Revisiting Medicaid Reform

A Status Report on Recommendations from the Ohio Commission to Reform Medicaid

Four Years Later: January 2005—January 2009

THE OHIO STATE UNIVERSITY
CENTER FOR HOPES
College of Public Health

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About the Center for Community Solutions

The Center for Community Solutions (CCS), established in 1913, provides strategic leadership to improve targeted health, social and economic conditions. The Center seeks to accomplish this mission through research, analysis, communication and organization of community resources for action.

About The Center for Health Outcomes, Policy and Evaluation Studies (HOPES)

The Center for HOPES was established in 1994 to respond to the needs of health care policy decision-makers at the local, state and national levels. The Center for HOPES, located within the College of Public Health at The Ohio State University, conducts applied health services research studies to help public and private organizations improve health care. The Center's studies focus on clinical effectiveness, outcomes assessment, quality-of-care measurement, cost analysis, and process improvement in health care settings.

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I. Executive Summary

Background and Purpose

Medicaid, a state administered entitlement program, provides health care coverage to low income parents, pregnant women and children and certain disabled and elderly populations. The program was enacted as part of the Social Security Act of 1965 and each state must operate its program in accordance with federal regulations and program requirements. Ohio's program became operational in 1968. The Ohio Department of Job and Family Services (ODJFS) serves as the state's designated Medicaid agency within the Office of Ohio Health Plans (OHP) charged with administration and oversight of the program. In addition, ODJFS contracts with other state agencies for administration of certain services (e.g., community mental health services) and programs (e.g., home and community-based waivers available through the mental retardation and developmental disabilities and aging systems).

In the 1990's and early 2000's, the Medicaid program in Ohio and Medicaid programs nationally consumed an ever growing portion of state budgets with expenditures increasing at a rate double that of state revenues. Due to concerns about the fiscal constraints such growth had on the state's budget and therefore other state programs and spending priorities, Ohio's House Bill 95 (signed in 2003) created a commission to evaluate the Medicaid program and to make reform and cost containment recommendations to the Governor by January 2005.

The "Ohio Commission to Reform Medicaid" (OCRM) issued a report in January of 2005 that included 24 recommendations and 48 associated action steps. The recommendations and action steps were grouped into six main categories: 1) long-term care, 2) care management, 3) pharmacy, 4) eligibility, 5) finance, and 6) structure and management.

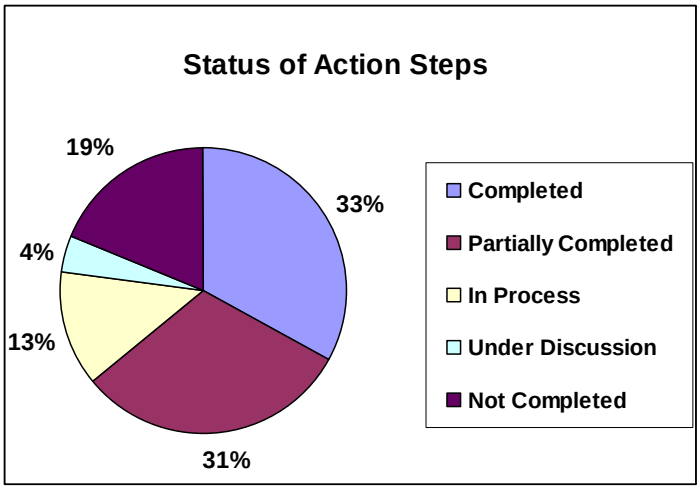
In the autumn of 2008, the Center for Community Solutions contracted with Ohio State University's Center for Health Outcomes, Policy and Evaluation Studies (HOPES) to conduct an evaluation of progress made by ODJFS on the recommendations and action steps issued in the January 2005 report.

Findings

In general, Ohio's Medicaid program has moved forward over the past four years in implementing most of the 2005 OCRM recommendations. Progress has been made despite substantial fiscal constraints related to a economic pressures at the state and national level, and growing Medicaid caseloads. The OHP appears to have taken the OCRM recommendations seriously, and has established systematic processes to track on the progress of the recommendations.

Various internal and external factors have affected the agency's ability to enact all OCRM recommendations including fiscal constraints, lack of political will or lack of stakeholder consensus, and changes in health care practices, such as the significant transition of care delivery from a fee-for-service environment to capitated managed care organizations that occurred during this time period (2005-2009). Other external factors affecting action on the OCRM recommendations including restrictions imposed by the federal Center for Medicare and Medicare Services (CMS) and, in some cases, the need to gain statutory authority or enabling regulations before moving ahead with new initiatives.

Overall, our assessment indicates that of the OCRM's original 48 recommended action steps, 16 of them (33%) were completed and 15 of them (31%) were partially completed. Six action steps (13%) are considered to be "in process" and two are currently "under discussion." Only nine action steps (19%) are considered not completed with little or no positive progress made. Our analysis indicated that in many of those cases, the ability to move ahead with implementation of the recommendation may have been due to factors outside of OHP's control



Methodology

This evaluation project received oversight from an Advisory Committee (Appendix C) comprised of nine members. The Advisory Committee was organized by The Center for Community Solutions. The charge of the committee was to provide suggestions for completing the project, to provide feedback on the draft report and input on policy implications.

The Center for HOPES collected information for the status report through two means: 1) collection and review of written documents, both public and internal to OHP, and 2) through face-to-face interviews conducted with 30 key informants, including OHP senior staff and knowledgeable individuals not currently affiliated with OHP. Over 100 documents were obtained for use in this review. The documents and literature that was reviewed were derived from a variety of sources. Some documents were available through website searches, some were made available by individuals external to OHP, and a large collection of documents were made available to the Center for HOPES by OHP directly. The documents reviewed ranged from testimony before the General Assembly to scholarly research articles to the Unified Long Term Care Budget report. OHP leadership provided our project team with information and documents previously assembled for use in the 2008 performance audit conducted by the Auditor of State. All documents used in this study are referenced in the attached bibliography (Appendix B).

Interviews with OHP staff were scheduled based upon the subject matter expertise of each staff member and their familiarity with the 2005 OCRM recommendation categories. Individuals external to OHP were identified and contacted by Center for HOPES staff. The interview sessions each took between 45 to 90 minutes. During these sessions, interviewees provided the Center for HOPES with status updates, background information related to the recommendations, as well as their perspectives as to why certain recommendations or actions steps did or did not move forward.

Status updates for each recommendation and its associated action steps were into a data reporting form (Appendix A). This form summarizes the current status of each recommendation along with factors impacting its status. The summary reporting form and draft report were shared with the Center for Community Solutions and the project's Advisory Committee prior to finalization of this report. Comments were received from both entities and changes were made to the draft report

and reporting form if required for accuracy. The draft report was not reviewed with OHP prior to publication.

Policy Implications

As of the publication of this report, in January 2009, Ohio's economy is mired in a deep recession. Consequently, substantial cuts are being made in the state's budget. Given the current budget environment, it is likely that that progress on reforms that require additional funding may need to be curtailed or delayed. Some of the progress already made on the 2005 OCRM recommendations may need to be tempered in order to address fiscal limitations (e.g., holding enrollment in waiver programs steady).

At the same time, several initiatives are nearing completion that may expedite progress in some areas. The impending release of the new Medicaid Information Technology System (MITS) that replaces the former Medicaid Management Information System (MMIS) is expected to introduce enhanced capabilities in several respects that are directly pertinent to the 2005 OCRM recommendations. For example, MITS will allow for expedited determination of claims payment and user eligibility, as well as facilitating the identification of providers acting inappropriately, all measures that were originally promoted in the 2005 OCRM report.

Proposals that can potentially result in cost savings will likely get increased attention beginning in 2009. The need to cut expenditures drastically may act as a catalyst for some of the OCRM recommendations, such as increased co-pays for pharmaceuticals, increased emphasis on programs (e.g., the HOME Choice program) that transition individuals from institutionalized to community-based long term care, and consolidating Medicaid and SSI disability determination processes.

Budget constraints may mean that fewer individuals will be able to qualify for waiver programs. Selective contracting for medical supplies, which previously has run into political opposition, may find more supporters if tangible cost savings can be realized. Less emphasis and fewer staff resources may be placed on certain programs that serve few individuals, such as the proposed Home Care Attendant option, or proposals to raise asset limits for waiver applicants who want to utilize the Medicaid Buy-in Program for Workers with Disabilities. In addition, there may be renewed pressure to curtail pharmacy costs and other program costs (e.g., perhaps decreasing coverage for certain optional Medicaid benefits for adults as was attempted in the past) as well as attempts to control enrollment expansions at a time when Medicaid caseloads are increasing due to the poor economic environment in the state.

Given the fact that the Aged, Blind and Disabled population consumes almost three-quarters of Medicaid service costs, it is likely that there will be additional emphasis placed on identifying ways to manage and/or curtail such costs.

II. Project Background and Purpose

Background

Due to concerns about the fiscal constraints Medicaid's program growth had on the state's budget and therefore other state programs and spending priorities, Ohio's House Bill 95 (signed in 2003) included a requirement for the creation of a commission to evaluate the Medicaid program and to make reform and cost containment recommendations to the Governor by January 2005. The OCRM began meeting in December of 2003 and issued a report in January of 2005.

Shortly thereafter, the Medicaid Administrative Study Council (MASC) was formed, as required by House Bill 66 (HB 66). The main charge of this group was to put forth recommendations related to improving the efficiency and structure of Ohio's Medicaid agency. The MASC began meeting in January of 2006 and issued a report recommending the creation of a new independent Medicaid agency in December of 2006.

The two entities and their respective reports were deemed a call to ODJFS and the Administration to make feasible and necessary changes to the Medicaid program.

Specific Aims of this Four-Year Review

In the fall of 2008, the Center for Community Solutions contracted with Ohio State University's Center for HOPES to conduct an evaluation of progress made by the Ohio Department of Job and Family Services on the recommendations and action steps issued in the January 2005 OCRM report. Their motivation was to continue placing emphasis on useful system reforms and to keep legislators and other policy makers apprised of critical needs within the state Medicaid system and available options for system improvement.

The aims for the project are to ascertain the current status of the OCRM recommendations and associated action steps, to identify factors that have impacted their status, and to identify possible policy implications. The main intended outcomes for the project are to: 1) create a consolidated reporting form clearly summarizing these developments for each recommendation and action step (provided in Appendix A); 2) draft a narrative report containing a high-level overview of the current status of such recommendations that can help to inform legislators and other policy makers, and 3) prepare and conduct several policy briefings around the state to engage officials and key stakeholders in a consideration of priorities and available options.

Application of Findings

The Center for HOPES anticipates that the report findings and policy briefings will be used by the Center for Community Solutions and Advisory Committee members to launch a consideration by the General Assembly about the current accomplishments and unmet needs within the state's Medicaid system, and to help guide deliberations about changes to the system during the upcoming biennial budget period (FY2010-2012). Agency officials and legislators may also benefit from these findings insofar as it represents an objective assessment from an independent academic research unit that can provide an unbiased perspective of system needs.

III. Methodology

The evaluation project received input and suggestions from an Advisory Committee comprised of nine members selected by the Center for Community Solutions (Advisory Committee members are listed in Appendix C). The charge of the committee was to provide suggestions for efficiently completing the project, identifying key stakeholders for acquiring credible information, and to provide feedback and reaction to the draft report along with input concerning policy implications.

The Center for HOPES collected information for the status report through a review of documents and conducting face-to-face interviews with key informants. Written records were maintained of the information supplied in each interviewed that were subsequently transferred to the consolidated reporting form contained in Appendix A.

Thirty Interviews were conducted with key informants over a five-week period from November 3, 2008 until December 4, 2008. Interviews with OHP staff were scheduled by OHP based upon the subject matter expertise of their staff members and their knowledge of the recommendation categories. Interviews with individuals external to OHP were scheduled by the Center for HOPES staff. Interviews were conducted on a face-to-face basis. During the interview sessions, which lasted between 45 to 90 minutes, interviewees provided the Center for HOPES with status updates, background information related to the various recommendations and action steps as well as their opinions as to why certain recommendations or actions steps did or did not move forward. A listing of the interviewees is itemized in the chart on the following pages:

Interviewee(s)	Interviewer	Date
External to the Office of Ohio Health Plans		
Doug Anderson, Chief Policy Advisor Ohio Department of Insurance	Allard Dembe	11/11/08
Jennifer Carlson, Government Relations Director James Cancer Hospital Ohio State University Medical Center	Lauren Phelps	11/10/08
Jerry Friedman, Government Relations Director Offices of Health Sciences Ohio State University Medical Center	Lauren Phelps	11/24/08
Bill Hayes, President Health Policy Institute of Ohio	Lauren Phelps	11/13/08
Roland Hornbostel, Deputy Director Long-Term Care Ohio Department of Aging	Barry Jamieson	11/3/08
Kelly McGivern, President and CEO Ohio Association of Health Plans	Lauren Phelps	12/1/08
Lorin Ranbom, Consultant Office of Health Sciences Ohio State University Medical Center	Barry Jamieson	10/29/08
Barbara Riley, Director Ohio Department of Aging	Barry Jamieson	11/4/08
Cristal Thomas, Executive Director Executive Medicaid Management Administration (EMMA)	Allard Dembe	11/25/08

Interviewee(s)	Interviewer	Date
External to the Office of Ohio Health Plans		
Pete Van Runkle, Executive Director Ohio Health Care Association	Barry Jamieson	10/28/08
Tracy Plouck, Deputy Director OBM Budget Section Office of Budget and Management	Allard Dembe	11/17/08
Internal to the Office of Ohio Health Plans		
Sara Abbott, Bureau Chief Bureau of Community Services and Policy	Barry Jamieson	11/13/08
Cynthia Afkami, Business Transformation Office of Ohio Health Plans – Deputy Directors' Office	Eric Seiber	11/17/08
Jon Barley, Bureau Chief Bureau of Managed Health Care	Naomi Adaniya	11/14/08
Heather Burdette, Assistant Deputy Director and CFO Office of Ohio Health Plans – Deputy Directors' Office	Barry Jamieson	11/14/08
Cynthia Callendar, Assistant Deputy Director and COO Office of Ohio Health Plans – Deputy Directors' Office	Eric Seiber	11/17/08 11/25/08
Robyn Colby, Bureau Chief Bureau of Policy and Benefits Management	Naomi Adaniya	11/18/08
Chris Carson, Assistant Bureau Chief Bureau of Audits	Eric Seiber	11/25/08
Maureen Corcoran, Assistant Deputy Director CPO Benefits Office of Ohio Health Plans – Deputy Directors' Office	Barry Jamieson Naomi Adaniya Naomi Adaniya Allard Dembe Allard Dembe	11/13/08 11/14/08 11/18/08 12/1/08 12/4/08
John Corlett, Medicaid Director Office of Ohio Health Plans	Allard Dembe	12/1/08
Julie Evers, Assistant Bureau Chief Bureau of Long-Term Care Facilities	Allard Dembe	11/14/08
Rodger Fouts, Acting Bureau Chief Bureau of Provider Services	Eric Seiber	11/12/08
Janet Histed, Bureau Chief Bureau of Budget Management and Analysis	Barry Jamieson	11/14/08
Kathy Hoeffer, Bureau Chief Bureau of Eligibility Support and Children's Health	Eric Seiber	11/17/08
Kevin Jones, MHSA 3 Office of Ohio Health Plans – Deputy Directors' Office	Eric Seiber	11/25/08
Jerry McKee, Project Manager Office of Ohio Health Plans – Deputy Directors' Office	Allard Dembe	12/4/08
Carolyn Nunez, MHSA 2 Bureau of Clinical Quality	Eric Seiber	11/17/08
Erika Robbins, MFP Project Director Bureau of Community Services and Policy	Barry Jamieson	11/13/08
Deborah Clement Saxe, Director, Health Services Research Health Services Research	Allard Dembe	12/4/08
Patrick Tighe, MHSA 3 Program Integrity Office of Ohio Health Plans – Deputy Directors' Office	Allard Dembe	11/14/08

The documents reviewed were derived from a variety of sources. Some documents were available through website searches; some were made available by individuals external to OHP in hard copy or via e-mail and a large assortment of documents were made available to the Center for HOPES directly by OHP either via flash drive, CD or via e-mail. The documents reviewed ranged from testimony before the General Assembly to Auditor of State Medicaid Performance Audit documents to the Unified Long Term Care Budget Report. All such documents are referenced in the attached bibliography (Appendix B).

Status updates as well as information about factors impacting the status of recommendations and action steps were data entered into a consolidated reporting form (Appendix A). Staff members completed the summary form based upon the interviews they conducted and/or the literature they reviewed. This information was utilized to develop the written status report.

The summary reporting form and draft report were shared with the Center for Community Solutions and the Advisory Committee (Appendix C) prior to finalization. Comments were received from both entities in writing and during an Advisory Committee meeting held in January of 2009. Edits were made to the draft report and matrix as necessary for accuracy based upon the comments received from the Center for Community Solutions and Advisory Committee members. Content of the draft report was not reviewed by OHP prior to publication.

IV. Findings: Status of 2005 OCRM Recommendations

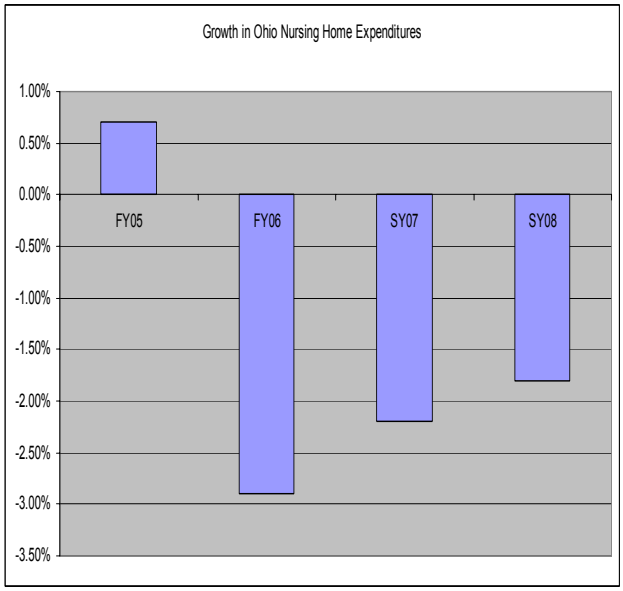
The following pages, along with the consolidated reporting form (Appendix A) provide an overview of the recommendations as set forth by the Ohio Commission to Reform Medicaid in their January 2005 report and the current status of those recommendations and associated action steps as of January 2009 based upon an exhaustive literature review and personal interviews with Ohio Department of Job and Family Services leadership and senior staff, both past and present as well as other informed individuals involved in Ohio's public health care arena.

It is important to note that the determination as to the status of some recommendations and associated action steps varies somewhat based upon the documents reviewed or the individuals interviewed. Discrepancies are noted when appropriate.

A. Summary: Long Term Care

The general theme behind the original 2005 OCRM long term care recommendations was to limit Medicaid costs by removing the "institutional bias" inherent in the long term care delivery system. The logic was that long term care institutional expenditures could be successfully reduced and at the same time more consumer-friendly and cheaper home-based care options could be created. Since long term care expenditures comprise nearly a third of the Medicaid budget, success in limiting this budget component could go a long way to limiting the growth in Medicaid expenditures overall.

At the time that the OCRM report was released, the amount of money spent for Medicaid Aged, Blind and Disabled (ABD) consumers was the fastest growing segment of Medicaid's budget. Those consumers comprised 24% of the Medicaid population but accounted for 74% of the program's spending as of 2005.



Since the issuance of the OCRM report, the growth in long term care (LTC) expenditures has moderated. There are two primary reasons for this restraint on nursing home expenditure growth: 1) yearly declines in the utilization of nursing homes, and 2) flat to modest rate increases during the same time period. The 2005 OCRM recommendations directly addressed these budget factors. Medicaid's progress in addressing these recommendations can be measured by the yardstick of LTC expenditure growth. The chart to the left illustrates that since FY06, nursing home expenditure growth has been negative. The average annual growth rate over this time frame has been -1.5%. Prior rates of growth in nursing home expenditures from FY00-FY04 ranged between 0.7% and 7.3%.

The flattening of nursing home rates can be attributed to the successful imposition of the nursing home pricing formula established in HB66. Twenty percent (20%) of nursing home providers currently receive a price set by the formula. The remaining providers are gradually moving towards the formula's prices. All prices and rates are set biennially by the General Assembly which so far has limited rate increases. However, it must be pointed out that the facility reimbursement formula has not been removed from state statute.

The success in the decline in nursing home utilization can in part be attributed to efforts by the state over the past four years to give consumers more home and community based care choices. There has also been considerable work done by various state agencies to give consumers more choices and more control over their direct care. For example, the Choices program, directed by the Ohio Department of Aging allows for consumers to hire service providers to provide community-based care. The program has been operational since 2001 and currently has several hundred consumers enrolled in selected areas of the state.

The state, through the creation of the Unified Long-Term Care Budget (ULTCB) and Money Follows the Person (MFP) workgroups in 2007 and 2008, met to continue to push the expansion of home and community based services and consumer choice. These groups established

parameters guiding the “Money Follows the Person” grant and its transition program (which transitions individuals from an institutional setting to a home and community-based setting). The transition program, referred to as “HOME Choice,” began enrolling individuals in October of 2008.

The ULTCB and MFP workgroups also developed recommendations that supported a “no wrong door” approach to long term care services. Their goal was to develop a system that is seamless, coordinated, flexible and easy for a consumer to navigate. Consumers would receive the information they need in a timely manner regardless of their system entry-point. The workgroups took this concept a step further and also recommended that a standardized screening and intake process be utilized at all entry points. To date, these recommendations are under discussion and work groups are making progress in identifying means to implement components of such a system.

However, some recommendations (for example, increasing assets that may be retained by individuals to avoid premature admission to an institutional setting) have not been and likely will not be implemented due to concerns about the state’s current budget status and the potential fiscal impact. Other changes (e.g., unified long-term care budget and associated recommendations) may take years to implement through incremental changes spread out over several fiscal years or biennial budget periods.

One issue impacting the possibility for individuals to remain or return to community long-term care settings is the loss of or lack of appropriate housing. The state has made strides in either developing or revising current long-term care programs. However, if consumers are to have a true “choice” and continuum of services, investments need to be made in housing and supportive services. Medicaid does not pay for (and cannot pay for room and board in a community settings per federal law; part of the institutional bias of the program). However, there are discussions underway related to housing and supportive services as part of the ULTCB work, the MFP grant and the Interagency Council on Homelessness and Affordable Housing (ICHAH) which was established by Governor Strickland’s Executive Order 2007-08S, as signed on April 23, 2007. The mission of the ICHAH is to “unite key state agencies to formulate policies and programs that address affordable housing issues and the needs of Ohioans who are homeless or at risk of becoming homeless.”

There are a host of other factors affecting the status of the OCRM Long-Term Care recommendations. For example, there are many interested advocacy and trade association representatives involved in the public policy process. Medicaid is currently the major purchaser of long-term care services; any reductions in payments could impact providers’ revenue streams. Medicaid long-term care services are provided through a variety of state and local delivery systems each of which has their own administrative and financing structure. There is a shortage of community-based providers that can hamper the ability of these local systems and programs to meet the needs of a growing community-based population.

Given the state’s current budget environment, it is possible that some of the progress made on recommendations may be tempered (e.g., holding enrollment in waiver programs steady) in order to address fiscal limitations. Movement on some action steps and associated recommendations that to date are considered in process or under discussion may be delayed or not further considered due to the state’s current fiscal situation. Some potential policy implications are that fewer individuals will be able to relocate from institutional to community-based settings, less emphasis and staff resources may be placed on redesigning the front door to long-term care systems or implementing voucher programs in the Medicaid waiver programs, and fewer individuals may be able to utilize the new Medicaid Buy-in Program for Workers with Disabilities.

B. Summary: Care Management

The OCRM report issued two main recommendations and five associated action steps related to the topic of care management. The recommendations primarily focused on expanding care management principles and structures statewide. However, other topics were addressed as well, such as recommending an increase in coordination between the Ohio Department of Health (ODH) and ODJFS, requiring surety bonds for full-risk managed care plans, and withholding payment of the graduate medical education (GME) subsidy from hospitals that fail to participate in the care management expansions.

By the time the OCRM recommendations were released, ODJFS already had started implementing an Enhanced Care Management (ECM) program in October 2004. In general, the ECM program, which was developed over a four-year period, emphasized incentives for providers to follow evidence-based care. However, as a result of budget negotiations, HB 66 contained language requiring that the ECM program be disbanded in favor of a full-risk managed care model.

In 2005, when the OCRM report was released, approximately 30 percent of the Medicaid population was enrolled in a managed care plan (MCP). By February 2008, ODJFS had enrolled most of the eligible CFC consumers into MCPs. As of December 2008, there were approximately 1.8 million consumers enrolled in Medicaid. Approximately 1.19 million individuals are now enrolled in a managed care plan, which is 94% of eligible individuals in the Covered Families and Children (CFC) population. Expansion of managed care plans to the ABD population occurred as well, but certain populations were exempt and kept on the Medicaid fee-for-service (FFS) program (see box below). Also, long term care was not included as part of the transition to managed care, presumably because long term care has distinctive systems for providing services to effected populations (e.g., nursing home residents) and for coordinating associated chronic care and social support needs, that would not necessarily be easy to handle within the commercial managed care plans that emerged in Ohio.

ABD Population Exempt from Managed Care Plans:

- **Consumers under age 21**
- **Institutionalized individuals**
- **Consumers eligible via spend-down**
- **Dual-eligibles**
- **Waiver recipients**

As ODJFS continues shifting towards MCPs, it is important to note that there are still individuals on the traditional Medicaid fee for service (FFS) plan.

ODJFS does conduct ongoing reviews of the MCPs to ensure appropriate delivery of services. ODJFS adopts financial incentives applicable to the Medicaid population as part of its overall MCP performance and quality of care assessments.

A variety of techniques are employed for controlling utilization of services, ensuring quality of care, and measuring patient outcomes. A dual system of responsibility has emerged in which OSJFS is responsible for some oversight in these areas and the individual MCPs also have systems in place for managing quality and utilization, and measuring quality of care. Some of the key strategies include:

- OHP encourages compliance with pre-established performance metrics by keeping a portion of the capitated payment “at risk” pending reporting of performance measures including the Consumer Assessment of Health Plans Survey (CAHPS) and the Health Employer Data Information Set (HEDIS) measures. This strategy forces plans to be aware of their performance.

- Actuaries used by ODJFS have noted that individuals who are eligible for Medicaid but who fail to select a MCP are generally healthier than those who do select an MCP. Beginning in November 2008, these individuals will be automatically assigned to managed care plans based on the plan’s

reported performance measures. It should be noted that currently, performance measures are based primarily on process measures and not necessarily on care performance and outcomes. Furthermore, available financial incentives are currently applied solely to MCPs and thus do not apply to providers in Medicaid's FFS program or home and community-based waivers.

● Utilization of services is monitored by OHP and individual MCPs. Managed care plans generally have their own utilization review procedures to control utilization, authorize services, and contain costs. OHP attempts to monitor these practices to assure that limits on service are not overly restrictive. ODJFS is attempting to ensure adequacy of primary care capacity within MCPs by increasing rates covering primary care services.

● To control delivery costs associated with births and ensure good outcomes, MCPs have an incentive to provide coordinated care at every stage of the pregnancy; including prenatal, birth, and postnatal care. This strategy puts some pressure on managed care plans to ensure that the mothers-to-be actually use their affiliated hospitals for the delivery.

ODJFS has made progress on many of the Care Management recommendations and associated action steps as delineated in the 2005 OCRM report, as indicated in the box below.

Recommendation/Action Step	Status
● Expand managed care to CFC	Completed
● Expand managed care to ABD	Completed
● Expand fiscal incentives	Partially Completed
● Eliminate duplicative ODH review	Completed
● Adopt national measures	Partially Completed
● Require Surety Bonds	Completed
● Establish a CMWG	Completed
● Inform MCPs about fiscal targets	Completed

There are fiscal incentives included in the MCP provider agreements. However, they appear to be based more on process and reporting measures more than patient outcomes. ODJFS did work with the Ohio Department of Health (ODH) to eliminate a duplicate provider panel review process.

In addition, to better assure actuarial soundness, MCPs are now required to purchase a $3 million surety bond. As noted above, ODJFS has used and continues to use nationally recognized performance measures. However, it is important to note that they are not always applicable to some populations, especially the ABD population. ODJFS also has established a Care Management Working Group (CMWG). That working group had a mandate to present interim summaries to the General Assembly and to publish a report at the end of 2007. Following their December 2007 publication, however, the CMWG was disbanded. ODJFS indicates that all of the responsibilities and tasks the CMWG addressed are now rolled up in the responsibilities of the Medical Care Advisory Committee (MCAC). The MCAC is a 30-member council consisting of individuals external to Medicaid. The council selects topics each year and passes on recommendations to OHP. Because the MCAC is not specified in any section of the Ohio Revised Code, the OHP retains discretion to choose whether or not to act on the MCAC recommendations.

With regards to the 2005 OCRM recommendation of withholding payment of the graduate medical education (GME) subsidy from hospitals that fail to participate in the care management expansions, this recommendation has been controversial from the beginning. Even the OCRM committee was not unanimous in making their original recommendation in this area. Today, implementing such a strategy would be extremely difficult because there is an exemption for all hospitals in counties having Medicaid managed care plans prior to HB66, and the GME payment is difficult to pull out of the system. Furthermore, the political will required to force this recommendation is lacking. In summary, ODJFS has moved forward on most of the original Care Management recommendations. The outcomes and effects of which are not yet fully determined.

C. Summary: Pharmacy

The OCRM issued five recommendations and twenty-one associated action steps related to the topic of pharmacy. The recommendations range in scope from the use of generics and purchasing pools to allowing for transparency of drug purchases, formulary restrictions, utilizing consumer co-payments and monitoring impacts of Medicare Part D on program costs.

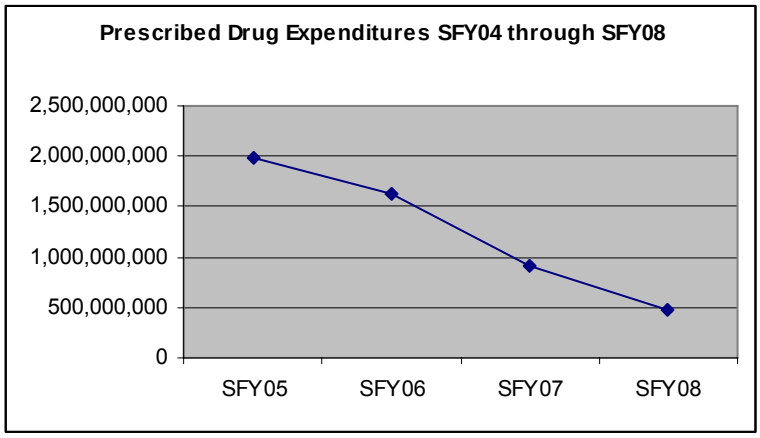
It is important to note that some of the pharmacy related recommendations are limited in their applicability to Ohio's program. This is due in part to the fact that some information about Ohio's program structure could not be made publicly available to the OCRM members per federal and or state law.

It is also important to note that ODJFS did not have control over some aspects of pharmacy reform and therefore could not comprehensively address the OCRM recommendations. For example, a large percentage of the Medicaid population moved into managed care since the issuance of the OCRM recommendations. Although managed care plans utilize the same preferred drug list (PDL), they can issue prior authorization for different drugs. The MCPs may not utilize the same dispensing fees as the fee-for-service program. In addition, due to federal law, MCPs do not currently receive the same supplemental rebates that ODJFS can obtain; therefore they cannot receive the potential savings. Another example is in regards to the implementation of copayments. HB 66 required the use of copayments for certain services for some Medicaid populations. ODJFS did implement such copayments for the FFS population. However, the MCPs chose not to require such copayments for their consumers.

Another barrier ODJFS faces in making changes to statues or rules is resistance from various stakeholders. For example, ODJFS could not move forward on some recommendations regarding prior authorization of certain drugs (e.g., mental health drugs) due to opposition from the various stakeholder communities. Despite the opposition, ODJFS did secure the ability to require prior authorization for drugs on the formulary, and in general, ODJFS tries to control pharmaceutical utilization by using a PDL.

To help determine the PDL and formulary, ODJFS has a Pharmacy and Therapeutics (P&T) Committee. The committee's role is to regularly evaluate and sponsor evidence-based research on the use of prescription drugs. One of their responsibilities is to decide which prescriptions are "clinically superior" without seeing cost information. On the research side, the P&T Committee is assessing prescriber compliance as part of a Behavioral Health Quality Initiative. They conducted a two-year program designed to ensure that individuals with mental illness are not overmedicated. However, it should be noted that MCPs currently are not included as part of the P&T Committee.

With regards to pharmaceuticals, ODJFS policy is to focus on the most cost effective yet therapeutically appropriate approach. In this regard, the OCRM report recommended the use of multi-state cost pools, the use of generics over brand name prescriptions, and the change of state and federal laws to increase drug purchasing transparency. ODJFS did investigate multi-state cost pools, and permissive language was included in HB 119. However, ODJFS has not moved forward aggressively on this recommendation because they have been able to directly negotiate relatively low costs without pools. In addition, although the OCRM recommendations supported greater use of generics, the costs of some brand name drugs were actually less expensive than their generic counterparts. This cost savings was due, in part, to the rebates that ODJFS has obtained from drug companies (which cannot be shared due to state and federal law). Finally, it is very unlikely that Ohio can persuade the federal government to change federal law in regards to transparency of drug purchases.



Ohio Medicaid experienced a 17.3% decrease in prescription drug expenditures from SFY05 ($1,978,832,662) to SFY06 ($1,636,313,288). Between SFY06 and SFY08 the decreases were even greater; 44.8% ($903,684,376) between SFY06 and SFY07 and from SFY07 to SFY08, the decrease in prescription drug expenditures was 48.2% ($468,314,558).

Source- ODJFS Office of Ohio Health Plans

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The data in the chart above reflect fee-for-service expenditures, which decreased substantially due to the implementation of Medicare Part D in 2006 and increased enrollment into managed care plans ODJFS has also attempted to reduce the state's expenditures at the point of sale. Through HB 66, pharmacist reimbursement was reduced from Wholesale Average Cost (WAC) plus 9% mark-up to WAC plus 7% mark-up. Dispensing fees are tracked by ODJFS, and every other year a survey is undertaken to inform the Director of OHP about fees, which allows the Director to change or maintain the fee at his/her discretion. These changes have only impacted the Medicaid plan; MCPs do not have to utilize the same dispensing fees. In addition to differences between the FFS plan and MCPs in pharmacist reimbursement, further differences exist regarding copayments. Consumers enrolled in Medicaid FFS pay a $2 copay for prescriptions on the PDL and $3 per prescription for medications requiring prior approval. As noted above, consumers enrolled in MCPs do not pay copays for pharmaceuticals. Another OCRM recommendation pertained to reducing state expenditures at point of sale by implementing a mail-order program. ODJFS considered implementing this program, but it was determined that the cost of implementation would negate any potential savings. It was considered to be logistically difficult to operationalize a mail-order program for the following reasons:

- Inaccuracies of mailing addresses due to a transient population
- Patients who qualify for Medicaid via spend-down may not be eligible every month
- Cost concerns related to changes in medication during the three-month mail order supply period

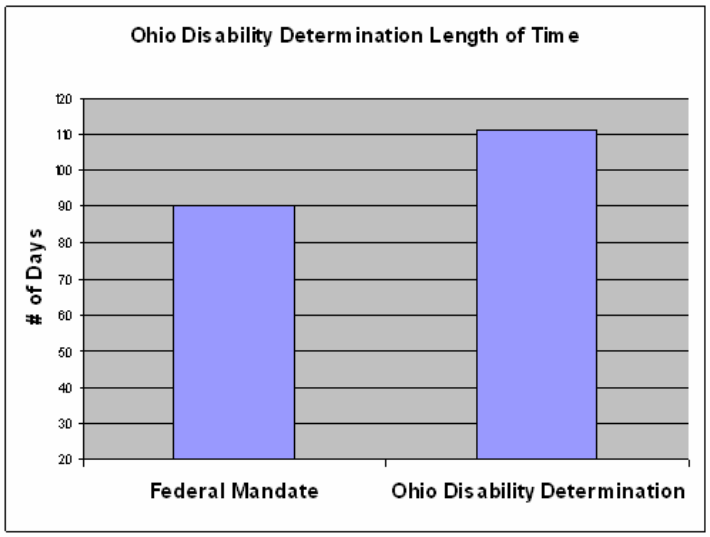
The OCRM report also recommended establishing systems to monitor cost-effective management of prescriptions. For the most part, this is an ongoing process, and thus far, ODJFS has only established the Primary Alternative Care and Treatment (PACT) program, under which a consumer is limited to a primary pharmacy. There are a relatively small number of consumers enrolled in the PACT program, and it may be as much an effort to reduce fraud and abuse as one focused on medication therapy management and cost control. Here again, the PACT program only applies to patients enrolled in the Medicaid FFS plan; it does not apply for consumers in MCPs.

In early 2009, ODJFS will be rolling out a system to provide Medicaid providers with online access to a Medicaid patient's FFS prescription claims that not only includes an e-prescribing function but also provides prescription price information. Finally, ODJFS closely monitors Medicare Part D benefits so as to not provide coverage for therapeutic classes covered under Part D, thus limiting Medicaid expenditures for enrollees with Part D coverage.

In summary, it appears that ODJFS actively considered the 2005 OCRM recommendations and some programmatic changes were made, especially as they apply to the FFS population. However, action was not taken on several of the recommendations either because they were not applicable given the structure of Ohio's program or not feasible due to state or federal law.

D. Summary: Eligibility

One of the primary 2005 OCRM suggestions regarding eligibility was to eliminate the duplicative eligibility processes. Currently, consumers under the age of 65 applying for Medicaid benefits must go through two disability determination processes, one conducted by the ODJFS Office of County Medical Services (CDJFS), and one conducted by the Bureau of Disability Determination Services at the Rehabilitation Services Commission (RSC) on behalf of the federal Social Security Administration (SSA). The duplicative process is time consuming and confusing to consumers and wasteful to the state and federal agencies involved in the process. The OCRM issued three main recommendations and three specific action steps to address the problems within the disability determination arena.



Inefficiencies associated with the duplicative process will likely become more pronounced as the aged, blind and disabled population (ABD) continues to grow. According to Disability Determination Workgroup, it takes 111 days to make a disability determination in Ohio compared to the Federal mandate of 90 days. Factors cited for the slow determination process are difficulty in obtaining the individual's medical history, unwillingness of medical providers to make individual assessments, the system being clogged by those not disabled and finally a duplication of efforts between RSC, SSA, ODJFS and CDJFS.

House Bill 66 did contain language to study better coordination between both systems. However, objections were raised by RSC about creating a single combined system. Concerns expressed by RSC included issues related to providing information to the federal government, funding requirements, and their desire to retain the panel of existing doctors who currently provide these evaluations for the RSC. ODJFS is currently trying to work with RSC, County JFS representatives, and advocacy officials to develop a more efficient determination process.

Another approach for streamlining the process would be to adopt a single set of disability determination criteria. This could be accomplished by amending the Ohio Medicaid State Plan and adopting the SSA's Supplemental Security Income (SSI) eligibility standard for Medicaid eligibility determination. Under Section 1634 of the Social Security Act, many states have developed contracts with the SSA to determine eligibility for Medicaid at the same time a determination is made for receipt of SSI benefits. Ohio is currently a "209(b) state," meaning that it has adopted more restrictive criteria for its aged, blind and disabled recipients than are used in the SSI program in one or more eligibility areas. This complicates the development of a single disability determination process.

This option of converting from a 209(b) to a Section 1634 state was considered by The Disability Determination Study Council, which recommended against making the change. The Council

reviewed available research findings and concluded that although changing Ohio's Medicaid financial eligibility might result in some administrative savings, those savings would likely be lower in comparison to the incremental new costs that would result from removing the more restrictive 209(b) eligibility criteria currently in effect. Other concerns expressed by ODFS and other officials was that a large segment of the "spend-down" population would be adversely affected and that the change would be administratively burdensome as it would require a major overhaul to current disability eligibility processes.

The 2005 OCRM report also included recommendations that encouraged Ohio Medicaid to operate more like private insurance plans. In the private insurance world, cost-sharing through copayments, deductibles and premium contributions are used to discourage unnecessary utilization of health care services. Medicaid currently does not collect premium contributions from persons receiving transitional Medicaid benefits, even though these consumers will be paying these costs when they obtain private insurance. Federal regulations allow a maximum premium of 5% of gross family income. The 2005 OCRM report suggested a 3% income premium contribution for transitional Medicaid adults only. OHP staff considered this suggestion, but determined that the cost of administering the collection of premiums would outweigh the savings obtained. Although premium contributions are not collected from the transitional Medicaid population, they are collected from other Medicaid enrollees.

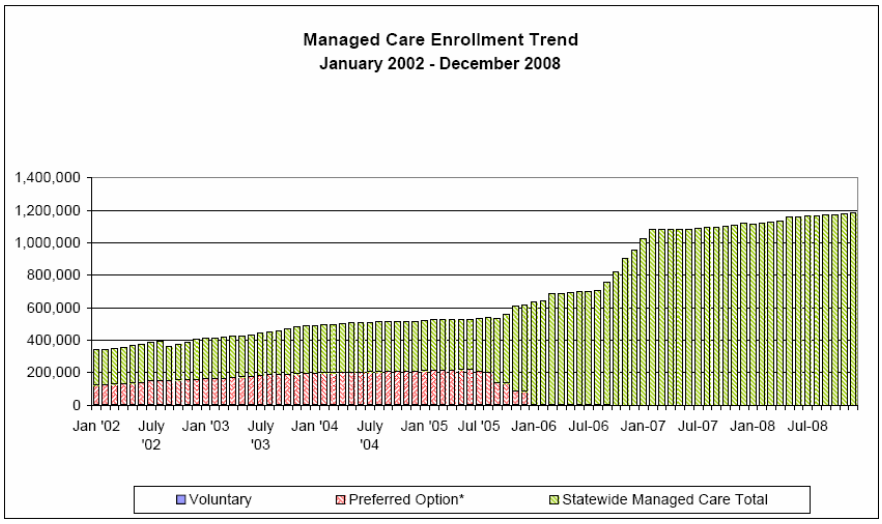
The OCRM recommended requiring Medicaid recipients to enroll in private employer insurance plans, if they were eligible for such plans either directly or through a family dependent. ODJFS considered this possibility but believed that there was insufficient basis or statutory authority to mandate such action. The state of Ohio has been investigating the possibility of extending premium assistance to Medicaid eligibles that are able to enroll in private employer insurance. The State Coverage Initiative (SCI) team recently recommended that financial assistance be made available to Medicaid eligibles who cannot afford to pay for private health insurance. Many of the SCI recommendations are being pursued in the upcoming biennial budget bill.

Finally, the OCRM recommended that a Medicaid Buy-in program be established for workers with disabilities. Under this program, employed people with disabilities who would not normally meet the income requirements for Medicaid would be able to qualify to obtain Medicaid coverage after paying a premium contribution. This program went into effect in April of 2008 for disabled employees earning up to 250% of the federal poverty level. Premiums are determined through a set of calculations based on income, family size, and certain standard deductions (e.g., health insurance premiums, impairment-related work expenses, etc.). Premiums are based on the consumer's income. If there is a reduction in income, there will also be a reduction in the premium amount. Preliminary studies indicate that more than 7,000 Ohioans with disabilities will participate in the Medicaid Buy-In program. Based on those participation rates, Medicaid Buy-In is expected to cost the state between $14 million to $22 million annually.

E. Summary: Finance

The 2005 OCRM report identified five key recommendations in the "finance" area that included: a) establishing a more systematic budgeting process, b) freezing payment levels of fee-for-service (FFS) payments and reducing payments for skilled nursing facilities and intermediate care facilities/mental retardation (ICF/MR) services, c) adopting a "just-in-time" bill payment practice so that bills could be paid later and thereby derive greater interest income, d) strengthening benefit coordination procedures to increase cost recovery for dually eligible beneficiaries, and e) adopting a prospective payment system for long-term acute care hospitals (LTACHs) and rehabilitation hospitals. All of these proposals were aimed at trying to identify ways of trying to lower costs for the Ohio Medicaid system, principally with respect to the way that Ohio Health Plans makes payments for services.

Our analyses as of December 2008 indicate that the Ohio Medicaid agency has carefully considered these proposals and has made very significant advances in some areas, particularly in the area of benefit coordination and cost recovery. Contextual and legal factors have affected the ability and rationale for moving ahead in some other areas. For instance, since the time of the publication of the original OCRM report in January 2005, a considerable proportion of the Medicaid caseload has migrated into a managed care environment. As of December 2008, 1,187,365 enrollees were in Medicaid Managed Care plans, up from 230,488 in April 1999 and 489,362 in January 2004, an increase of 143% during the past five years.



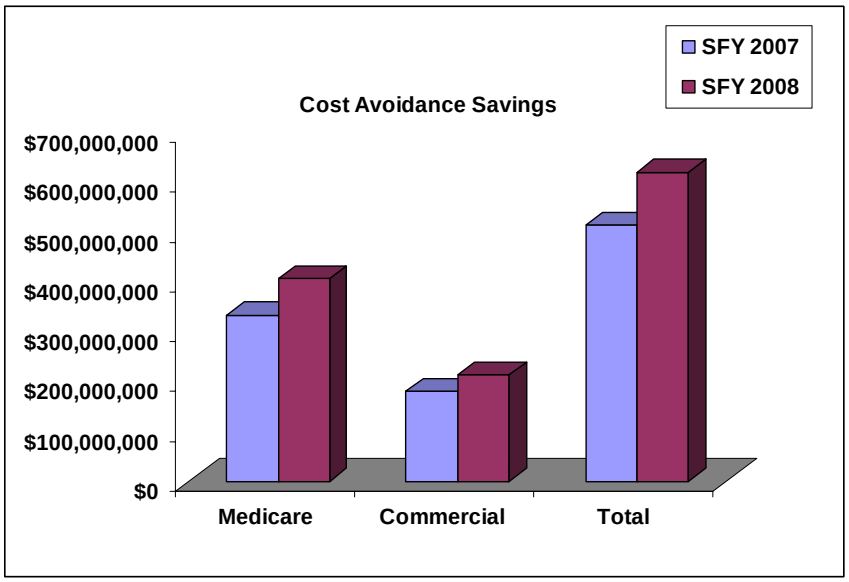
This has resulted in considerably less use of FFS payments by the Ohio Health plans, and a much greater reliance on the use of capitated rate plans within the Medicaid managed care plans. It has also led to a considerably different budgeting forecasting process in which OHP's budget is increasingly dependent on MCPs specific contract provisions with providers and the corresponding calculation of actuarially sound rates.

These contextual changes have affected OHP's approach to several of the recommendations proposed in the 2005 OCRM report. For example, OHP's ability to more stringently manage utilization rates and prices has become more difficult since there are fewer FFS payments in the systems and considerably more reliance on MCPs for utilization management within the capitated plans. Similarly, freezing or reducing FFS rates for inpatient care as originally recommended by the OCRM will have corresponding less effect for the same reason. A similar point could be made relative to the proposal to process FFS bills at a later time in the monthly billing cycle.

Despite these contextual changes, the OHP has made tangible progress is addressing several of the recommendations from the 2005 OCRM report. As recommended by the OCRM, FFS rates for community providers were frozen in 2005 and stayed frozen until a 3% rate increase in FY 2008. Nursing facility and intermediate care facility rates were also frozen until recent small (1-2%) increases were put into effect.

The area in which most progress was made was benefit coordination for dually eligible beneficiaries. Administrative code sections have been strengthened requiring providers to identify cross-over claims and take steps to obtain third-party payments before submitting claims to Medicaid. Cost recovery efforts have proceeded in three areas: cost avoidance, third-party liability (TPL) recoveries and tort actions. The most important of these is cost avoidance. Within the past couple years, new processes and procedures have been put into place to foster expanded cost avoidance. These processes have included the routine sending of Ohio Medicaid claims to CMS in Washington so that matches can be identified of claimants who are duly eligible. When identified, the claim becomes the responsibility of Medicare and the beneficiary is notified accordingly.

A similar cost avoidance strategy has been employed to identify Medicaid enrollees who are eligible for payment through commercial private insurance. Currently 12 Ohio insurance carriers have voluntarily made their eligibility files available to OHP for this purpose, and efforts are underway to secure this cooperation form all 20 major Ohio commercial carriers. Data enhancements are being made in MITS that will help facilitate additional cost recovery in this manner.



In Fiscal Years 2007 and 2008, more than $620 million was saved from these cost avoidance activities (see chart above). Similar successes are occurring with respect to TPL and tort action recoveries. Total recoveries through those mechanisms increased from about $17 million in 2001 to a peak of approximately $72 million in SFY 2005. Since then, those recoveries have declined to a level of $55 million in SFY 2008. The decline from 2005 and 2008 does not reflect a poorer result: rather, it is indicative of the success in cost avoidance. Because more dually eligible claims are identified before payment is made and routed to the appropriate payer (e.g., Medicare), then correspondingly less recovery through TPL actions is needed retroactive to the payment.

Little specific progress was made between January 2005 and December 2008 with respect to the OCRM recommendation pertaining to “just-in-time” payment of bills and with respect to recommendation which called for shifting payments to LTACHs and rehabilitation hospitals from a FFS to a prospective basis. The former idea was considered but rejected by ODJFS leadership because it was perceived to be administratively burdensome and would disrupt the efficiency of the current system of generating payments. Also, it was thought that the potential savings from delaying payments would be minimal. However, the rollout of the new MITS system might help revive this idea. The proposal to move to a prospective reimbursement system for LTACH facilities and rehabilitation hospitals was not considered a top priority by ODJFS leadership. For one thing, the number of LTACH facilities has declined from 23 to 15 since 2005. Additionally, such a change would probably need legislative authority. The amount of potential cost savings is considered small.

F. Summary: Structure and Management:

The 2005 OCRM report contained five main recommendations and fifteen associated action steps related to the structure and management of Ohio Medicaid. The recommendations ranged from forming a comprehensive program of performance and fiscal audits to increasing Medicaid's access to clinical and analytical resources by collaborating with academic researchers and analysts located at state universities in Ohio.

The key themes for the structure and management section of the report focused on making Medicaid as effective as possible through transforming program integrity, modernizing information technology architecture, maximizing buying power, increased use of selective contracting and pay-for-performance, and partnering with the Academic Medical Centers.

The broad and ongoing nature of the recommendations proposed under Structure and Management has limited many of the recommendations from being fully completed. Recommended actions that were successfully completed include: authorizing the Auditor of State to conduct a performance audit of Ohio's Medicaid program, instituting new measures to review provider qualifications periodically, moving the SURS unit out of OHP, and completing initial development of the new MITS information system.

Below is a summary of progress made in each of the main "structure and management" areas delineated in the 2005 OCRM report:

1. *Restructuring Medicaid*: The OCRM recommended that Medicaid be restructured as a separate cabinet level agency reporting directly to the Governor, a suggestion which was echoed by the Ohio Medicaid Administrative Study Council's (MASC) final report in December of 2006. This recommendation has not been acted on, in part because of the complexity of the resulting program structure and associated IT system needs. To a great extent, many of the goals envisioned by this recommendation have been achieved through the establishment of the Executive Medicaid Management Administration (EMMA) in December 2007. EMMA acts to develop, analyze and coordinate Medicaid policy, and facilitate interaction with other sister agencies around Medicaid-relevant issues.

2. *Compliance Audits*: The Auditor of State (AOS) gained auditing authority for Medicaid under House Bill 119. A fiscal mechanism was established for budgeting and allocating sufficient funds to cover audit costs within ODJFS' budget. Beginning in 2005, the AOS no longer needed to seek clearance from ODJFS to conduct performance audits of the agency. An audit was conducted in 2006 and a follow-up audit was conducted in 2008. This Follow-Up Report, published in December 2008, found that only 14% of the audit items identified in 2006 had been fully completed. Status of audit findings from 2008 are provided in the table below.

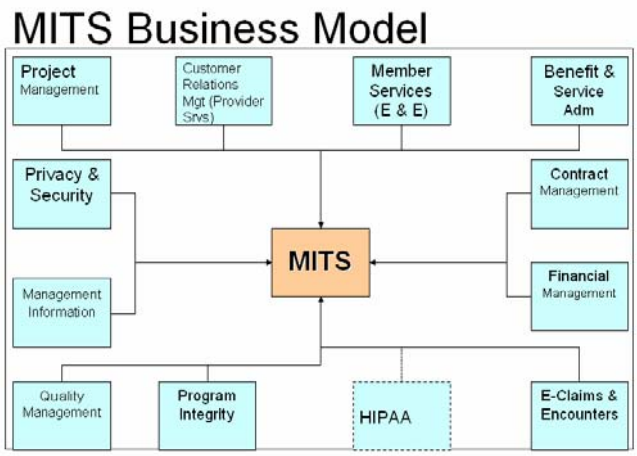
Table 1-1: Implementation Status of 2006 Audit Recommendations

	Report Section											
	Organizational Issues		Service Provision		Managed Care/ Care Mgt.		Technology		Program Integrity		Total	
Status	No.	%	No.	%	No.	%	No.	%	No.	%	**No.**	**%**
Fully Implemented	3	14.3%	2	8.7%	2	7.1%	3	15.8%	5	27.8%	**15**	**13.8%**
Partially Implemented	7	33.3%	9	39.1%	13	46.4%	9	47.4%	2	11.1%	**40**	**36.7%**
Not Implemented	11	52.4%	12	52.2%	13	46.4%	7	36.8%	11	61.1%	**54**	**49.5%**

3. *Program Integrity*: An interagency subcommittee of the Executive Medicaid Management Administration (EMMA) has been formed to deal with program integrity issues. Additionally, Ohio has established a Medi-Medi program, which is a joint state/federal project administered through AdvanceMed (a Medicare Program Safeguard Contractor) to perform analytical studies on Medicare and Medicaid data to identify potential fraud, waste, or abuse. The interagency Ohio Program Integrity Group (PIG) has undertaken a series of efforts to better protect program integrity by coordinating efforts among ODJFS, the AOS, and Attorney General's office.

4. *Provider Qualification*: Time limits have been established to identify providers who have not submitted claims within specific time frames. HR 119 requires that providers be reviewed for re-enrollment every three years. Also, systems have been established to identify providers with criminal records. The Surveillance and Utilization Review Unit (SURS) has developed new systems for identifying providers who are "outliers" with respect to utilization or costs. Initial development in underway to develop systems for calculating error rates by practicing providers. SURS has been performing statistical analyses of claims data to identify potentially improper provider payments.

5. *Medicaid Information Systems*. A business case for developing the new Ohio Medicaid Technology Information System was completed in 2005-2006, and development efforts initiated shortly thereafter. Initial roll-out of the MITS system, including on-line claims status and bill submissions began in late 2008. MITS represents an important advance for the agency in its ability to track and management eligibility, claims, and payments. A comprehensive data warehouse also has been developed by Thomason Medstat and a vendor (EDS) selected for development of a Decision Support System. Work in this area is currently proceeding on building clinical and data capabilities to facilitate financial analyses, resource planning, and risk assessment. Phase 1 implementation is expected by the end of 2009.



6. *Selective Contracting and Pay-for Performance*: Only limited progress has been made in the area of selective contracting. Attempts to implement selective contracting for oxygen, adult diapers, and durable medical equipment were attempted, but met with considerable opposition from local suppliers, and trade associations. Additional progress in this area would require legislative approval and more receptive political environment. Initiatives to enact a pay-for-performance system for Medical providers has also been slow due to budget constraints and questions about what standards and criteria to use in basing the system. Various pay-for-performance plans have been adopted by several of the participating MCPs. Specific pilot programs to identify and reward high-performing providers in certain areas are being conducted.

7. *Research and Analytical Collaboration with State Universities*: Proposals have been made to draw upon the analytical and research capabilities of state universities to help Medicaid better evaluate its needs and program performance. A related potential advantage involves securing additional federal matching funds to support this effort. A few initial programs have been initiated in this area, including development and roll-out of the 2008 Ohio Family Health Survey. It has been suggested that future efforts in this area might be pursued on an interagency basis.

V. Conclusion and Implications

Overall, this review has found that substantial progress has been made on many of the recommendation contained in the original 2005 OCRM Report. A majority (64%) of the Commission's original 48 suggested action steps have either been either fully or partially completed. Work is currently in process on some of the others. Only 19% of the report's main recommendations have had no tangible action taken.

Among the recommendations that have not been completed, various external factors have inhibited progress in a variety of ways. In some cases, financial constraints imposed limitations. In other cases, progress has been limited due to political pressures or the interests of particular groups. Action could not be taken in other areas because of legal or legislative contracts, or because of actions taken by the Centers for Medicare and Medicaid Services (CMS) or other federal agencies.

Consistently, our evaluation found evidence that ODJFS and OHP staff took the OCRM recommendations very seriously and conscientiously appraised their merits and disadvantages. In many cases, special committees and working groups were charged with more fully exploring the issues raised in the report. Internal tracking systems were devised for systematically monitoring and documenting progress in each area. Our general impression is that the 2005 OCRM Report and the work of the associated Ohio Administrative Study Council were instrumental in helping to stimulate positive changes in many areas. Progress has occurred under governors from both parties, and through both executive and legislative initiatives.

Further progress on achieving these recommendations will be affected by Ohio's ability to recover financially from the current recession and corresponding budget limitations. It is unlikely that significant expansion or new program development will take place in the foreseeable future, unless those programs are tied to demonstrable cost savings. Some retrenchments are possible, for instance in waiver programs and other non-essential services.

One can anticipate that Ohio Medicaid policy will be driven strongly by cost containment considerations during this period. Certain OCRM recommendations, such as the suggestions of eliminating duplicative disability determination processes may gain momentum because of the potential for gaining cost efficiencies. For the same reasons, efforts will likely continue to facilitate the transition from institutionalized care to community-based care for people with disabilities and serious chronic health conditions.

The impending release of the MITS system along with the additional analytical support capabilities inherent in the new information warehouse and decision support systems will continue to play an important role in streamlining Medicaid operations and providing a foundation for quicker, more cost-effective billing, payment, and claims handling.

Despite (or possibly because of) the state's fiscal problems, the state Medicaid program will be squarely in the center of focus for state lawmakers and officials during the coming year. The recent release of the Performance Audit Follow-Up Report by the state auditor's office will bring increased attention to questions of how best to reduce costs within Ohio Medicaid, while ensuring effective service delivery.

Although the timing of this report coincides closely with the release of the 2008 state auditor's report, and thus may elicit comparisons, it is important to recognize that scope, time frame, and aims of the two reports differ. This report covers four years from January 2005 to January 2009; the state auditor's report reflects a two-year follow-up from December 19, 2006 to December 18, 2008. Substantial progress on many of the 2005 OCRM recommendations was made during calendar years 2005 and 2006, the initial two years following release of the OCRM report. Thus, direct comparisons in assessing the extent of progress on recommendations from this report and the state auditor's report are difficult to make.

Moreover, this report addresses the status of recommendations which were contained in the 2005 OCRM report, which embody only selected key themes and issues that were perceived to be of primary importance to that group at that time. The scope of the AOS's report was significantly broader covering a comprehensive assortment of Medicaid operational areas. The state auditor's primary objective, appropriately, was to focus specifically on financial considerations and the ability of the agency to reduce system costs and thereby positively impact the state budget. The OCRM, while addressing cost savings potential in many areas, was more broadly focused on a variety of system objectives including optimizing consumer benefits, identifying potential enhancements and expansions in service delivery, and optimizing the quality of care for Medicaid beneficiaries. For these reasons, direct comparison between the findings of the reports should be made with caution.

VI. Appendices

A. Tabular Summary: Status of Recommendations and Action Steps

B. Bibliography

C. Advisory Committee Members

APPENDIX A- Tabular Summary: Status of Recommendations and Action Steps

Recommendation	Action Steps	Status as of Fall 2008	Factors Affecting Status
Long Term Care 1: Ensure access to a wide array of long-term care service and financing options in home and community based settings or in institutions.			ODJFS is committed to enhancing community-based options. But political, financial, resource, and other issues have impeded moving forward aggressively in this area. Resources are being directed to dealing with the expanded Medicaid caseload and new technologies. In addition, multiple state agencies and local systems are involved in the administration of and/or financing of long-term care programs which adds to the complexity of moving program changes forward.
	Action Step 1: Remove the nursing facility reimbursement formula from Ohio statute, and give the executive branch authority to negotiate fair and reasonable rates that require nursing facilities to achieve performance-based outcomes and objectives. This should happen in connection with the phase out of Certificate of Need (CON).	**NOT COMPLETED** OHP was unsuccessful in including this provision in HB 66 and removing it from statute. But the agency has been successful in altering the reimbursement approach and moving towards a price rather than a cost reimbursement basis. The new pricing system was implemented in SFY 07 and SFY 06 rates were frozen. There was a rate increase enacted per HB 119 via "stop loss-stop gain." ODJFS has obtained overall greater control over nursing home rates. Nursing homes have to compete for funding in a similar fashion as other Medicaid providers The agency is also placing emphasis on trying to measure quality-of-care outcomes and increase care quality for the long-term care population.	The nursing home trade associations are powerful and have been able to block full changes (i.e., totally removing reimbursement formula from state statute language).
	Action Step 2: Phase out the current CON for Ohio's nursing facilities.	**NOT COMPLETED** The LTC bed moratorium remains in temporary statute; (in place since 1993). The elimination of CON has not been formally proposed. Phasing out of CON has not been completed, although continues to be discussed in various venues. The cost of CON is no longer reimbursable. ODH is leading a study group to follow up on certain "Money Follows the Person" workgroup recommendations. This ODH group has discussed changing CON formula to allow for moving beds across county lines; however, the overall number of beds would stay the same. CONs currently cannot be moved from county to county. There is limited use without a CON license. The Medicaid pricing system accomplished some of the goals that originally motivated this recommendation.	The nursing home industry is split on whether moratorium should be changed.
Long Term Care 2: Ensure that elderly and disabled Ohioans, their families and/ or caregivers have easy, immediate access to a full range of cost-effective options and needed information about			The Assisted Living waiver was established and is currently in effect, although utilization is small. Local agencies and regional collaboratives are attempting to move forward with establishing resources capability, but progress has been slow. Pre-screening processes are being considered but are not as yet in place widely.

APPENDIX A- Tabular Summary: Status of Recommendations and Action Steps

Recommendation	Action Steps	Status as of Fall 2008	Factors Affecting Status
long-term care service options, especially in a crisis situation.			
	Action Step 1: Create a comprehensive pre-admission screening process for any Ohioan in need of Medicaid-funded long-term care, especially nursing facility care.	**UNDER DISCUSSION** Pre-screening is provided for consumers in the PASSPORT program. The PASSPORT system helps older adults and their families to make long-term care choices and enables eligible older adults to remain at home and in the community. But similar pre-screening is not available routinely prior to care in nursing facilities. The Ohio Department of Aging and ODJFS have made some improvements in this area as part of the Money Follows the Person project **(**MFP**)**. Also, Preadmission Screening and Resident Review (PASRR) has been adopted as part of ODMRDD screening for people with mental retardation and developmental disabilities and serious mental illness (SMI). An interagency subcommittee was formed in January 2008 and is meeting under the leadership of EMMA to discuss this and other initiatives in the LTC area. The PASRR rules are being updated to reflect the recommendations of the MFP/Unified LTC Budget workgroup. The recommendation is receiving consideration and analysis from EMMA, e.g., identifying where gaps are today. Recommendations to the Administration are under development.	The recommendation has received increased attention since Governor Strickland took office. Changes in preadmission processes and associated requirements will impact multiple stakeholder groups and provider entities (including but not necessarily limited to: local Area Agencies on Aging, hospital discharge planners, nursing home staff, local mental health and developmental disability evaluators).
	Action Step 2: Establish Long-Term Care Resources Centers in each Area Agency on Aging service area.	**IN PROCESS** Regional collaboratives were recommended in Unified Long-Term Care Budget (ULTCB) report. There is one pilot Aging and Disability Resource Network (ADRN) in place in Cleveland. Each local Area Agency on Aging potentially has that capacity. The agency's goal is to provide information to people wherever they apply for long-term care assistance. Local agencies, (including County Departments of Job and Family Services and Area Agencies on Aging (AAA), are collaborating in some areas. In Hamilton county, the AAA is "co located" with the local JFS office. How the local entities collaborate is playing out differently depending on the location. The ULTCB report recommends a "no wrong door" approach. The ODA is very supportive of that idea, but it is not currently occurring.	The development of this program has been slow and complicated because of the number of organizations involved, and the vying interests and perspectives of each.
	Action Step 3: Offer assisted living as a Medicaid option.	**COMPLETED** The Assisted Living Waiver (ALW) program was authorized under HB66 and received authorization from the federal Centers for Medicare and Medicaid Services (CMS). The ALW program began July 2006; and consumers are currently being enrolled The waiver can serve a maximum of 1,800 consumers, and 1,300 are now receiving services. There have been reductions in funding the Assisted Living Waiver (ALW) since it was enacted. There is now a relatively small waiting list of about 75 consumers. Rules have changed to allow for private assisted living residents who exhaust resources to apply for the ALW. Residents still cannot come directly from the community to the program.	While the program has been put into effect, rates are not attractive to many providers and consumer utilization is low.

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	Action Step 4: Increase the clinical capacity and flexibility of home care options for consumers.	**IN PROCESS** Medicaid waiver consumers can receive all state plan Medicaid services. Changes have been relatively recently made to state plan Private Duty Nursing and Home Health services. The array of waiver services available on each Medicaid waiver is being reviewed in the MFP initiative. ODJFS is proposing a Home Care Attendant option for individuals on the ODJFS administered waivers. Services under PASSPORT are considered too restrictive and have not yet been changed. However, the PASSPORT and Home Care waiver caps now have exemptions to allow residents to spend 100% of the nursing facility rate. In addition, the ULTCB report recommends consumer direction be included in all Medicaid waivers.	Home-based options for long term care in Ohio still trails other states. Impediments include a lack of good data about these programs, and inadequate availability of support services for home care in some areas.
Long Term Care 3: Encourage personal choice and responsibility for long-term care by modifying estate and asset recovery, as well as state funding policy.		Medicaid Estate Recovery is a federally mandated program that began in Ohio on January 1, 1995. Some changes have been made. For example, H.B. 66 expanded the property in an individual's estate that is subject to adjustment or recovery by including all real and personal property and other assets in which the individual had any legal title or interest at the time of death. The CHOICES and PASSPORT programs have expanded options for personal choice of LTC options.	
	Action Step 1: Modify Ohio's estate recovery process to the maximum extent allowed under federal Medicaid estate recovery law. In addition, use waivers to create an estate recovery model that provides incentives for consumers to select the lowest cost care options.	**PARTIALLY COMPLETED** There have been changes resulting from federal Deficit Reduction Act (DRA) that effect eligibility – greater look behind period, and increased penalty provisions. HB66 included additional assets to be included in the recovery process. Changes include: increased look-back to 5 years, extended to 13 months the Homestead Exclusion and expanded the estate beyond probate. Changes required by DRA have been implemented. However, a waiver was not utilized to create an estate recovery model (tiered approach) that encouraged consumers to select lower cost options.	Supporting federal law and state law changes were required to implement some of the proposed changes.
	Action Step 2: Establish a long-term care "voucher program" to accommodate "cash and counseling" and "money follows the person" approaches to improve care and reduce costs.	**IN PROCESS** The Choices program (part of PASSPORT) has allowed people to self-direct which providers to use. The program has received enhanced federal reimbursement. The Choices program has expanded to approximately 400 residents and is operational in many rural areas. Choices clients tend to be more impaired than other LTC clients. The ULTCB report recommended expanding consumer directed option for all waiver programs. The ODA Choices waiver is being expanded in the Toledo area. Other Medicaid waivers are expanding self direction practices. Money Follows the Person (MFP) and Cash and Counseling were a major part of the ULTCB discussions, but are not yet fully implemented.	Expanded personal choice programs, such as Cash and Counseling have faced opposition from some disability advocacy groups and encountered concerns about the availability and quality of counseling and other local support services to support these initiatives.
	Action Step 3: Increase	**PARTIALLY COMPLETED**	

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	assets that may be retained by income-eligible Medicaid waiver applicants to avoid premature admission to an institutional setting, and explore tiered asset recovery policies	This recommendation was adopted in the ULTCB report, and some states including Pennsylvania have increased the asset threshold. But implementation in Ohio's unlikely given its potential fiscal impact in the current budget environment. The recommendation was not implemented, and was perceived by ODJFS officials to be cost prohibitive. However, if a person buys a "partnership policy" they may retain more assets. In addition, the Medicaid Buy-in for Workers with Disabilities (MBIWD) program allows consumers (some on Medicaid waivers) to have assets up to $10,000.	Considered to be cost prohibitive (Plouck interview, 11/17/08).
Long Term Care 4: Create a cost efficient long-term care system with consolidated budgets, data collection and planning.		A large variety of agencies are involved in providing LTC services in Ohio, posing a challenge for better coordination and planning.	EMMA may help play a coordinating role.
	Action Step 1: Create a unified long-term care budget managed across all state and all local governmental agencies and service settings, and establish a single accountable head to provide leadership and direction for meeting the long-term care needs of Ohioans.	**IN PROCESS** Recommendations for implementation were included in HB 119 and the most recent Unified Long Term Care Budget report. But implementation has not yet occurred. Implementation is projected to occur in steps, tied to the deployment of the MITS system. In the FY 09/10 biennium, it is proposed that the agencies will consolidate their waiver programs into one line. This consolidation of lines will give ODA more flexibility in managing their programs. However, consolidating line items does not make it any easier for the consumer to obtain services. Currently, many consumers have difficulty navigating between all the programs and agencies. A consolidated LTC budget, by itself, will likely not reduce this confusion. Considerable planning work was done in FY 2008 and is anticipated to speed up in FY 2009. Four phases for implementation are anticipated covering various populations: institutionalized, MRDD, behavioral health, and state plan. ODA and EMMA are playing the lead roles. EMMA has created a working group that is working to explore implementation of the original ULTCB recommendations.	The process and implementation status/timeline may be impacted by the state's current budget situation. Stakeholder support (or lack thereof) may impact the ability for this concept to move forward across all systems.
	Action Step 2: Establish a long-term care policy coordinating entity with authority that spans all state long-term care plans and programs.	**COMPLETED** The Executive Medicaid Management Authority (EMMA) has been set up to coordinate Medicaid policy. EMMA currently is holding many internal meetings in order to coordinate LTC policy that cross over among multiple agencies. This role being played by EMMA represents a different tactic compared to the recommendations made originally by the Medicaid Administrative Study Council. While coordinating mechanisms have been established, they still need to be implemented in the field.	EMMA can be an effective coordinating agency for long term care. But practical considerations will affect its ability to enact changes in actual service delivery practices among multiple agencies.
Care Management 1: Establish a statewide care management program for all Medicaid recipients.		Compared to 2005, a large proportion of Medicaid care has been transitioned to private managed care plans (MCPs), thus introducing expanded ability to managed care, utilization and costs.	Current MCPs are providing care at a deficit. Independent rate agreements established by MCPs with particular provider organizations will

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			stress Medicaid's ability to control its budget, particularly as new actuarially determined rates are calculated and enacted that reflect those price increases.
	Action Step 1: Expand the current full-risk managed care program to all Medicaid-covered families and children (CFC) throughout Ohio.	**COMPLETED** This has been accomplished through contractual arrangements with participating MCPs. Statewide expansion is virtually complete for the CFC population. As of February 2008, about 1.2 million CFC Medicaid consumers are receiving their health care via managed care arrangements.	Although managed care was rolled out successfully in Ohio, current financial pressures are stressing the MCP system. Some commercial plans have recently withdrawn or cut back on providing care in certain areas. Demands for increased reimbursement rates from hospitals and provider organizations have further stressed the MCPs ability to delivery services at a reasonable cost.
	Action Step 2: Apply care management to the ABD population through the most effective approach, recognizing established medical relationships within special needs populations, such as those in intermediate care facilities for the mentally retarded (ICFs/MR).	**COMPLETED** This has been accomplished (except for certain federally excluded populations). The original OCRM recommendations for the CFC and ABD populations were predicated on testing various models, e.g., Enhanced Care Management (ECM), and commercial managed care plans). After initial testing, the ECM was dropped. This decision occurred as part of the biennial budget process and full-risk managed care was required in HB 66. Managed care enrollment has grown and is now strong. About 126,000 ABD consumers are receiving their care via managed care plans as of 2008. Movement of ABD population to managed care was about 6-months behind the same policy for CFC population. In some regions, enrollment has declined due to managed care plans discontinuing contracts. As of December 2008, a Request for Proposals is being prepared to seek new plans in those locations.	While managed care has been extended to the ABD population, MCPs still do not cover some children, institutionalized persons, dually eligible consumers, and those on spend-down. The ABD full-risk program was a brand new system (so it took longer than the shift to managed care in CFC population), but now it's up and running. The decision to discontinue ECM and go with managed care was related, in part, to market considerations and not entirely in the control of the ODJFS.
	Action Step 3: Expand financial incentives in various Medicaid managed care capitation rates using managed care plans that develop and implement protocols to improve outcomes through patient education and compliance, community health education and outreach, and coordination with social service organizations.	**PARTIALLY COMPLETED** Expanded use of financial incentives for managed care provider organizations is now being considered as part of the ongoing review of statewide managed care operations. In some plans, a portion of the capitation payment is "at risk" dependent on meeting specified performance measures (e.g., HEDIS scores, process & outcomes measures). There is also the auto-assignment protocol whereby consumers are automatically enrolled into higher performing plans. However, that performance measure is based primarily on how the plan deals with providers; for example, how they process claims and prior authorizations, and not necessary on outcomes or quality of care. Regional MCPs have been effective in engaging the larger Medicaid community (e.g., behavioral health and specialty providers). Pay for Performance initiatives and payment mechanisms are being developed within some MCPs. There are also attempts to provide incentives to delivery of preventive services. Further progress depends on addressing provider relationship issues.	It is difficult to directly apply some HEDIS measures to financial incentives within the existing MCPs for the Medicaid population. Pay for performance systems will test the relationships between the Medicaid managed care plans and participating medical providers. There are also concerns about the sources of and availability of funds to support expanded pay for performance initiatives.

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	Action Step 4: Improve the management, quality review, and financial strength of Medicaid care management with the following steps:	**PARTIALLY COMPLETED**	During the past 4 years, much of the responsibility for ensuring high-quality care has been transitioned to MCPs. Consequently OSJFS oversight is often "at arms' length."
	1. Increase the coordination between the Ohio Department of Insurance (ODI), ODJFS, and the state-contracted actuary in July 2005 to determine the actuarially sound capitation rates to be paid to the Medicaid managed care plans.	**COMPLETED** ODJFS uses an external commercial vendor to set capitation rates, and ODI has little involvement in that effort. However, ODI has been active in reviewing the financial solvency of participating MCPs.	If MCPs continue to experience operating deficits, the ODI will become increasingly concerned about solvency issues.
	2. Eliminate duplicative review requirements between the Ohio Department of Health (ODH) and ODJFS to ensure better management of the health plan licensing process.	**COMPLETED** For a managed care plan to get licensed for Medicaid, the plan used to have to go through review by ODH and ODJFS besides the ODI. Originally, the ODH involvement was intended to evaluate the provider panel of the managed care plan to make sure there are enough providers. However, that ODH function now has been eliminated and it is performed by ODJFS.	Licensing was streamlined by consolidating functions with ODJFS.
	3. Adopt nationally recognized performance standards for Medicaid managed care.	**PARTIALLY COMPLETED** OHP currently uses CAHPS and HEDIS measures to assess ongoing system performance. ODJFS requires MCPs to also use these measures. However, HEDIS is not well adaptable to some populations, such as Medicaid's ABD population. States are required by the federal government to use external quality review organizations EQROs. Ohio pays $5 million per year to provide their services, which include chart reviews. ODJFS has hired an EQRO. EQRO makes sure that all of the guidelines established by CMS are followed and examines other measures that the state might decide to implement.	Not all performance measures (like HEDIS) can be applied easily to all Medicaid populations. Additional measures are under consideration.
	4. Require full-risk managed care plans to purchase surety bonds as a component of their risk-based capital and financial solvency requirements under Ohio law.	**COMPLETED** HB66 authorized ODI to increase standards for HMO actuarial soundness Managed care plans must now purchase a surety bond for $3 million in order to offer their plan to Medicaid beneficiaries. ODI is heavily involved in evaluating the solvency of Medicaid MCPs.	Financial performance and solvency of MCPs will continue to be an issue that requires close scrutiny.
	5. Inform care management plans doing or seeking to	**COMPLETED** ODJFS informs managed care plans by: (1) organized state-wide listening	During the past year, negotiations between

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	do business in Ohio about Ohio Medicaid's expenditure growth target, and invite initiatives that will enable them to support state government in meeting spending targets.	sessions (2) meeting with the health plans, who are invited to come up with cost-containment initiatives, and (3) utilizing rate setting mechanisms to contain costs. ODJFS have limited flexibility in this area because they are required by federal regulations to pay for rates that are "actuarially sound." In Ohio, the state pays the rate that the actuary has determined. The plans can decide whether they want to participate based on those rates. However, the ability of MCPs to develop independent pricing arrangements with specific MCPs threatens ODJFS' ability to accurately predict future cost trends and expenditure requirements.	MCPs and provider organizations have introduced difficulties for patients and the agency. There have been calls to implement safeguards to limit the ability of MCPs to unilaterally pull out of the Medicaid system. Currently statutory language requires doing business with all providers; FFS and managed care. If a provider can demand a particular price from an MCP, and the MCP agrees to it, the agency loses considerable control over cost containment.
	Action Step 5: Establish a Care Management Working Group (CMWG), including representatives from Medicaid care management plans, major health care and behavioral health professional and trade associations, consumer advocates, county agencies, ODJFS, ODH, ODI, ODA, ODMH, Alcohol and Drug Addiction Services (ODADAS), Mental Retardation/Developmental Disabilities (ODMR/DD), and the RSC.	**COMPLETED** A Care Management Work Group (CMWG) was established, met, and issued a report in December 2007. The group disbanded at that point, but an advisory function and some members were added to the ODJFS Medicaid Care Advisory Committee. The CMWG had requirements to fulfill that the state spelled out such as giving reports the State Assembly and to ODJFS. The CMWG was intended to create a forum to address issues dealing to the expansion of managed care from 17 to 88 counties. It was disbanded because the issues dealing with this change had been dealt with. The responsibilities/tasks that the CMWG addressed are now rolled up in the responsibilities/tasks of the Medical Care Advisory Committee (MCAC).	The MCAC will continue to play an important role in establishing managed care policy and overseeing the effectiveness of the MCP care delivery process.
Care Management 2: Withhold payment of the hospital Graduate Medical Education (GME) Medicaid subsidy from hospitals that fail to participate in expansion of managed care and other care management strategies. (recommendation not unanimous)		**PARTIALLY COMPLETED** Originally, HB 66 contained language that was in conformity to the OCRM recommendation. But an amendment to HB 66 deleted the provision which mandated that ODJFS would not pay graduate medical education (GME) costs associated with the delivery of services to Medicaid patients unless a hospital contracts with at least one Medicaid MCP. One difficulty with the proposal was that it was very difficult to isolate the GME payments in the OHP data system. From the hospital's point-of-view, it still gets same GME reimbursement even if it doesn't have a contract with an MCP. In addition, there was an exemption for hospitals in counties that had Medicaid managed care plans prior to HB 66 (primarily urban counties). Hospitals covered by the exemption were not required to accept Medicaid managed care plan members. Development of the new MITS system would help enable this idea.	GME payments are difficult to identify and estimate in the ODJFS data system. However, the new MITS system is expected to have this capability and could facilitate further movement in this area. Tight budgets at both the state and federal (CMS) levels have led to attempts to shift costs between systems. Federal GME subsidies, in general, have decreased.

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Pharmacy 1: Secure the best prices for pharmaceuticals (brand, generics and over-the counter medications) through expansion of buying power and creation of a more competitive market for price negotiation.		The OCRM had several recommendations aimed at controlling pharmaceutical costs and streamlining the purchasing process. The focus of their proposal, participation in state purchasing pools, has not been done, mainly because the prices available through independent negotiation were competitive with what could have been secured through pooling arrangements.	
	Action Step 1: Consolidate all pharmaceutical purchasing by the state and other public entities with Ohio Medicaid to create an efficient pharmacy program through negotiating better rebates and overall prices for individual drugs. Participate in a multi-state drug purchasing pool.	**NOT COMPLETED** HB 66 contained permissive language for ODJFS to pursue involvement in state purchasing pools, if it would be to Ohio's benefit. However, OHP was able to negotiate rebates and prices that were comparable or better that could be derived through the multi-state drug pools. Pharmacy purchasing consolidation was also recommended by a committee including the Department of Rehabilitation and Corrections, Mental Health, MRDD and others. Medicaid staff assessed the impact of the Medicaid managed care expansion and Medicare Part D implementation and provided a report to the General Assembly per HB 119.	After consideration and assessment, ODJFS determined that entering a multi-state drug pool was not currently beneficial. This may change in the future depending on market conditions.
	Action Step 2: Lift restrictions in the supplemental rebate system that exclude certain Medicaid drug purchases from negotiated cost recovery. These include mental health and HIV/AIDS drugs. Seek rebates on physicians' office purchases and purchases in the Disability Assistance Medical program.	**PARTIALLY COMPLETED** Medicaid rebate revenue (federal and supplemental) was approximately 36% for SFY 2006 and 39% as of December 2007. Provisions contained in HB 119 charged ODJFS with studying the impact on drug purchasing and costs resulting from the introduction of managed care and Medicare Part D and reporting to the General Assembly. HB 66 directed ODJFS to collect supplemental drug rebates for mental health and HIV/AIDS drugs and drugs administered by a provider in the provider's office. MCPs have their own rebates. They cannot obtain the additional rebates that OHP can obtain/negotiate as the Medicaid agency because of federal limitations (such federal allowances do not extend to Medicaid managed care nor Medicare. When Part D was implemented, Medicaid experienced a loss in rebate revenue. In general, the recent trend of increased use of generics has positively affected drug purchasing for the Medicaid population and moderated, to some extent, the importance of rebates.	The proposal would require approval from the Joint Committee **o**n Agency Rule Review (JCARR). There is a federal law currently pending to extend same rebate options to MCPs and Medicare.
	Action Step 3: Change state and federal law and regulations so that drug purchases are transparent.	**NOT COMPLETED** State and federal laws prohibit such transparency (ORC 5101.31 and OBRA 90). It is not likely that Ohio can persuade CMS and to make changes at the federal level.	While current federal and state law prohibits transparency, sharing drug purchasing information and price information could, in theory, positively impact a state agency's ability to negotiate prices and rebates.
Pharmacy 2: Restrict drugs eligible for payment under		Pharmacy management programs are becoming more common, with cost	

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the Medicaid program using a more limited formulary than the current one, with preferred status going to similar, if not identical, lower cost drugs.		containment programs focusing on formularies, utilization review, tiered pricing systems, and requirements for use of generics, when possible.	
	Action Step 1: Limit the number of preferred drugs to equivalent, lower cost products, and require documentation and prior authorization (PA) for use of non-preferred drugs.	**COMPLETED** The OHP has a preferred drug list (PDL), although they are federally prohibited from restricting drug purchases only to those on formulary. Per OAC rule 5101:3-9-12, certain classes of anti-psychotics and antidepressants now require pre-authorization. The PDL includes the most commonly prescribed drugs and does not require prior authorization. Prescriptions that do not require prior authorization are those deemed "clinically superior" and/or lowest cost. The Pharmacy and Therapeutics (P&T) Committee receives information to help determine which drugs are "clinically superior." Cost information is not considered in this decision. Technology-assisted purchasing is now possible through the OHP web portal. MITS development will further facilitate this purchasing option.	Medicaid MCPs use the same formulary as for FFS, but MCPs can require prior authorization, utilization management, and institute other cost control measures.
	Action Step 2: Regularly evaluate and sponsor evidence-based research on the use of prescription drug therapies and use prior authorization to align drug therapies with the most up-to-date research.	**PARTIALLY COMPLETED** The Pharmacy and Therapeutics (P&T) committee evaluates evidence-based research pertaining to prescription drugs used in the Medicaid system. The Behavioral Health Quality Initiative assessed prescriber compliance with clinical quality guidelines. Additional quality oversight for prescription drug usage is performed directly by managed care plans with ODJFS oversight. In addition, there is an external vendor that Medicaid contracts with to collect data and clinical information about pharmacy practices. This information is Provided to the P&T Committee.	Managed care plans may have their own P&T committees. To date, they have not been invited to participate in the JFS P&T committee.
	Action Step 3: Set incremental goals for increasing the use of generics as opposed to patented drugs as a percentage of all drug expenditures.	**COMPLETED** Ohio Medicaid is applying a variety of techniques to maximize the cost and clinically effective use of generics. MCPs manage utilization in a similar fashion. In some case, trade name drugs may be less expensive than the generics given the rebates. Medicaid's goal is to derive the net lowest cost, through use of generics if appropriate, but also with non-generics if a total lower cost can be realized.	National and state trends point to an increasing use of generics, especially as more trade-name drugs come off patent protection during the next few years.
Pharmacy 3: Reduce state expenditure at the point-of-sale of Medicaid drugs.		Alternative mechanisms for improved pharmacy purchasing practices at the point of sale have been considered, including mail-order and internet purchasing, increased patient cost-sharing, and negotiating lower dispensing fees.	
	Action Step 1: Bring Medicaid pharmacy	**COMPLETED** HB 66 reduced retail pricing to Wholesale Average Cost (WAC) + 7% from	MCPs may not necessarily utilize the same

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	reimbursement into parity with commercial insurers	the previous level of WAC +9%; and that pricing change has been implemented. The agency's goal is to further decrease this fee, while still assuring access to appropriate service. State law requires ODJFS to conduct a survey every other year to obtain information on market prices for such fees. The OHP Director, at his/her discretion, can use that information to change the dispensing fee or keep it the same. Currently the fee is $3.70 for professional fees.	dispensing fees as the FFS program.
	Action Step 2: Create a system of modest patient cost-sharing for drug purchases.	**PARTIALLY COMPLETED** HB 66 instituted a $2 co-pay for trade-name PDL drugs and $3 for prescription drugs requiring prior authorization. There are certain enrollee groups exempt from having to pay co-pays, per federal CMS rules The $2 and $3 co-pay levels that are currently used in Ohio were determined from following federal guidelines as to what consumers can be required to pay. In order to determine the co-pay amount (or change it), the total number of prescription drugs an individual or family obtains must be known, since there is a cap on how much can be spent on co-pays for pharmacy per year.	Managed care plans have the option to implement co-payments but are not required to do so. Thus far, only one managed care plan requires that its Medicaid beneficiaries pay a modest co-payment for prescription drugs. MCPs would be required to limit any co-payment to no greater than what is paid for through FFS.
	Action Step 3: Implement a mail-order program for Chronic Care Maintenance Medications.	**NOT COMPLETED** ODJFS is studying this option in view of the introduction of Medicare Part D and increased managed care enrollment. ODJFS has concerns with mail-order purchasing which have led them to not mandate its usage. For example, mail order may not be appropriate for Medicaid's chronic care population, many of whom are on "spend-down" for long term care. In many cases, community pharmacy purchasing may be as competitive as mail order purchasing. Also, a patient can go on and off Medicaid (especially ABD population), so at one time in the month, they may not have Medicaid coverage and at another time in the month they do. That makes it difficult to mail out a large prescription drug order (covering many months), as changes in eligibility may occur during that period.	One possible factor affecting the status is the logistics of implementing such a program for a Medicaid population. In addition, inaccurate mail addresses in the data arise because of the transient nature of the Medicaid population. There are also concerns about possible fraud or theft.
Pharmacy 4: Set up systems to monitor cost-effective management of drugs by Medicaid-reimbursed prescribing physicians and health plans.		Since 2005, considerable changes have occurred in prescription use practices at hospitals and physician offices, owing to advances in electronic order and tracking systems. Consideration is now being given as to how to most effectively use these systems to enhance prescription drug cost and management.	
	Action Step 1: Initiate medication therapy management.	**PARTIALLY COMPLETED** Medication therapy management (MTM) involves a range of services provided to individual patients to optimize therapeutic outcomes and detect and prevent costly medication problems. The effectiveness of MTM programs is a function of how they are implemented. Some concerns have been expressed that programs proposed by OCRM are intended to focus too much on cost containment rather than drug effectiveness and patient	The acceptance and effectiveness MTM in Ohio Medicaid would depend heavily on how the program was designed, and the relative balance of cost-containment and pharmaceutical effectiveness and management measures.

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		outcomes. Under the Primary Alternative Care and Treatment (PACT) program, a primary care coordinator is available to help patients manage their prescription drug usage. The Behavioral Health Quality Initiative also addresses this need to some extent. In addition, medication therapy management is a tool available within several Ohio Medicaid managed care plans.	An additional concern would be the incremental funds needed to fund such a program.
	Action Step 2: Provide incentives for physicians and hospitals to use electronic prescribing.	**PARTIALLY COMPLETED** ODJFS has entered into a contract with Affiliated Computer Services (ACS) to provide online access to view FFS prescription drug claims history for their patients. It is expected that this system will be rolled out in December 2008 beginning with large provider groups and hospital emergency departments. ODJFS is developing an e-prescribing system (Cyber Access) as part of the existing PBM contract; negotiations are ongoing with a Board of Pharmacy. Target implementation date early 2009. ODJFS submitted a Medicaid Transformation Grant application to CMS to fund e-prescribing and electronic health record development. ODJFS will not be limiting access to this system to only certain physicians, but ODJFS will target Emergency Departments and other large providers.	It is unclear if the use of ODJFS e-prescribing system will be extended to managed care plans as well.
Pharmacy 5: Monitor the shift to the Medicare Part D formulary for the dually eligible population, operating on the premise that Ohio will not provide additional subsidies for products covered in the Ohio formulary and not in the federal schedule, but will consult with other states and with Medicare if clinically important differences become apparent.		**COMPLETED** Limited optional Medicaid drugs for dual-eligibles. ODJFS has implemented a policy to continue limited Medicaid coverage for Part D enrollees, for drugs not covered under Part D. Medicare Part D has to cover drugs in certain therapeutic classes. Medicaid, therefore, cannot pay for any drugs that fall under those therapeutic classes.	It is not clear whether restrictions on drug coverage for dually eligible enrollees will be curtailed because of budget limitations.
Eligibility 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		**IN PROCESS** HB 66 contained language to study both systems; ODJFS and the Ohio Rehabilitation Services Commission (RSC). There were recommendations made from that study to merge the systems. But it was not implemented due to objections from RSC. Today, there are still separate systems, but the matter is still being considered and discussed. The Disability Determination Study Council has investigated the issues involved and issued a report. Discussions are now underway with RSC; trying to make progress on enacting a consolidated process. Counties are also involved. Issues exist concerning data sharing with SSA and CMS Beginning July 2008, Medicaid and RSC have established 4 subcommittees to create a common application	Various concerns have been raised including providing information to the federal government, funding implications, and trying to retain the large group of doctors working for RSC. The changes would need some changes in the current budgeting process, but would not require any statutory changes. There is not yet a consensus on whether or not

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(OASDI) and Supplemental Security Income (SSI), and base disability determinations upon disability reviews conducted for the Social Security Administration (SSA) by the Bureau of Disability Determination at the Rehabilitation Services Commission (RSC).		procedure. The policy and process subcommittee has been meeting weekly with the goal of a single application that consolidates the information needs of both Medicaid and SSI. Work is ongoing, but multiple hurdles including federal approval and technology interfacing remain before feasibility can be shown.	consolidating such determinations will actually be more simple and expeditious. There are issues about the length of time needed to make a determination and the relative size differences of the affected Medicaid and RSC populations.
Eligibility 2: Develop further data and policy alternatives for amending Ohio's Medicaid State Plan to shift from being a "209(b) state" and adopt the eligibility criteria for SSI.		**NOT COMPLETED** The Disability Determination Study Council report studied and recommended not making this change to becoming a "Section 1634" state, which means that Ohio would rely on the Social Security Administration to determine Medicaid eligibility for Ohio SSI beneficiaries. Several other states have considered this idea and decided not to do it. It would affect all 150 eligibility categories and require significant system overhaul. It is a one-way decision; the state cannot go back to the original plan later. It would eliminate blind persons from ABD category. The Council's review also found that a large part of the spend down population might be adversely affected. The change would also require a complete IT overhaul. A further concern was the likelihood that it would harm the disabled population, triggering lawsuits under the Americans with Disabilities Act.	There is little political momentum in Ohio currently to undertake this change.
Eligibility 3: Expand health care coverage through a better-defined relationship between Medicaid and employer-based health plans.		Little progress has been made in this area. However, the reform proposals recently released by the State Coverage Initiative (SCI) team, might lead to new consideration of synergies between employer-sponsored health insurance and Medicaid plan needs.	
	Action Step 1: Collect premiums from persons receiving transitional Medicaid benefits.	**NOT COMPLETED** ODJFS performed a comprehensive study of consumer cost sharing and chose to focus on other populations. ODJFS currently has no plans to pursue this idea. One concern was the economic feasibility of the suggestion. Federal regulations allow a maximum premium of 5% of gross family income. This regulation requires close tracking of monthly income during the transition period, leading to administrative costs exceeding premiums collected. There were also legal concerns	There is little current interest in this approach, although the recent SCI reform proposals may stimulate new thinking in this area.
	Action Step 2: Require certain Medicaid recipients to enroll in private employer	**UNDER DISCUSSION** The federal Deficit Reduction Act (DRA) provides some opportunities for	Changes would require statutory authority and

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	insurance.	moving in this direction. A Health Insurance Flexibility Accountability (HIFA) program was considered but not pursued. Similar ideas were included in Governor Strickland's original health care platform. This action step is still under consideration but is on hold while the State Coverage Initiative (SCI) reforms are being considered. ODJFS has no plans to independently pursue this proposal.	federal approval. Related proposals have been put forth by the SCI team.
	Action Step 3: Establish a Medicaid Buy-In Program for People with Disabilities after implementing Commission recommendations to control the rapid growth in Medicaid spending.	**COMPLETED** This was authorized through state plan amendment and HB 119. It was part of Governor Strickland's Turnaround Ohio initiative. The new Medicaid Buy-In Program for Workers with Disabilities (MBIWD) went into effect April 1, 2008 for employees earning up to 250% FPL (after deducting the first $20,000 of earned income). Those with incomes over 150% FPL will be required to pay monthly premiums. As of October 2008 1,700 people are enrolled.	This waiver program was successfully implemented. Budget pressures may cause some reconsideration of program benefits.
Finance 1: Establish firm annual spending targets for Medicaid. Beginning with the SFY 2006-07 biennium, appropriations to the Ohio Department of Job and Family Services' line-tem 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, health care costs, and state revenues.		**COMPLETED** This was accomplished within the existing Medicaid spending projection and budgeting process. OHP uses a hybrid approach for budgeting that involves trending from previous year, along with caseload projections and utilization estimates. The OCRM recommendation was aiming at trying to make the budgeting process more transparent, and clarify the assumptions used. No major changes have been made in this regard. OHP is attempting to control spending by implementing Medicaid selective contracting for certain goods and services, thereby maximizing competition and getting the best possible price. OHP is also requiring Medicaid Managed Care Plans to adopt more expanded value purchasing strategies. ODJFS plans to hire a staff actuary to help its independent contracted actuary (Milliman) in setting actuarially sound rates. Nationally, CMS has entered into a contract with "Global Insights, Inc." to devise caseload forecasting methods for Medicaid using economic modeling techniques.	The introduction of MITS and the new decision support system will further enhance the agency's budgeting capabilities.
	Action Step 1: Beginning with the SFY 2006-2007 biennial budget, give ODJFS the power within state law and regulation, in consultation with interested parties, and subject to legislative oversight, to manage utilization rates and prices paid for health care services within appropriation levels. Toward this end, statutes	**PARTIALLY COMPLETED** HB 119 contained various measures to control costs including disciplined growth in managed care rates and limiting intermediate care rates (both implemented) and recalibrating inpatient hospital rates. Plans to recalibrate inpatient hospital rates have been postponed indefinitely to offer relief to hospitals. Medicaid growth has been restrained. For the 525 account, the annual growth rates have been: 04/05 – 5.9%, 05/06 – 2.4%, 06/07 – 1.7%. The NF/MR rate formula rates remain in statute; however, they are greatly controlled through a "pricing system." Prices are not updated unless authorized by the General Assembly. Managed care rates however must be set, per federal regulation, by a certified independent actuary. Rates are set every year and sometimes within the year.	A variety of utilization and cost control strategies have been put into effect. The migration to MCPs since 2005 has further expanded the ability to apply utilization and price controls over services.

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	establishing payment methodologies for specific services should be repealed. (See the Long-Term Care Section for a separate discussion of nursing facility reimbursement policies.)		
Finance 2: During the State Fiscal Year (SFY) 2006-2007 biennium, freeze at SFY 2005 levels fee-for-service payment rates for hospital inpatient services, and reduce by up to 3% payment for nursing facilities and intermediate care facility/mental retardation (ICF/MR services), recognizing potential differences between the two in the final reduction determination.		**COMPLETED** All provider rates were frozen in FY 2006 and FY 2007. Nursing Facility rates were frozen (with a franchise fee increase), ICF/MR rates frozen, and hospital rates frozen as of 1/1/06. Rate increases for all three provider groups were included in HB 119. Under HB 119, FFS rates for community providers went up 3% in FY 2008, after having been frozen since 2005. Community provider rates are scheduled to go up another 3% in FY 2009. Nursing facility rates went up 1% in FY 2008 with no additional rate increase in FY 2009. The rates for intermediate care facilities went up by 2% in FY 2008 and 2% in FY 2009. Growth in provider rates have been as follows: For FY06 (Dentists, -2%; NFs + .5%; ICFs/MR +.3%). All other provider rates were flat; however children's hospitals did receive their "supplemental" payment. For FY07: NFs -.5%. All other provider rates were flat; however children hospitals did get their "supplemental" payment. For FY08: NFs +1%; ICFs/MR +2%. For FY09: community providers +3%; NFs+1.5 % and ICFs/MR +2%.	After freezes being in effect for several years, slight increases were granted recently. The agency will need to monitor this situation closely to assure that low rates will not discourage provider participation in the system.
Finance 3: Optimize payment and cash flow schedule with a "just-in-time" program that pays all bills no sooner than the end of the month after receipt of a valid invoice.		**NOT COMPLETED** This suggestion was considered and rejected by the Administration. Just in time provider payments would reduce the State's flexibility in making timing adjustments to providers across fiscal years. In some fiscal years the State's budget is tighter than others. If all payments were set to the end of the month the state would lose the flexibility of adjusting payments between fiscal years. This idea could become more of a reality when MITS roll-out is completed. It could be facilitated through OAKs (the statewide accounting system). The state's Office of Budget and Management (OBM) routinely performs this function to manage the cash flow and balance	There are concerns that it would be burdensome to determine the optimal payment schedule for every claim. It's a matter of reaching a balance between gaining more efficiency (paying early), or deriving cost savings "through just-in-time payments." There are also concerns that this approach might negatively impact some (especially smaller) providers, insofar as they do not have the cash flow base as do other providers (e.g., hospitals).
Finance 4: Review and improve the coordination of benefit procedures to ensure that Medicare is the first payer for all dually eligible individuals. Extend these procedures to other		**COMPLETED** ODJFS has greatly improved the processing of crossover claims for dually-eligibles. The Medicare/Medicaid ("Medi-Medi") project is underway. Third party liability improvements enacted in HB 119 are being implemented Ohio Administrative Code section 5101:3-9-06 (E)(1) states the ODJFS is the payer of last resort. Section 5101:3-1-08 was revised on 12/18/2006 specifying rules requiring providers to provide documentation of crossover	Medicaid cost recovery efforts encompass three areas: Cost avoidance, third-party liability (TPL) recoveries, and tort actions. The most important of these in cost avoidance, which involves Medicaid denying a claim based on information of current eligibility of coverage from Medicare or

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public programs as permitted by law.		claims and take steps to obtain all third party payments prior to submission of claims to Medicaid. Aggressive efforts to assure that Medicaid is the payer of last resort have resulted in significant cost recovery totaling $620,528,009 by cost avoidance in SFY 2008 ($406,667,862 Medicare cost avoidance and $213,860,147 commercial insurer cost avoidance), $39.1 million by TPL "pay and chase" measures in SFY 2008, and $13.4 million by tort actions (subrogation) in SFY 2008. Attempts to mandate enrollment in Medicare by dually eligible beneficiaries has proved to be challenging because of legal concerns and limited incentive among consumers and county departments of job and family services. The new Claims Editing System (CES) will help achieve greater cost avoidance, but CES is delayed until the new MITS system is fully implemented in SFY 2010.	a commercial insurance carrier. The way that eligibility is determined is by matching the claim either to CMS Medicare eligibility files or to eligibility files provided by Ohio commercial carriers. When evidence of such dual eligibility is found, the County ODJFS office notifies the consumer of the denial of coverage. Currently, 12 Ohio carriers have voluntarily provided their eligibility files to OHP. Efforts are underway to collect these files from all 20 major Ohio health insurance carriers. To make this happen and improve efficiency of the process, OHP is working to 1) develop additional data use agreements with the carriers, b) recode the supplied data to be uniform with OHP coding systems, and c) adopt the CMS 271 roster that includes use of a uniform data reporting form for use by all commercial insurers. Recovery of TPL claims involves trying to track down and recover money retroactively that was already paid to a Medicaid beneficiary after finding out that they are dually eligible. The OHP calls this process "pay and chase." Tort actions are formal actions to recovery money from dually eligible individuals through a formal subrogation process. By far, most cost recovery is accomplished through cost avoidance. If cost avoidance is successful (denying the claim up front based on indication of dual eligibility, then that implies the recovery through TPL and tort actions will decrease, which is exactly what has happened during the past three years.
	Action Step 1: Modify the current benefit coordination practices to ensure that Medicare is the first payer for all dually eligible individuals.	**COMPLETED** ODJFS implementing limits on Medicaid payment of "crossover" claims for dual eligibles. The Medicare/Medicaid (Medi-Medi) project underway to help share data that can be useful in this respect. Third party liability improvements were enacted in HB 119.	OHP is supposed to send/share cost avoidance information with MCPs. However, this is not occurring often.
	Action Step 2: Improve the benefit coordination procedures so that non-Medicaid insurance plans are billed first.	**COMPLETED** Claims files have been obtained from most major commercial insurers in Ohio, to facilitate better identification of dually eligible Medicaid enrollees. The number of active third-party liability (TPL) files as of May 16, 2008 was 590,992, up from 238,606 in January 2007.	Efforts are still underway to match eligibility and claims files will additional commercial insurers in Ohio.

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Finance 5: Shift Medicaid reimbursement for long-term acute care hospitals and rehabilitation hospitals from a cost-plus basis to a prospective diagnostic and risk-adjusted capitated rate, similar to that used by Medicare.		**NOT COMPLETED** ODJFS is monitoring significant Medicare payment changes and evaluating alternatives in the context of increased Medicaid managed care. Switching to prospective payment for long-term acute care and rehabilitation hospitals has not been not made. Converting to a DRG-based payment system would likely require legislative authority.	In 2005, there were 23 LTACHs in Ohio. As of December 2008, there were 15. This is considered a minor issue by ODJFS and top a top priority at present
Structure & Management 1: Design and implement a comprehensive program of performance and fiscal compliance audits to improve effectiveness and operation of the Medicaid program.		**PARTIALLY COMPLETED** Performance and fiscal performance audits are being done. EMMA is helping to coordinate and implement these. In addition, the Auditor of State provider a performance audit of the state Medicaid system in 2006, and issued a follow-up status report in December 2008.	
	Action Step 1: Provide the Auditor of State (AOS) with statutory authority to conduct program performance audits of the entire Medicaid system.	**COMPLETED** The Auditor of State (AOS) was granted independent audit authority through HB 119. AOS already had the authority under Chapter 117, but that authority was subject to interpretation. The AOS completed its performance audit of Ohio Medicaid in December 2006, with a follow-up report issues in December 2008. These audits are funded by charge-backs to the audited agency.	This 2009 follow-up report to the 2005 OCRM recommendations adds further information for use in the performance assessment process.
	Action Step 2: Create an Audit Integrity Fund within the Auditor of State's (AOS) office.	**NOT COMPLETED** The June 2007 budget requires audit costs to be reimbursed by ODJFS. For fiscal year 2008, AOS requested $2 million in their budget for audits but that request was vetoed. For 2008, an arrangement was instituted whereby audit costs are still charged back to ODJFS, but the AOS agreed that total audit costs would not exceed an agreed amount.	For long-term purposes, auditing funds and resources will need to be included in the state's budget planning process.
	Action Step 3: Provide the AOS with statutory authority to conduct provider audits within Medicaid.	**COMPLETED** Beginning in 2005, AOS no longer needed to request clearance from ODJFS to perform provider audits. The June 2007 budget explicitly grants this authorization. Some action has been taken to move forward in this regard, in this regard, for example, with regards to performing nursing facility audits.	It is yet to be seen how active the AOS office will be in auditing providers. The source of continuing funding for these activities has not been clarified.
	Action Step 4: Create a multi-agency Program Integrity Task Force to develop a strategic plan to combat fraud, waste, and	**IN PROCESS** This was addressed in ODJFS corrective action plan to the OIG report and as part of the AOS performance review . As indicated earlier, some action has been taken to implement "Medi-Medi" programs to address fraud. EMMA has a standing Program Integrity subcommittee. This interagency subcommittee	Many changes are expected in the state/federal collaborations. Medi-Medi will be absorbed by the new Medicare Zone Program Integrity Contractors (ZPICs). Ohio will also be a pilot

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	abuse.	meets weekly. The subcommittee is close to developing a strategic plan. In addition, the Behavioral Health System is moving towards a fee schedule system and doing cost report reconciliation. Multiple multi-agency work groups are ongoing.	state for the new One PI (program integrity data modernization) project.
	Action Step 5: Tighten enrollment controls to keep abusive providers out of the program.	**COMPLETED AND IN PROCESS** The June 2007 budget allows termination for providers not submitting claims in the last two years. Stepped up enforcement with provisions were included in HB 119. With regard to alleged fraud, there is now a "hold and review" process for medical payments, and, if there are grounds, the department will refuse to pay until decided. If a doctor is indicted but not convicted, he/she can be suspended or terminated. The department overall has become more aggressive from a consumer protection standpoint. Systematic efforts are being made by the Surveillance and Utilization Review Subsystem (SURS) unit to enhance software for identifying outliers. The agency purged inactive providers in 2007. The agency sent a letter to those who had been inactive for a year, and if they did not hear back, the provider was removed from the system. HB 119 requires that all active providers must be reenrolled every 3 years. All new Medicaid provider agreements have a 3 year duration before renewal. For existing providers, Medicaid is implementing a rolling notification process where all 80,000 providers will be converted to new agreements over a 2 year period. Medicaid has formed a new provider compliance group to take action against indicted and convicted providers. Previously, action could not be taken against indicted providers, only after conviction. This initiative is in conjunction with the AG who now sends letters to Medicaid upon indicting a provider for any of a broad array of crimes. Medicaid also actively matches with the Ohio Medical Association and the Ohio Medical Transportation Board to identify active providers.	The new MITS system will expand ODJFS' ability to monitor provider enrollment. There is a need for coordination with other cabinet level agencies implementing Medicaid provider enrollment/certification processes.
	***Action Step 6*:** Develop and implement techniques that calculate provider-specific and provider type-specific error rates.	**PARTIALLY COMPLETED** Some work is being done in conjunction with OSU to calculate error rates. The SURS unit uses claims data to develop statistical profiles on providers and beneficiaries to identify potential improper payments. Limited resources allow calculation of error rates only for audited providers. Medicaid is targeting audits towards high risk providers through risk assessment processes. To expand technical expertise, Medicaid is bidding out a personal services contract for a statistician to do statistically valid sampling of provider claims to allow for robust extrapolations for error rates. Ohio is also participating in the federal Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid program and the State Children's Health Insurance Program (SCHIP). For PERM, CMS is using a national contracting strategy consisting of three contractors to perform statistical calculations, medical records collection, and medical/data processing review of selected State Medicaid and SCHIP FFS and managed care claims. PERM is conducted every 3 years. Ohio's last rotation was 2006.	A contract is under bid for a statistician to sample for error rate calculations for Ohio Medicaid.

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	Action Step 7: Reposition the Surveillance Utilization Review Section (SURS) as an independent entity within ODJFS.	**COMPLETED** The SURS unit was moved out of OHP and relocated to ORAA (Office of Research Assessment and Accountability" at ODJFS on April 4, 2005. Although this transition was accomplished, it was not necessarily entirely successful. There have been concerns about data sharing, particularly sharing of information by SURS and the Office of the OHP. There are some technical issues that make this difficult. The new organizational structure with SURS under ORAA consolidates audits independent of plan administration responsibilities.	Additional systems and processes are needed to ensure that interagency collaboration is working effectively in this area.
	Action Step 8: Amend state laws, and seek change to federal laws that hamper the implementation of an effective program integrity system.	**PARTIALLY COMPLETED** The June 2007 Budget allowed collection of overpayments made within five years of payment year. Provisions to accomplish this were included in HB 119. Progress was made on care coordination and data sharing, for instance, through the Health Care Integrity and Protection Database. Medicare data is also shared with the states.	With respect to fraud, ODJFS has to pay back CMS immediately whether or not ODJFS is able to recoup the savings. Thus almost providing a disincentive to identify and report fraud. State Medicaid Medical Directors are trying to forge better relationship and understanding with CMS about this issue. The CMS requirement that the federal contribution in any overpayment be repaid within 60 days of detection remains a problem. Ohio Medicaid is advocating for a change in the 60 day rule through the national SURS organization (NAMPI). The request is under review at CMS and the OBM, but no changes are yet evident.
Structure & Management 2: Update Ohio's Medicaid information systems with current technology for the financial, health care delivery, eligibility, and data management functions.		**IN PROCESS** Initial planning for the MITS system was completed. A vendor was selected for Data Warehouse enhancement and development. Plans are under way for development and implementation of a decision support system. Overall OHP data analysis and planning capabilities have been upgraded considerably by these developments. Roll-out of systems will begin during 2009.	
	Action Step 1: Develop a business case analysis for a comprehensive Medicaid Management Information System (MMIS), consistent with the Medicaid Information Technology Architecture (MITA) initiative by the Centers for Medicare and Medicaid Services (CMS).	**COMPLETED** The business case analysis for MITS was completed in 2005-2006. The Advance Planning Document was sent to CMS in Spring of 2007 for MITS. EDS was selected as the vendor after an RFA process. Work began in August of 2007. MITS is being developed as a comprehensive system. Additional user capabilities include Web interface. The cost is approximately $100 million, along with $40 million for web hosting. MITS Replaces the old MITA Claims Management System. Providers will be better able to submit and see claims. On-Line submission of claims was achieved in April 2008. On-line eligibility verification was achieved in July 2008.	The MITS system is currently being developed to make the agencies claiming and reporting systems more uniform. This recommendation has progressed in fits and starts because of the change in Administration and because each state Medicaid system is organized differently. It is not merely a case of buying "off the shelf" software.

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	Action Step 2: Immediately design and implement an Enterprise Data Warehouse.	**IN PROCESS** A data warehouse was developed by Thomson Medstat and is being implemented. Significant enhancements were made in 2006 and 2007. The design of the data warehouse is now essentially done. The implementation has not yet been completed, but is being pursued as part of the MITS information system. An external vendor (Quick Solutions) conducted a needs assessment in early 2008. They found that that MITS accomplishes 81% of needs. Additional 19% of gaps to be filled by system are being designed and constructed by EDS. Received final approval for EDS to proceed with new Decision Support System in December 2008. They are currently working on clinical and data capabilities to facilitate data analyses, including resource intensity, case-mix, and risk assessment. The system will also include new reporting capabilities. It will take 60-90 days to finalize the impact analysis and then roll-out is expected to take 12-14 months. It should be fully implemented by the middle of 2010	This is a complicated process, which, when completed, should add significant efficiencies and capabilities to the Medicaid system.
	Action Step 3: Establish a paperless system for submitting and paying provider claims.	**PARTIALLY COMPLETED** MITS will include online adjudication of claims accessible by the submitting provider. On-line claims submission capabilities through a web portal were introduced in July 2008, to be used by 70,000-80,000 providers. Capabilities will be more robust after full MITS implementation. CMS will still require some hard-copy paper forms that will not be able to be converted to a paperless system (e.g., regarding abortion approvals).	The new electronic claims submission and payment system should be able to derive considerable savings compared to the old system.
Structure & Management 3: Restructure Ohio Medicaid through a two-step process.			
	Action Step 1: Immediately appoint a Medicaid Transition Council.	**NOT COMPLETED** Recommendations for a transition council was Included in the 2006-2007 budget submission to the General Assembly. This resulted in creation of the Medicaid Administrative Study Council (MASC). The MASC successfully completed its work in December 2006. However, many of the MASC recommendations about Medicaid administrative structure were not implemented.	More recently, EMMA has taken over consideration of larger-scale structure and policy proposals involving Medicaid.
	Action Step 2: Create an Ohio Department of Medicaid to be effective July 1, 2007.	**NOT COMPLETED** A separate Medicaid department has not been created. In theory, a separate department would allow the Medicaid agency increased authority to direct resources within the agency. Instead, HB 119 created EMMA to coordinate Medicaid business and policy across agencies. As described by the OHP Director, John Corlett, OHP is focusing more on what needs to be done rather than the structure of how to accomplish it. EMMA is facilitating	Issues affecting Medicaid arise in a variety of other departments, including Mental Health, Aging, OMRDD, and Health. An interagency body, such as EMMA, can examine Medicaid policy in a broader perspective compared to what can be done within ODJFS alone.

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		interagency meetings every 2-3 weeks through the Directors Council (i.e., directors of all sister agencies), thus achieving improved relationships between departments and enhanced collaboration.	
Structure & Management 4: Leverage Ohio Medicaid's buying power through greater use of care management, selective contracting and pay for performance.		**PARTIALLY COMPLETED** Selected contracting was part of the managed care expansion and part of HB 119 assumptions for some services. ODJFS is pursuing selective contracting for some medical equipment provided via its fee for service program. Some attempts have been made in this direction, but only with limited success.	Selective contracting initiatives face push back from impacted provider associations. Pay for performance has been delayed due to a lack of funding and questions about design of the plan.
	Action Step 1: Replace the practice of doing business with everyone ("any willing provider") with selective contracting to the extent permitted by federal law.	**PARTIALLY COMPLETED** No rule was established, with the exception of service provided by MCPs. Partial implementation was tried at 995 nursing homes, whereby a Medicaid beneficiary can use any provider. Medicaid would set certain parameters and minimum requirements. Issues exist about legislative authority to pursue this idea. OHP tried to do this with respect to purchasing of oxygen, adult diapers, and diabetic supplies, but was rebuffed by the controlling board. Also, attempts were made to secure transportation vendors; however, MCPs eventually took over most transportation responsibilities. The agency also tried to establish selective contracting for durable medical equipment and incontinence garments. They met resistance from providers and the legislature. Small and moderate sized providers brought political pressure to bear – were afraid of losing job and economic impact on the state. Some success was achieved with respect to selective contracting for eyeglasses (2 vendors were selected). At the national level, selective contracting was scheduled to go into effect for Medicare on January 1, 2008; but that was stopped at the federal level because of similar concerns expressed by provider trade associations. The killing of that measure had a "chilling effect" on state plans to expand selective contracting in state Medicaid programs Most of the impediments pertain to FFS services. Within MCPs, there is considerably greater flexibility and use of selective contracting.	This would need legislative (JCARR) approval The political and economic environment has not previously been conducive to these proposals. However, the current budget crisis may spur some re-evaluation of the possibilities. Much of the original intent of this proposal has been accomplished by the migration to care within MCPs.
	Action Step 2: Implement a pay-for-performance strategy for providers to maximize state return on investments.	**PARTIALLY COMPLETED** Nothing has been established yet outside of what's being done by particular MCPs. Some MCPs have developed specific performance standards and do use pay for performance with physician groups to improve outcomes and reporting. In addition the MCPs must meet certain metrics. They have an "at risk amount" (1% of capitation payment) that must return if certain performance metrics are not achieved. And, if they meet more stringent requirements they can receive a bonus.	A pay for performance strategy was developed by OHP at the end of 2006, but budget pressures began to grow at that time and continued into 2007. Concerns about mechanisms to fund pay for performance have retarded growth of those programs. With respect to the future, interest in pay for performance continues, and consideration still being given about how to best

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		Medicaid and other payers are aligning forces to launch various quality assurance programs. Grants have been secured to launch quality improvement studies (of diabetes care, in Cleveland, of asthma care in Cincinnati). Medicaid transformation grant from CMS obtained to improve neonatal and NICU care. Childhood development disability screening program launched A survey of provider readiness for pay for performance systems is being conducted by University of Cincinnati.	accomplish it.
Structure & Management 5: **Increase Medicaid's access to clinical and analytical resources for the improvement of health care delivery and financing through collaborations with the state's Academic Medical Centers (AMC).**		**UNDER DISCUSSION** State universities already collaborate with Medicaid on research via the MEDTAPP program. ODJFS leadership is open to considering other options Some new initiatives are underway, such as those that involve state universities providing analytical services, including research services that would qualify for enhanced federal matching. It is not clear whether state medical centers represent the best structure to achieve the agency's needs. Attempts continue to be made to find the right opportunities. There is a need for an evidence-based framework to help guide OHP decision making. The Clinical subcommittee of EMMA is attempting to pull resources together on a shared interagency basis. Other possibilities are being considered. The JFS Medical Director now reports directly to the OHP Administrator, thus enhancing health and health policy conversations within ODJFS. The roll-out of the 2008 Ohio Family Health Survey is being done cooperatively with a consortium of universities through the MEDTAPP framework	Some questions have arisen about whether this model assures appropriate "client-focus" to provide Medicaid with needed information in a timely and appropriate way. An alternative might be an interagency policy analysis center with dedicated research staff, which could include representatives from academic institutions.

Appendix B – References

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