Health Transformation Team

• Greg Moody, Office of Health Transformation
• Ted Wymyslo, MD, Health
• John McCarthy, Medicaid
• Tracy Plouck, Mental Health
• Orman Hall, Alcohol and Drug Addiction Services
• John Martin, Developmental Disabilities
• Bonnie Kantor-Burman, Aging
Ohio’s Health System Performance

Health Outcomes – 42\textsuperscript{nd} overall\textsuperscript{1}
– 42\textsuperscript{nd} in preventing infant mortality (only 8 states have higher mortality)
– 37\textsuperscript{th} in preventing childhood obesity
– 44\textsuperscript{th} in breast cancer deaths and 38\textsuperscript{th} in colorectal cancer deaths

Prevention, Primary Care, and Care Coordination\textsuperscript{1}
– 37\textsuperscript{th} in preventing avoidable deaths before age 75
– 44\textsuperscript{th} in avoiding Medicare hospital admissions for preventable conditions
– 40\textsuperscript{th} in avoiding Medicare hospital readmissions

Affordability of Health Services\textsuperscript{2}
– 37\textsuperscript{th} most affordable (Ohio spends more per person than all but 13 states)
– 38\textsuperscript{th} most affordable for hospital care and 45\textsuperscript{th} for nursing homes
– 44\textsuperscript{th} most affordable Medicaid for seniors

Sources: (1) Commonwealth Fund 2009 State Scorecard on Health System Performance, (2) Kaiser Family Foundation State Health Facts (updated March 2011)
A few high-cost cases account for most Medicaid spending

1% of the Medicaid population consumes 23% of total Medicaid spending

4% of the Medicaid population consumes 51% of total spending

Source: Ohio Department of Job and Family Services; SFY 2010 for all Medicaid populations and all medical (not administrative) costs
<table>
<thead>
<tr>
<th>Fragmentation</th>
<th>vs.</th>
<th>Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple separate providers</td>
<td></td>
<td>Accountable medical home</td>
</tr>
<tr>
<td>Provider-centered care</td>
<td></td>
<td>Patient-centered care</td>
</tr>
<tr>
<td>Reimbursement rewards volume</td>
<td></td>
<td>Reimbursement rewards value</td>
</tr>
<tr>
<td>Lack of comparison data</td>
<td></td>
<td>Price and quality transparency</td>
</tr>
<tr>
<td>Outdated information technology</td>
<td></td>
<td>Electronic information exchange</td>
</tr>
<tr>
<td>No accountability</td>
<td></td>
<td>Performance measures</td>
</tr>
<tr>
<td>Institutional bias</td>
<td></td>
<td>Continuum of care</td>
</tr>
<tr>
<td>Separate government systems</td>
<td></td>
<td>Medicare/Medicaid/Exchanges</td>
</tr>
<tr>
<td>Complicated categorical eligibility</td>
<td></td>
<td>Streamlined income eligibility</td>
</tr>
<tr>
<td>Rapid cost growth</td>
<td></td>
<td>Sustainable growth over time</td>
</tr>
</tbody>
</table>

SOURCE: Adapted from Melanie Bella, *State Innovative Programs for Dual Eligibles*, NASMD (November 2009)
Ohio Medicaid Spending Trend
9 percent average annual growth, 2008-2011

Source: Office of Health Transformation Consolidated Medicaid Budget, All Funds, All Agencies; actual SFY 2008-2010 and estimated SFY 2011-2013; “All Other” includes Federal Funds and Non-General Revenue Funds (non-GRF)
Health Transformation Priorities

• Improve Care Coordination
• Integrate Behavioral/Physical Health Care
• Rebalance Long-Term Care
• Modernize Reimbursement
• Balance the Budget
Improve Care Coordination

Coordinate care to achieve better health and cost savings through improvement

RECOMMENDATIONS:

• Promote Health Homes
• Provide accountable care for children
• Create a single point of care coordination
The Vision for Better Care Coordination

• The vision is to create a person-centered care management approach – not a provider, program, or payer approach
• Services are integrated for all physical, behavioral, long-term care, and social needs
• Services are provided in the setting of choice
• Easy to navigate for consumers and providers
• Transition seamlessly among settings as needs change
• Link payment to person-centered performance outcomes
Medical Hot Spot:
Emergency Department Utilization: Ohio vs. US

Hospital Emergency Room Visits per 1,000 Population

United States | Ohio
---|---
1999 | 365 | 366
2000 | 436 | 452
2001 | 450 | 450
2002 | 449 | 449
2003 | 468 | 472
2004 | 488 | 488
2005 | 509 | 523
2006 | 516 | 516
2007 | 401 | 401
2008 | 404 | 404

RECOMMENDATION: Promote Health Homes

HB 153 directs the Director of the Ohio Department of Health to define Medicaid Health Homes to ensure consistency in delivery of care and set a standard for reimbursement (3701.032)

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings
- Patient and family support (including authorized reps)
- Referral to community and social support services
- Use of health information technology to link services
- $900,000 in FY 2012 and $46,350,000 in FY 2013
Children with Disabilities Eligible for Managed Care Expansion
Average Per Member Per Month Cost

<table>
<thead>
<tr>
<th>Year</th>
<th>Dollars</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2007</td>
<td>$543.85</td>
<td>7.8%</td>
</tr>
<tr>
<td>FY 2008</td>
<td>$586.02</td>
<td>8.1%</td>
</tr>
<tr>
<td>FY 2009</td>
<td>$633.35</td>
<td>8.7%</td>
</tr>
<tr>
<td>FY 2010</td>
<td>$688.75</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

Based on claims incurred in FY 2010 and paid through January 2011. Prescription drug rebates not included. Includes children not institutionalized, retroactive, backdated, spend down, dual eligible, or enrolled in waivers.
RECOMMENDATION:
Provide Accountable Care for Children

• 37,544 children with disabilities in Medicaid fee-for-service
• Complicated cases but no care coordination
• Pediatric Accountable Care Organizations (ACOs) show promise – but few are ready to take risk and responsibility
• Create a path toward better care coordination
• $87.1 million in FY 2013 ($28.6 million in utilization savings are offset by one-time costs of moving from FFS to managed care)
RECOMMENDATION (continued):
Provide Accountable Care for Children

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Current</th>
<th>Option I</th>
<th>Option II</th>
<th>Option III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Contract</td>
<td>FFS</td>
<td>MCP</td>
<td>MCP</td>
<td>ACO</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>None</td>
<td>MCP</td>
<td>ACO</td>
<td>ACO</td>
</tr>
<tr>
<td>Financial Risk</td>
<td>Medicaid</td>
<td>MCP</td>
<td>MCP</td>
<td>ACO</td>
</tr>
<tr>
<td>Savings</td>
<td>None</td>
<td>Medicaid</td>
<td>MCP &amp; ACO</td>
<td>ACO &amp; Medicaid</td>
</tr>
</tbody>
</table>
RECOMMENDATION:
Create a Single Point of Care Coordination

Implement an Integrated Care Delivery System:
• Focus first on 113,000 dual eligibles in nursing homes and on waivers, and individuals with severe mental illness
• Explore options for delivery models, including managed care, accountable care organizations, health homes, and other
• Require providers to have one point of care coordination
• Triple aim: improve the experience of care, enhance the health of populations, and reduce costs through improvement
• Seek the necessary federal waivers
• Budget neutral (with potential for significant future savings)
Medicaid Hot Spot:
Enrollment and Spending for Severe Mental Illness

<table>
<thead>
<tr>
<th>Enrollment</th>
<th>Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>74%</td>
</tr>
</tbody>
</table>

Source: Ohio Colleges of Medicine Government Resource Center and Health Management Associates, Ohio Medicaid Claims Analysis (February 2011)
Integrate Behavioral/Physical Health

*Treat the whole person, including physical and behavioral health care needs*

**RECOMMENDATIONS:**

- Integrate behavioral and physical health benefits
- “Elevate” behavioral health financing to the state
- Manage behavioral health service utilization through a variety of strategies to avoid across-the-board rate cuts (saves $243 million over the biennium)
- Consolidate housing programs
The National Medical Costs of Opiate Addiction

“The high cost of opioid abuse were driven primarily by high prevalence rates of costly co-morbidities and high utilization of medical services and prescription drugs.”

– Journal of Managed Care Pharmacy

Medical Costs

<table>
<thead>
<tr>
<th>Cost</th>
<th>Opioid Abusers</th>
<th>Non Abusers</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td></td>
<td>$1,830</td>
</tr>
<tr>
<td>$2,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$4,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$6,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$8,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$10,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$12,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$14,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$16,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$18,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Journal of Managed Care Pharmacy, 2005
Rebalance Long Term Care

Enable seniors and people with disabilities to live with dignity in the settings they prefer

RECOMMENDATIONS:

• Align programs for people with developmental disabilities
• Create a Unified Long Term Care System
• Reform nursing facility payment
A Case Study in Transformation: Ohio Department of Developmental Disabilities

GRF = $335M

Number of Individuals

Waivers (Home and Community-based Care)  DC (Developmental Center)
A Case Study in Transformation:
Ohio Department of Developmental Disabilities

Number of Individuals

GRF = $335M
GRF = $331M

Waivers (Home and Community-based Care)  DC (Developmental Center)
RECOMMENDATION:
Align Programs for People with DD

• Continue the transformation already underway
• Transfer Intermediate Care Facilities (ICFs) from ODJFS to DODD
• Transfer Transitions waiver from ODJFS to DODD
• Consolidate DODD Medicaid funding into one line item
• Utilization management
• Continued institution/community realignment
• Saves $62.0 million over the biennium
RECOMMENDATION:
Create a Unified Long-Term Care System

• Make services seamless for consumers and families
• Create a single point of access by consolidating PASSPORT, Ohio Home Care, Transitions/Aging, Choices, Assisted Living
• Transfer Medicaid waiver funding to ODJFS 600-525
• Create a clear “front door” into the delivery system
• Budget neutral
Reform Nursing Facility Payments

- Payment reform is needed to rebalance long-term care
- Ohio’s Medicaid reimbursement per bed per day for nursing homes is $4.75 higher than the national average\(^1\)
- Ohio has more nursing homes than all but 2 states.\(^2\)
- Ohioans are more likely to live near a nursing home than a public high school\(^3\)
- 15% of Ohio nursing home beds are empty on average
- Medicaid reforms in FY 2007 began the process of addressing these issues by transitioning to a price-based payment system

Sources:
3. There are 962 nursing homes and 897 public high schools in Ohio
Ohio has more nursing home beds than any neighboring state

<table>
<thead>
<tr>
<th>State</th>
<th>Population Age 65+ Compared to 1,515,900 in Ohio¹</th>
<th>Nursing Facility Beds Compared to 92,789 in Ohio²</th>
<th>NF Beds Per 1,000 Pop. Compared to 8.0 in Ohio²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michigan</td>
<td>18% fewer seniors</td>
<td>50% fewer beds</td>
<td>4.7</td>
</tr>
<tr>
<td>Tennessee</td>
<td>43% fewer seniors</td>
<td>61% fewer beds</td>
<td>5.8</td>
</tr>
<tr>
<td>West Virginia</td>
<td>80% fewer seniors</td>
<td>88% fewer beds</td>
<td>5.9</td>
</tr>
<tr>
<td>Kentucky</td>
<td>63% fewer seniors</td>
<td>72% fewer beds</td>
<td>5.9</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>23% more seniors</td>
<td>4% fewer beds</td>
<td>7.0</td>
</tr>
<tr>
<td>Indiana</td>
<td>45% fewer seniors</td>
<td>48% fewer beds</td>
<td>7.5</td>
</tr>
</tbody>
</table>

Source:
1. [http://www.statehealthfacts.org/comparetable.jsp?typ=1&ind=2&cat=1&sub=1](http://www.statehealthfacts.org/comparetable.jsp?typ=1&ind=2&cat=1&sub=1)
2. [http://www.statehealthfacts.org/comparetable.jsp?ind=413&cat=8&sub=97&yr=92&typ=1](http://www.statehealthfacts.org/comparetable.jsp?ind=413&cat=8&sub=97&yr=92&typ=1)
98.6% of Medicaid enrollees live within 10 miles of a nursing facility
RECOMMENDATION:
Reform Nursing Facility Payments

• Complete the transition to a price-based system enacted in 2005 (keep price at the 25th percentile for direct care and ancillary/support services)
• Eliminate the statutory add-on and set capital at the 25th percentile
• Increase the quality incentive payment from 1.7 to 8.75 percent
• Increase the portion of the rate that is related to direct care and quality from 50% to 60%
• Limit Medicare cost sharing obligations to no more than Medicaid
• Decrease Medicaid payments to “hold” empty beds from 50% of the facilities rate for 30 days to 25% of the rate for 15 days
• Reduce the nursing home franchise fee from $11.95 per bed to $11.38 in FY 2012 and $11.60 in FY 2013
Medicaid Budget:
Ohio Medicaid Spending on Nursing Homes

2011 Estimated: $2,681
2012 Budget: $2,472 (-7.8%)
2013 Budget: $2,459 (-0.6%)

Sources: Ohio Department of Job and Family Services Office of Health Plans (May 10, 2011)
Medicaid Budget:

Percent Change in Medicaid Nursing Home Rate
(FY 2012 HB 66 Rate vs. FY 2012 Executive Budget)

888 Facilities (95%) will receive less than a 10% rate reduction

933 Nursing Homes Reimbursed by Medicaid

Source: Ohio Department of Job and Family Services Office of Health Plans (May 10, 2011)
Medicaid Budget: Average Nursing Facility Per Diem

Source: Ohio Department of Job and Family Services Office of Health Plans (May 10, 2011); the Executive Budget moves “Other” payments related to the franchise fee, workforce development, and consolidated (bundled) services into direct care and quality in FY 2012.
Quality Incentives in Nursing Homes

“Research suggests that person-centered care is associated with improved organizational performance including higher resident and staff satisfaction, better workforce performance and higher occupancy rates.”

2010 Annual Quality Report, Alliance for Quality Nursing Home Care and American Health Care Association
RECOMMENDATION:

Reward Person-Centered Outcomes

- Nursing facility payments currently include a small (1.7 percent) quality incentive payment that averages $3.03 per day
- The current incentive is linked to business process measures and results in winners and losers and will be phased out
- Focus instead on person-centered performance measures that emphasize resident control and choice
- Increase the quality incentive to 8.75 percent and make it available for every facility to earn based on performance
- Timing issues need to be resolved
- Budget neutral
Medicaid Budget:
Rebalance Medicaid Spending on Institutions vs. Home and Community Based Services

<table>
<thead>
<tr>
<th>in millions</th>
<th>2011 Estimated</th>
<th>2012 Budget</th>
<th>2013 Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility-Based</td>
<td>$3,527</td>
<td>$3,294</td>
<td>$3,269</td>
</tr>
<tr>
<td>(Nursing Facilities, ICFs-DD, and Developmental Centers)</td>
<td>64%</td>
<td>61%</td>
<td>58%</td>
</tr>
<tr>
<td>$2,029</td>
<td>$2,141</td>
<td>$2,337</td>
<td></td>
</tr>
<tr>
<td>36%</td>
<td>39%</td>
<td>42%</td>
<td></td>
</tr>
<tr>
<td>HCBS Waiver</td>
<td>$258M (7.3%)</td>
<td>$308M</td>
<td></td>
</tr>
<tr>
<td>(Aging, JFS, and DD waivers)</td>
<td>15.2%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Ohio Department of Job and Family Services; based on average monthly recipients for SFYs 2006-2010.
Medicaid Budget:
PASSPORT/Choices Waiver

- Provides home and community based services to delay or prevent nursing facility placement for low-income Ohioans over age 60
- Not clear why administrative costs varied 77% across the state and spending for PASSPORT services, which federal law requires to be uniform statewide, varied 56% in FY 2010

<table>
<thead>
<tr>
<th>All Funds</th>
<th>FY 2011 Estimated</th>
<th>FY 2012 Budget</th>
<th>Percent Change</th>
<th>FY 2013 Budget</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caseload</td>
<td>32,158</td>
<td>34,570</td>
<td>7.5%</td>
<td>36,958</td>
<td>6.9%</td>
</tr>
<tr>
<td>Executive</td>
<td>$518,685,418</td>
<td>$499,788,037</td>
<td>-3.6%</td>
<td>$499,992,491</td>
<td>0.0%</td>
</tr>
<tr>
<td>PMPM</td>
<td>$1,344</td>
<td>$1,205</td>
<td>-10.4%</td>
<td>$1,127</td>
<td>-6.4%</td>
</tr>
<tr>
<td>House</td>
<td>$518,685,418</td>
<td>$513,692,375</td>
<td>-1.0%</td>
<td>$527,886,494</td>
<td>2.8%</td>
</tr>
<tr>
<td>PMPM</td>
<td>$1,344</td>
<td>$1,238</td>
<td>-7.9%</td>
<td>$1,190</td>
<td>-3.9%</td>
</tr>
</tbody>
</table>

Source: Office Department of Aging. “Executive” and “House” includes spending on PASSPORT/Choices waiver services and Administrative Agency case management and administration; “caseload” and “PMPM” are monthly averages statewide.
Modernize Reimbursement

*Reset Medicaid payment rules to reward value instead of volume*

**RECOMMENDATIONS:**
- Nursing facility payments
- Managed care plan payments
- Hospital payments
RECOMMENDATION:

Reform Managed Care Plan Payments

• Create a pay-for-performance program, linked to nationally recognized performance measures, and withhold 1 percent of payment for plans to earn back as an incentive for performance
• Reduce the administrative burden on plans and reduce the administrative component of the capitation rate
• Include pharmacy in the managed care benefit
• Require Medicaid reimbursement to default to FFS rates for hospitals that will not contract with Medicaid managed care
• Eliminate the Children’s Buy-In Program (but allow the five children currently enrolled to continue to receive care)
• Saves $159 million over the biennium
RECOMMENDATION:
Modernize Hospital Payments

- Outdated reimbursement system dates to the 1980s and rewards more care not better care
  - Update the diagnosis-related group (DRG) system to make more accurate and efficient payments
  - Limit payments for health acquired conditions (errors)
  - Limit outlier payments
  - Set specific Medicaid managed care capital rates
  - Bring outpatient payment policy in line with Ohio’s Medicaid State Plan Amendment
    - Limit Medicare Part B cost sharing to no more than Medicaid
    - Eliminate supplemental payments for children’s hospitals

- Saves $478 million over the biennium
### Medicaid Budget: Children’s Hospitals

<table>
<thead>
<tr>
<th>Children's Hospital</th>
<th>A. Franchise Fee Net Impact 2012-2013</th>
<th>B. Payment Reductions 2012-2013</th>
<th>C. Net Impact (A + B) 2012-2013</th>
<th>D. Discontinue Supplemental 2012-2013</th>
<th>E. Total Impact (A + B + D) 2012-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cincinnati</td>
<td>$3,225,464</td>
<td>$(9,492,592)</td>
<td>$(6,267,127)</td>
<td>$(8,729,444)</td>
<td>$(14,996,571)</td>
</tr>
<tr>
<td>Akron</td>
<td>$12,375,029</td>
<td>$(8,823,439)</td>
<td>$3,551,590</td>
<td>$(4,717,571)</td>
<td>$(1,165,982)</td>
</tr>
<tr>
<td>Dayton</td>
<td>$6,780,528</td>
<td>$(7,078,499)</td>
<td>$(297,971)</td>
<td>$(2,873,978)</td>
<td>$(3,171,949)</td>
</tr>
<tr>
<td>Columbus</td>
<td>$13,600,060</td>
<td>$(17,296,279)</td>
<td>$(3,696,218)</td>
<td>$(10,176,341)</td>
<td>$(13,872,559)</td>
</tr>
<tr>
<td>Toledo</td>
<td>$2,648,082</td>
<td>$(2,648,219)</td>
<td>$(137)</td>
<td>$(1,571,658)</td>
<td>$(1,571,795)</td>
</tr>
<tr>
<td>Cleveland</td>
<td>$14,278,382</td>
<td>$(2,241,733)</td>
<td>$12,036,649</td>
<td>$(5,352,617)</td>
<td>$6,684,033</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$52,907,546</strong></td>
<td><strong>$(47,580,760)</strong></td>
<td><strong>$5,326,786</strong></td>
<td><strong>$(33,421,608)</strong></td>
<td><strong>$(28,094,822)</strong></td>
</tr>
</tbody>
</table>

*SOURCE: Ohio Department of Job and Family Services. Amounts are biennial totals and include Ohio Medicaid Fee-for-Service and Managed Care Program spending. “Payment Reductions” includes Outlier Payments ($32.0 million), Medicare Crossover Payments ($163,825), and Inpatient Capital Rates ($17.7 million). “Payment Reductions” also includes a net gain for Children’s Hospitals related to Outpatient Service Payments ($2.3 million increase). Children’s Hospitals estimate Outlier Payment savings may exceed the ODJFS estimate based on managed care contract data available to the hospitals but not the state (the state has offered to recalculate Outlier savings if the hospitals choose to share that information).*

- House restored $4 million ($11.1 million all funds) 2012-2013
Balance the Budget

Contain Medicaid program costs in the short term and ensure financial stability over time

RESULTS:

• A sustainable system
• $1.4 billion in net savings over the biennium
• Align priorities for consumers (better health outcomes) and taxpayers (better value)
• Challenge the system to improve performance (better care and cost savings through improvement)
## Ohio Medicaid All Funds Total

<table>
<thead>
<tr>
<th>All Funds</th>
<th>SFY 2011</th>
<th>SFY 2012</th>
<th>%</th>
<th>SFY 2013</th>
<th>%</th>
<th>SFY 2012-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Trend</td>
<td>$18,020,279,696</td>
<td>$19,342,184,313</td>
<td>7.3%</td>
<td>$20,796,914,822</td>
<td>7.5%</td>
<td>$40,139,099,135</td>
</tr>
<tr>
<td>Revised Baseline</td>
<td>$ (157,570,224)</td>
<td>$ (379,813,566)</td>
<td></td>
<td>$ (454,545,028)</td>
<td></td>
<td>$ (834,358,593)</td>
</tr>
<tr>
<td>Additional Costs</td>
<td>$ 959,811,555</td>
<td>$ 1,849,269,574</td>
<td></td>
<td>$ 2,809,081,129</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Franchise Fee Revenue</td>
<td>$ 449,395,358</td>
<td>$ 438,657,744</td>
<td></td>
<td>$ 888,053,102</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Savings and Cost Avoidance</td>
<td>$ (1,530,847,617)</td>
<td>$ (2,779,029,597)</td>
<td></td>
<td>$ (4,309,877,214)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>$ (501,454,269)</td>
<td>$ (945,647,307)</td>
<td></td>
<td>$ (1,447,101,576)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Budget</strong></td>
<td>$17,862,709,472</td>
<td>$18,840,730,044</td>
<td>5.4%</td>
<td>$19,851,267,515</td>
<td>5.4%</td>
<td>$38,691,997,559</td>
</tr>
<tr>
<td><strong>525 All Funds</strong></td>
<td>$10,480,554,867</td>
<td>$11,814,893,179</td>
<td>12.7%</td>
<td>$13,171,301,005</td>
<td>11.5%</td>
<td>$24,986,194,184</td>
</tr>
</tbody>
</table>

Revised Baseline updated February 28, 2011; Savings and Cost Avoidance updated May 10, 2011; includes all departments; does not include Medicare Part D
## Ohio Medicaid State Share Total

<table>
<thead>
<tr>
<th></th>
<th>SFY 2011</th>
<th>SFY2012</th>
<th>%</th>
<th>SFY 2013</th>
<th>%</th>
<th>SFY 2012-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Trend</strong></td>
<td>$3,737,265,147</td>
<td>$5,335,729,055</td>
<td>42.8%</td>
<td>$5,680,339,444</td>
<td>6.5%</td>
<td>$11,016,068,499</td>
</tr>
<tr>
<td><strong>Revised Baseline</strong></td>
<td>$18,796,793</td>
<td>$(82,727,222)</td>
<td></td>
<td>$(103,091,587)</td>
<td></td>
<td>$(185,818,809)</td>
</tr>
<tr>
<td><strong>Additional Costs</strong></td>
<td>$343,728,971</td>
<td>$649,428,780</td>
<td></td>
<td></td>
<td></td>
<td>$993,157,751</td>
</tr>
<tr>
<td><strong>Franchise Fee Revenue</strong></td>
<td>$(294,997,317)</td>
<td>$(313,730,704)</td>
<td></td>
<td></td>
<td></td>
<td>$(608,728,021)</td>
</tr>
<tr>
<td><strong>Savings and Cost Avoidance</strong></td>
<td>$(488,673,323)</td>
<td>$(904,666,724)</td>
<td></td>
<td></td>
<td></td>
<td>$(1,393,340,047)</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>$(522,668,892)</td>
<td>$(673,106,887)</td>
<td></td>
<td></td>
<td></td>
<td>$(1,194,729,126)</td>
</tr>
<tr>
<td><strong>Budget</strong></td>
<td>$3,756,034,940</td>
<td>$4,813,460,258</td>
<td>28.1%</td>
<td>$5,008,279,210</td>
<td>4.1%</td>
<td>$9,821,339,373</td>
</tr>
<tr>
<td><strong>525 State Share</strong></td>
<td>$3,143,279,568</td>
<td>$4,301,495,337</td>
<td>36.8%</td>
<td>$4,705,852,933</td>
<td>9.4%</td>
<td>$9,007,348,270</td>
</tr>
</tbody>
</table>

Revised Baseline updated February 28, 2011; Franchise Fee Revenue and Savings and Cost Avoidance updated May 10, 2011; includes all departments; does not include Medicare Part D
Managed care expenditures are distributed to providers according to information from Milliman. Hospitals include inpatient and outpatient expenditures as well as HCAP Home and community services, which include waivers as well as home health and private duty nursing.
Medicaid Budget:
Savings and Investments

Modernize Hospital Payments
Reform Nursing Facility Payments
Manage Behavioral Health Service Utilization
Reform Managed Care Plan Payments
Reduce PASSPORT rates and service utilization
Align Programs for People with DD
Nursing and Home Health Payment Reform
Reduce Admin for Federal Agencies on Aging
Link Nursing Home Payments to Quality
Create a Unified Long Term Care System
Elevate Behavioral Health Financing to the State
Integrate Behavioral/Physical Health Benefits
Create a Single Point of Coordination
Implement Federal Reform Mandates
Promote Health Homes
Provide Accountable Care for Children

Source: Office of Health Transformation (March 15, 2011); savings are measured from the Ohio Department of Job and Family Services February 28, 2011 estimate of baseline growth absent change
Greg Moody, Office of Health Transformation
Élise Spriggs, Director of Government Affairs
John Martin, Developmental Disabilities
Zach Haughawout, Legislative
Bonnie Kantor-Burman, Aging
Jennifer Seidel, Legislative
John McCarthy, Medicaid
Melissa Bacon & Aaron Crooks, Legislative
Ted Wymyslo, MD, Health
Steve Wermuth & Erika Cybulskis, Legislative
Tracy Plouck, Mental Health
Missy Craddock, Legislative
Orman Hall, Alcohol and Drug Addiction Services
Jenelle Donovan Lyle, Legislative