universities could make up shortfalls in funding

		Detail	Savings
Savings opportunities at the university/ college level	**Elimination of unfunded mandates**	▪ Elimination of construction mandate and other state-imposed mandates that drive up cost of university and college operations	$250+
	Consolidation of back-office/ admin	▪ Schools could consolidate functions not core to programs (e.g., payroll, admissions process)	<$100M
	Elimination of programs	▪ State could restrict payouts in select programs (e.g., limit number of law schools, de-prioritize certain masters programs)	<$100M
Savings at state-wide program level (non- tuition support savings)	**Minimize/ eliminate certain programs**	▪ State could cut or eliminate small grant programs no longer deemed priority- *BRT goal of avoiding cuts to access programs*	<$100M
	Efficiencies at admin level	▪ Rigorous efficiency programs throughout the state's additional programs (e.g., Board of Regents, Choose Ohio First) could lead to cost savings	<$50M

Max opportunity- $600M annually, though $450M shared at university level

SOURCE: Interviews, Higher education literature review; team analysis

Aggregating levers across categories provides a series of options that can more than close the $8 Billion budget gap



Appendix – Other Opportunities and Levers

There are a set of opportunities that we have considered but would take further effort to size and verify

	Description	Size of opportunity
General savings in other program areas	▪ While we did not complete deep dives in all program areas, best practices from other states suggest potential to cut 3-5% of program budgets that can be made up for in operational and administrative savings	Large- over $500 million annually
Greater improvements to state-wide purchasing	▪ While Department of Administrative Services runs some purchasing programs, opportunities still exist- for instance, recent study showed $200 million in savings possible from pooling all state and local government employee health care	Large- over $500 million annually
Addressing Ohio's workers compensation program	▪ Ohio continues to operate a state run workers comp program- while team did not analyze, likely similar challenges to state's pensions and benefits programs, with savings opportunities. Statewide task force reviewing the feasibility to allow employers the option to obtain private insurance to insure their obligations is expected to issue its report in December 2010	Medium- $100-500 million annually
Sale or lease of state assets	▪ Ohio has broad assets has billions worth of state assets in land, buildings, programs that could be sold off, rolled off to third parties for management, etc- significant time required to understand the full measure and trade-offs of opportunity	Very large, but likely one-time savings

There are a set of opportunities that we have considered but would take further effort to size and verify

	Description	Size of opportunity
Maximizing federal reimbursement	▪ Potential to increase federal reimbursement for activities in other program areas. State should catalogue all federal opportunities and manage state expenditures to maximize federal reimbursement. The state must closely monitor where changes in policy and/or budget decisions impact the ability to draw down additional dollars. ▪ Ex: Examine current wastage of federal TANF dollars, which flow through the Ohio Department of Job & Family Services, and the $150 million loss of available TANF dollars. ▪ Ex: Audit the child care expenditures for fraud and evaluate appropriate payment levels and policies ▪ Ex: Examine Ohio Department of Health compliance issues related to Center for Disease Control funding	Large- over $500 million annually
Examine further efficiencies in Public Safety	▪ Potential to save on annual highway patrol spend through elimination of duplicate programs overlaps ▪ Ohio State Highway Patrol Mission Review Task Force minority report suggests further review of some functions and programs that appeared to duplicate or overlap with services provided elsewhere in Ohio's law enforcement structure. They also encouraged further research on possibilities for more collaboration, coordination, and consolidation	Medium- $100-500 million annually
Elimination of local government overlaps	▪ Redundancy in local governments is a huge problem to address in Ohio- townships, counties, cities all have admin and operational spend that could be eliminated. We have addressed some redundancies (e.g., county mental health boards) but more opportunities exist	Large-though most savings at local levels