

# OHIO MEDICAID

## ANNUAL REPORT

STATE FISCAL YEAR

# 2014



# Ohio

Department of Medicaid

John R. Kasich, Governor

John B. McCarthy, Director



***The Ohio Department of Medicaid  
Annual Report - State Fiscal Year 2014  
(July 1, 2013 to June 30, 2014)***

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John R. Kasich, Governor  
John B. McCarthy, Director

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[www.medicaid.ohio.gov](http://www.medicaid.ohio.gov)







## LETTER FROM THE DIRECTOR

Dear Governor Kasich:

It is with great pleasure that I present to you this report of the official business and proceedings of the Ohio Department of Medicaid for state fiscal year 2014.

This past year marked a new day for Ohio Medicaid as the Kasich Administration's vision for a stand-alone, Cabinet-level Medicaid agency became realized in July 2013. In its new form, the agency continued its commitment to transforming the health care landscape across Ohio by working with various stakeholder and advocacy groups, as well as in close conjunction with its sister state agencies. This collaboration has helped us to further modernize Medicaid in Ohio and foster an innovative approach to care that aims to be both person-centered and high quality.

In this report, you will learn more about a number of recent accomplishments and reforms that have occurred over the past year, including:

- » a successful launch of Ohio Benefits, a new, state-of-the-art integrated eligibility system;
- » implementation of a new Medicaid managed care program across the state;
- » the extension of health care coverage to newly eligible, uninsured Ohioans;
- » introduction of MyCare Ohio, an innovative new program for residents served by both Medicaid and Medicare;
- » the linkage of managed care capitation payments to overall quality in service; and
- » being recognized as a national leader in transitioning individuals out of nursing facilities and back into settings within the community.

Strides such as these were only made possible by the Medicaid-related reforms of the previous two years. Those reforms, in fact, reduced the annual rate of program growth from 8.9 percent annually (2009-2011) to 3.3 percent per year (2012-2013) and saved Ohio taxpayers a total of \$3 billion dollars. While much has been accomplished, a great deal of work remains. It is with confidence that I say that the tasks undertaken over the previous twelve months have helped to further Ohio's recovery and strengthen the foundation of our state economy.

It is my hope that you find this report to be a helpful tool in understanding the critical role that Ohio Medicaid serves in communities across Ohio.

Sincerely,

A handwritten signature in blue ink that reads "John B. McCarthy". The signature is fluid and cursive, written in a professional style.

John B. McCarthy  
Director, Ohio Department of Medicaid





# Ohio

**Department of Medicaid**  
John R. Kasich, Governor  
John B. McCarthy, Director

## OUR MISSION:

**Providing accessible and cost effective health care coverage for Ohioans by promoting personal responsibility and choice through transformative and coordinated quality care.**

## OUR VISION:

**We are dedicated to being a national leader in health care coverage innovation that improves the lives of Ohioans and strengthens families.**

# GUIDING PRINCIPLES

## FOR OUR MARKET

**VALUE:** Promote a system which is dedicated to quality over volume by linking payment to health outcomes.

**INNOVATION:** Foster approaches that continue to improve the health and economic vitality of Ohioans.

**TRANSPARENCY:** Provide clear, straight-forward information concerning the cost and quality of Ohio's Medicaid program to providers, individuals and stakeholders.

**RESPONSIVENESS:** Promote a health care market that offers high quality services in a culturally competent manner in an individual's setting of choice.

## FOR OHIOANS

**COORDINATION:** Foster person-centered care coordination across a full continuum of benefits and services.

**ACCESS:** Create new avenues of accessible care for people across the state.

**DECISION-MAKING:** Empower individuals with the tools and information that assist them in making responsible decisions about their care, and promote independence.

## FOR OUR PARTNERS & PROVIDERS

**SHARED OUTCOMES:** Promote a standard of collaboration among stakeholders in order to achieve desired outcomes.

**ACCOUNTABILITY:** Create an environment that promotes accountability for outcomes.

**INTEGRITY:** Foster an environment forged on accountability by curbing instances of fraud, waste, and abuse, and terminating our relationships with those who take advantage of Ohio taxpayers.

## FOR OUR ORGANIZATION & STAFF

**MISSION FOCUS:** Focus on what we do best and leverage the expertise of our business partners and providers in servicing the residents of Ohio.

**INFORMATION-BASED:** Provide accurate and timely information to support evidence-based decision making and to drive program performance.

**TEAM-BASED:** Maintain ODM as a collaborative partnership with Sister State Agencies built on staff experience and service.

**ADAPTABLE:** Promote a culture of change, creativity, and continuous learning that challenges the status quo.

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**1**

**ADMINISTRATION**

# 1

## ADMINISTRATION

### A NEW STATE MEDICAID AGENCY

Governor John R. Kasich's Executive Budget for Fiscal Years 2014-15 paved the way for the creation of Ohio's first stand-alone state Medicaid agency. The possible creation of a Cabinet-level Medicaid agency had long been discussed and multiple panels had previously alluded to the need for such change.<sup>1</sup>

As the largest health care payer in Ohio, the time to turn Ohio Medicaid into a stand-alone executive agency was long overdue. Governor Kasich had taken a major step toward this in his first Mid Biennium Review (MBR), House Bill 487 (Amstutz, 129th General Assembly). Included in that proposal was a provision formalizing the state Medicaid Director as a full member of the Governor's cabinet.

One year later, the final piece for agency creation was put forth in the Executive Budget proposal, House Bill 59 (Amstutz, 130th General Assembly). The budget bill was signed and became effective on July 1, 2013 – making way for the creation of the new Medicaid agency.

The first six months of state fiscal year 2014 saw the transition of approximately 140 Ohio Department of Job and Family Services (ODJFS) Medicaid staff to the Department of Medicaid. Independent offices dedicated to information technology, human resources, and fiscal management were soon created within the newly-minted agency. Additionally, the department worked closely with ODJFS and the Ohio Legislative Service Commission to renumber rules found under the Ohio Administrative Code to reflect their transfer to the Ohio Department of Medicaid (ODM).

### MEDICAID STATE PLAN

Every state's Medicaid program is administered through a set of guidelines and standards known as the Medicaid State Plan. As times change and certain factors evolve, changes are often required to be made to a Medicaid program's State Plan. This is done through the application for and approval of State Plan Amendments (SPAs).

During SFY 14, ODM submitted 42 State Plan Amendments to the Centers for Medicare and Medicaid Services (CMS). While several addressed administrative requirements with regard to the establishment of the State's first stand-alone state Medicaid agency, the vast majority sought approval for implementation of services and adjustments to payment methodologies to providers.

<sup>1</sup>Both the Ohio Commission to Reform Medicaid (2005) and the Ohio Medicaid Study Administrative Council (2006) had previously addressed the possible need for a stand-alone state Medicaid agency. The final recommendations of those panels can be found [here](#).

# 1

## ADMINISTRATION

Some highlights of recent changes sought through federally approved amendments to the State Plan include:

- » eligibility changes for both children and adults;
- » increases in the personal needs allowance for residents of nursing facilities;
- » modified reimbursements to nursing facilities;
- » modifications to inpatient hospital payment methodology;
- » updates to pharmaceutical coverage;
- » methodology changes for payment of certain home health services.

For comprehensive information on the State Plan and all recent amendments, please visit: <http://medicaid.ohio.gov/StatePlan>

## JOINT MEDICAID OVERSIGHT COMMITTEE

The Ohio General Assembly established the Joint Medicaid Oversight Committee (JMOC) that, in part, requires the Director of the Department of Medicaid to implement reforms to the Medicaid program limiting the growth in the program's per member per month cost and prescribes parameters for limiting the overall cost growth.

In addition, the legislative measure:

- » encourages the department to achieve greater cost savings for the Medicaid program than is required under the Director-initiated reforms;
- » requires the Director to implement reforms that reduce the prevalence of co-morbid health conditions among, and the mortality and infant mortality rates of, Medicaid recipients; and
- » requires the Director to establish systems that: (1) encourage providers to serve recipients in culturally and linguistically appropriate manners, (2) improve the health of Medicaid recipients through the use of population health measures, and (3) reduce health disparities.

ODM Director McCarthy and his staff met with legislators on several occasions to assist JMOC in its organizational phase. The first three JMOC meetings were held in April, May and June of 2014.

Director McCarthy's recent testimonies are available online:

<http://medicaid.ohio.gov/RESOURCES/TestimonyandPresentations.aspx>



# 2 POLICY

*In order to effectively administer an insurance program as robust and diverse as Ohio Medicaid, a constant eye must be kept on the ever-changing world of health care. The Ohio Department of Medicaid's (ODM) policy staff is committed to monitoring potential changes in federal and state regulation and identifying impacts they may have on Ohio's health care system.*

*State fiscal year 2014 served as a period of great change due to a number of innovative initiatives at the state level, as well the introduction of new regulations and mandates put forth by the federal government. Areas impacted by considerable change included provider payments, hospital policy, and eligibility guidelines.*

*The following sections will provide an overview of some of the ways in which the Ohio Medicaid program changed over the past fiscal year.*

# 2

## POLICY

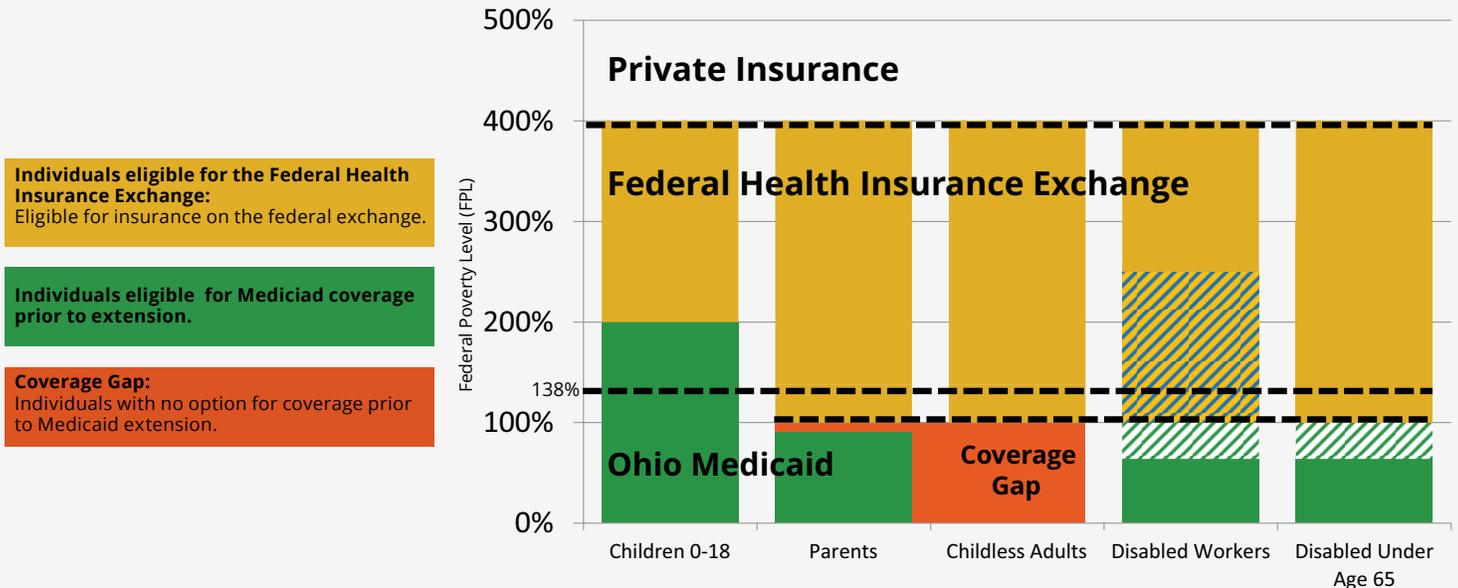
### EXTENDING BENEFITS TO MORE OHIOANS

The “as introduced” version of Gov. John R. Kasich’s SFY 2014-2015 Executive Budget included a provision to extend Medicaid benefits to uninsured Ohioans living at up to 138 percent of the federal poverty level (FPL). Estimates indicated that as many 366,000 uninsured Ohio residents would gain access to health care through the proposal.

The provision to extend Medicaid was later removed from the budget bill during deliberations in the Ohio House of Representatives in order to give added consideration to the proposal. As House Bill 59 was eventually passed by both legislative chambers and sent to the Governor’s desk for signature, the dialogue around extending health care coverage to a new population continued throughout the summer months.

The Kasich Administration entered SFY 14 committed to extending health care coverage to residents in need. With wide-ranging support from advocates and stakeholders across Ohio, the Ohio Department of Medicaid joined the Governor’s Office of Health Transformation (OHT) to further advance the effort to close the “coverage gap” created by the Affordable Care Act<sup>1</sup>.

**Figure 2.1: Ohio Medicaid and Insurance Exchange Eligibility<sup>2</sup>**  
(as of January 2014 without Medicaid extension)



**Individuals eligible for the Federal Health Insurance Exchange:**  
Eligible for insurance on the federal exchange.

**Individuals eligible for Medicaid coverage prior to extension.**

**Coverage Gap:**  
Individuals with no option for coverage prior to Medicaid extension.

On October 10, 2013, the Centers for Medicare and Medicaid Services (CMS) approved Ohio’s request for a State Plan Amendment (SPA) that would adjust Medicaid eligibility in accordance with the Administration’s proposal and provide 100 percent federal reimbursement for the newly eligible population over the course of the state biennium budget. The presence of

<sup>1</sup>Due to design issues with the federal Affordable Care Act (ACA), Ohio faced the creation of a “coverage gap” had it not succeeded in extending Medicaid benefits to more Ohioans. Under the ACA and without Medicaid extension, the following categories would not have access to Medicaid coverage: childless adults living at 0 – 100 percent FPL and parents living between 91 – 100 percent FPL.

<sup>2</sup>Source: The Governor’s Office of Health Transformation. Ohio Medicaid; Medicaid eligibility as of February 2013; Federal Health Insurance Exchange eligibility as of January 2014.

# 2

## POLICY

additional federal funds meant that an adjustment would have to be made to the Department of Medicaid’s annual appropriations for both fiscal years 2014 and 2015.

In late October, Director John McCarthy and OHT Director Greg Moody went before the State Controlling Board seeking an appropriation increase of \$2.56 billion in federal funds. The request was passed by the seven-member legislative panel with a 5-2 vote.

In order to bring up an entirely new eligibility group, Medicaid staff spent months working on an Alternative Benefit Plan for the population – known formally as “Group VIII.”<sup>3</sup> State Medicaid agencies opting to extend Medicaid eligibility to certain individuals whose income is up to 138 percent of the Federal Poverty Level (FPL) have authority under section 1937 of the Social Security Act to design benefit packages for this population. The federal benefit package must include certain specified services such as inpatient and outpatient hospital services, physician and surgical services, laboratory and x-ray services and well-baby visits, including immunizations.

After months of work, the Ohio Department of Medicaid received approval for its Alternative Benefit Plan in December 2013, with an effective date of January 1, 2014

The newly eligible population was able to begin the enrollment process through the *Ohio Benefits* online portal on December 9, 2013, with eligibility for benefits beginning on January 1, 2014. In the first month of Group VIII eligibility in Ohio, 115,394 previously uninsured residents enrolled for coverage through Medicaid. By the close of June 2014, 285,533 newly eligible residents successfully enrolled for coverage in the program.

**Figure 2.2: SFY 2014 Month By Month Enrollment - Group VIII**



*Monthly enrollment reporting for Medicaid eligibility categories include estimates for retroactive/backdated enrollment and are subject to minor change from month-to-month. Group VIII figures do not include such estimates as no historic enrollment exists as of yet, therefore, numbers for this newly eligible group will change from month-to-month.*

<sup>3</sup>Section 2001 (a)(1) (as amended by section 10201) of the ACA established a new eligibility group (VIII) under section 1902 (a)(10)(A)(i) of the Act.

# 2

## POLICY

### OHIO BENEFITS

At the start of Gov. Kasich’s administration, Ohio’s eligibility processes for health and human services were fragmented, overly complex, and contingent on the three-decades old Client Registry Information System – Enhanced (CRISe). Plans were soon devised to create a new, integrated eligibility system that would not only modernize the technology, but also improve the consumer experience and significantly reduce the costs associated with eligibility processing.

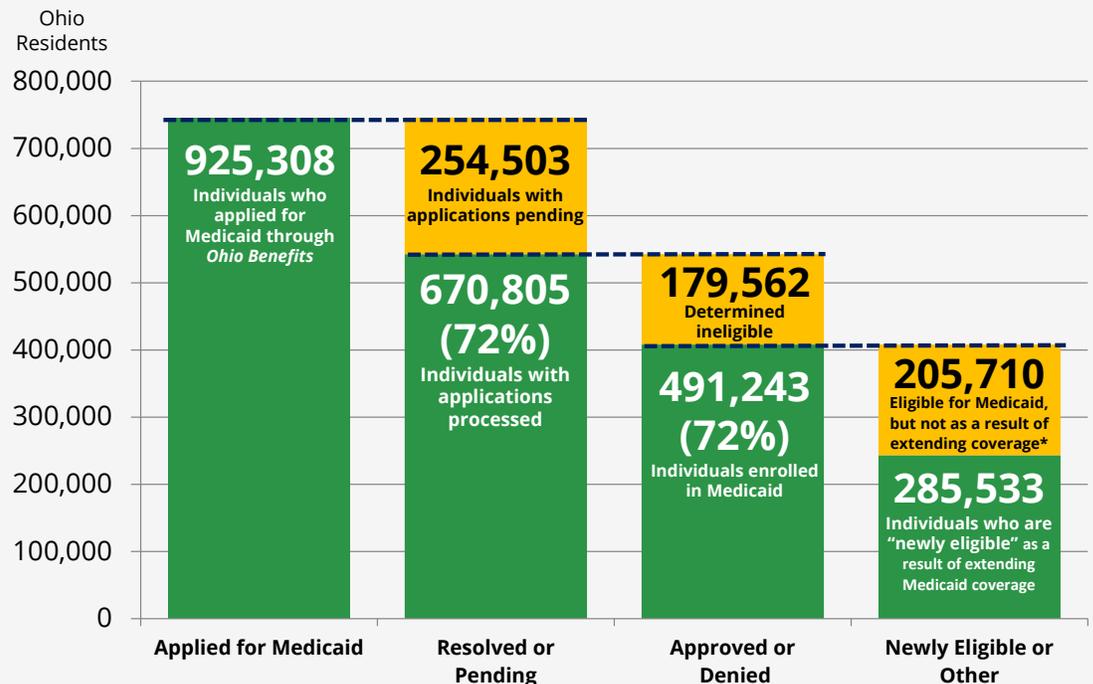
The effort to modernize Medicaid eligibility determination reached full speed in February 2013 with the procurement of Accenture LLC to build and implement the new system. Deloitte was also added through a separate contract to lead organizational change management efforts related to system implementation at the county level.

With a project build budget of \$230 million (\$204 million federal cost share; \$26 million state funds) over state fiscal years 2014 and 2015, work on the system accelerated at the start of SFY14 with the system’s ‘go live’ date occurring on October 1, 2013. Named Ohio Benefits, the system is accessible through an online web portal at Benefits.Ohio.gov and marks the first-time that Ohio residents can apply for Medicaid benefits online.

On December 9, 2013, all non-ABD (Aged, Blind and Disabled) Medicaid-eligible individuals became eligible to apply online through Benefits.Ohio.gov. As of June 30, 2014, the system had accepted applications on behalf of 925,308 Ohioans seeking Medicaid benefits.

By the end of **June 2013**, the system processed applications on behalf of **925,308** Ohioans seeking benefits.

Figure 2.3: *Ohio Benefits Update (October 1, 2013 - June 30, 2014)*<sup>4</sup>



<sup>4</sup>SOURCE: Ohio Integrated Eligibility System, as of April 30, 2014. Does not include Ohioans who became eligible for Medicaid as a result of disability or other categorical criterion that required enrollment through CRIS-E instead of Benefits.Ohio.gov.

# 2

## POLICY

### Connection with the Federal Marketplace

The Federally Facilitated Marketplace (FFM) launched on the same day as Ohio Benefits, but was plagued with a series of problems at the onset. Particularly, issues concerning access and connectivity with state systems caused lengthy delays in the processing of applications originating through the FFM. Uncertainty around the federal system – and acknowledgement of up to 10 major defects with the federal data – led the Department of Medicaid to seek testing of the connection between the federal and state systems.

While adequate testing never occurred, ODM made the decision to accept federal applications beginning in late-February 2014. By that time, a backlog had accumulated comprised of 245,700 individuals that federal authorities had determined to be eligible for Medicaid.

In conjunction with the Department of Administrative Services and the Governor’s Office of Health Transformation, Ohio Medicaid worked with a team of county representatives to formulate a plan for handling the federal backlog and the potentially defective data. Over subsequent months, it was found that the bulk of the applicants either already had pending applications in the state system or were not eligible for Medicaid under Ohio criteria. Those cases found to be ineligible for Medicaid in Ohio were then sent back to the federal government for further consideration through the FFM. Medicaid-eligible applications were either processed automatically through the Ohio Benefits system or passed onto appropriate counties for resolution.

By the end of May, the entirety of the initial federal backlog had been fully processed.

### Policy Changes Related to Integrated Eligibility

As Ohio Medicaid prepared for January 1, 2014, and the significant changes in health care and eligibility that would come on that date, it successfully leveraged the state-of-the-art Ohio Benefits system to accommodate the new eligibility landscape.

Policy changes related to integrated eligibility include the following effective January 1, 2014:

- » new Modified Adjusted Gross Income (MAGI) budgeting methodology for children, pregnant women and parent/caretaker relatives;
- » extended eligibility to certain individuals with income at or below 138 percent FPL using MAGI budgeting;
- » presumptive eligibility for certain individuals with income at or below 138 percent FPL, and parents/caretaker relatives;
- » extended eligibility age for former foster care individuals to 26;
- » established hospitals as qualified entities for presumptive eligibility;

# 2

## POLICY

- » removed the five-year bar for children and pregnant women with qualified non-citizen status; and
- » 21 New Ohio Administrative Code (OAC) eligibility rule changes.

### CONSUMER HOTLINE

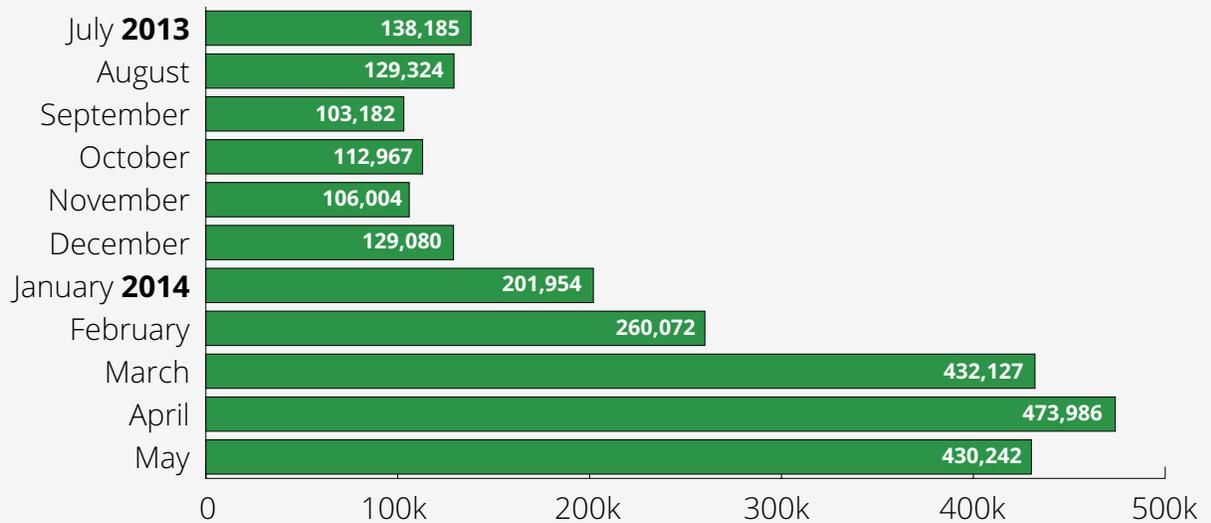
The Ohio Medicaid Consumer Hotline assists Ohio residents in answering questions and concerns related to the Medicaid program. This includes inquiries related to applications eligibility, changes in coverage and billing. The Hotline’s primary responsibility is to assist individuals enrolling into Medicaid managed care plans (MCPs). The five Medicaid managed care plans provide coverage to more than 2 million individuals insured through the state Medicaid program.

The Ohio Department of Medicaid partners with Automated Health Systems (AHS) in the administration of the Medicaid Consumer Hotline.

During SFY 14, the Consumer Hotline played a critical role in assisting newly eligible Ohioans with questions about the program as well as guiding prospective MyCare Ohio beneficiaries through the enrollment process. Both of these initiatives contributed to an increase in call volume over the second half of SFY 14. Additionally, questions and concerns regarding extended delays with the federal marketplace factored into increase traffic with the hotline.

Overall call volume increased by more than 63,700 from July 2013 to January 2014. Volume then more than doubled from 201,954 in January to a record 473,986 calls in April 2014. To meet this demand, AHS increased its call center staff from 65 in July 2013 to 154 by June 2014. By taking appropriate steps to train and add staff, Ohio Medicaid managed to successfully handle the increased call volume over time.

Figure 2.4: Consumer Hotline Call Volume



# 2

## POLICY

### METROHEALTH CARE PLUS PROGRAM

In 2012, Ohio Medicaid began to collaborate with The MetroHealth System of Cleveland on the possibility of bringing Medicaid coverage to more uninsured residents in Northeast Ohio. Months of work resulted in the Centers of Medicare and Medicaid Services (CMS) awarding an 1115 demonstration waiver to Ohio for MetroHealth to proceed with its initiative to expand care. Under the program – named MetroHealth Care Plus – MetroHealth would expand health care access to individuals whose income was at or below 133 percent of the federal poverty level (FPL) through the MetroHealth System network. In doing so, MetroHealth would draw down the federal share while covering the entirety of state share.

#### Implementation and Success

MetroHealth Care Plus launched in January 2013 and remained available to Cuyahoga County residents through mid-April 2014. Throughout that time, approximately 28,000 individuals received care through the initiative. The program proved highly successful in a number of areas, specifically in reducing emergency room visits among high utilization patients and lowering overall costs. Throughout the program’s duration, MetroHealth also witnessed improved health outcomes concerning diabetes and hypertension as well as an increase in primary care utilization.

The conclusion of the MetroHealth Care Plus program coincided with the eventual statewide extension of Medicaid coverage to more uninsured Ohioans. Upon the program’s conclusion, Ohio Medicaid worked with MetroHealth to transition 26,000 residents from MetroHealth Care Plus to full Medicaid coverage through managed care.

### HOSPITAL PAYMENTS

In July of 2013, ODM enacted updated payment policies for inpatient hospital services. The updates included implementing the 3M Health Information System’s All Patient Refined – Diagnosis Related Grouper (APR-DRG) and replaced the outdated DRG system payment rates which had not been rebased since the late 1980’s. The APR-DRG Classification System is widely used throughout the United States for adjusting health care claims for severity of illness and risk of mortality. Public and commercial organizations in more than 30 states use the 3M APR-DRGs for payment or public quality reporting.

With the implementation of the new grouper and updated payment rates, Ohio Medicaid was able to improve the accuracy of reimbursement by capturing differences in severity of illness at a much more discrete level among patients. Ohio went from roughly 500 DRGs and no severity of illness categories to 1256 DRG and severity of illness combinations. Additional payment reforms included moving to an outlier methodology that is more in line with standard practices for high cost cases moving from 34% of all cases being paid on an outlier basis to 8.7% of cases being paid on an outlier basis.

# 2

## POLICY

### Hospital Care Assurance Program

The Ohio Hospital Care Assurance Program (HCAP) is Ohio's primary means of implementing the federal disproportionate share hospital (DSH) payment program, which provides additional payments to hospitals that provide care to a disproportionate share of indigent patients. Ohio hospitals fund the state share of this program through a provider assessment. During SFY 14, \$579 million were paid to Ohio's hospitals through HCAP.

## PAYMENT INNOVATION

The Governor's Advisory Council for Payment Reform was convened in January 2013 under the leadership of the Office of Health Transformation. The panel began to engage public and private sector partners in setting clear expectations for better health, better care and cost savings through improvement. As part of this multi-payer effort, Ohio applied for and received a State Innovation Model (SIM) design grant from the Center for Medicare and Medicaid Innovation (CMMI). Funding commenced in April 2013 and work began immediately to define the State's two part strategy of patient centered medical homes (PCMH) and episode (of care) based payment.

Throughout SFY 14, Medicaid collaborated with its Medicaid managed care plans and private insurers to create multi-payer charters to establish episode designs that were "standardized" across plans when alignment was critical for success, "aligned in principle" when differences were necessary and "different by design" when required by laws or regulations.

The State of Ohio submitted its State Healthcare Innovation Plan to CMMI in November 2013 and proceeded to convene clinical advisory groups to define the detailed clinical parameters of the five episodes of care that will be initially implemented. That work concluded in February 2014, and the following episodes were identified: Perinatal, Total Joint Replacement (TJR), Asthma Exacerbation, Chronic Obstructive Pulmonary Disease (COPD Exacerbation), and Percutaneous Coronary Intervention (PCI).

On May 22, 2014, CMMI announced the next round of funding that will support model testing for up to 12 states. Ohio submitted a letter of intent on June 5, 2014 and awaits CMMI's decision while continuing to prepare.

In partnership with McKinsey & Company, Ohio Medicaid is now collaborating with stakeholders around the implementation of the episode-based model of payment. Initial results are set to be shared with providers in November 2014. At that time, providers will be able to see how the care they provide compares to their colleagues in terms of cost and quality.

# 2

## POLICY

### PROFESSIONAL SERVICES PAYMENT MODIFICATION

The department has made changes in payment for professional services to bring pricing payment more in line with Medicare payment methodology and to achieve consistency across provider types.

The following changes were implemented effective for dates of service on or after January 1, 2014:

- » Medicaid has extended the site differential to additional care settings where physicians, advanced practice nurses and physician assistants are not incurring the full practice expense. This includes services provided in hospitals, ambulatory surgery centers, and nursing facilities. The effect of this change means that entities such as these cannot bill Medicaid for use of its facility when Medicaid already accounts for that “overhead” in its payment to the professionals providing the service.
- » The department has included skilled therapies and certain imaging procedures for a reduction in payments when they are performing multiple procedures on the same date of service to the same person. Providers are paid 100 percent for the first performance of service and a reduced amount for subsequent services on the same day to the same patient.
- » Ohio Medicaid has implemented a change in Medicare Part B cost sharing for non-institutional providers except physician services to bring it in line with cost sharing for hospitals, nursing homes and Medicare Part C Advantage Plans.

### PRIMARY CARE PROVIDER RATE INCREASE

The Affordable Care Act required an increase in Medicaid fees to at least the levels paid by Medicare to family physicians, internists and pediatricians for many primary care services. Physicians in both Medicaid fee-for-service and managed care who meet the qualifications under federal law and successfully attest are able to get the enhanced rates. In order to successfully attest, physicians must inform ODM that they qualify under an online system that allows ODM to verify their claim. More than 10,000 Ohio physicians successfully attested in SFY 14. The differential in payments made to qualifying physicians totaled \$636 million in SFY 14, all of which is paid for by the federal government.

# 2

## POLICY

### PROVIDER ELECTRONIC RECORDS GROWTH

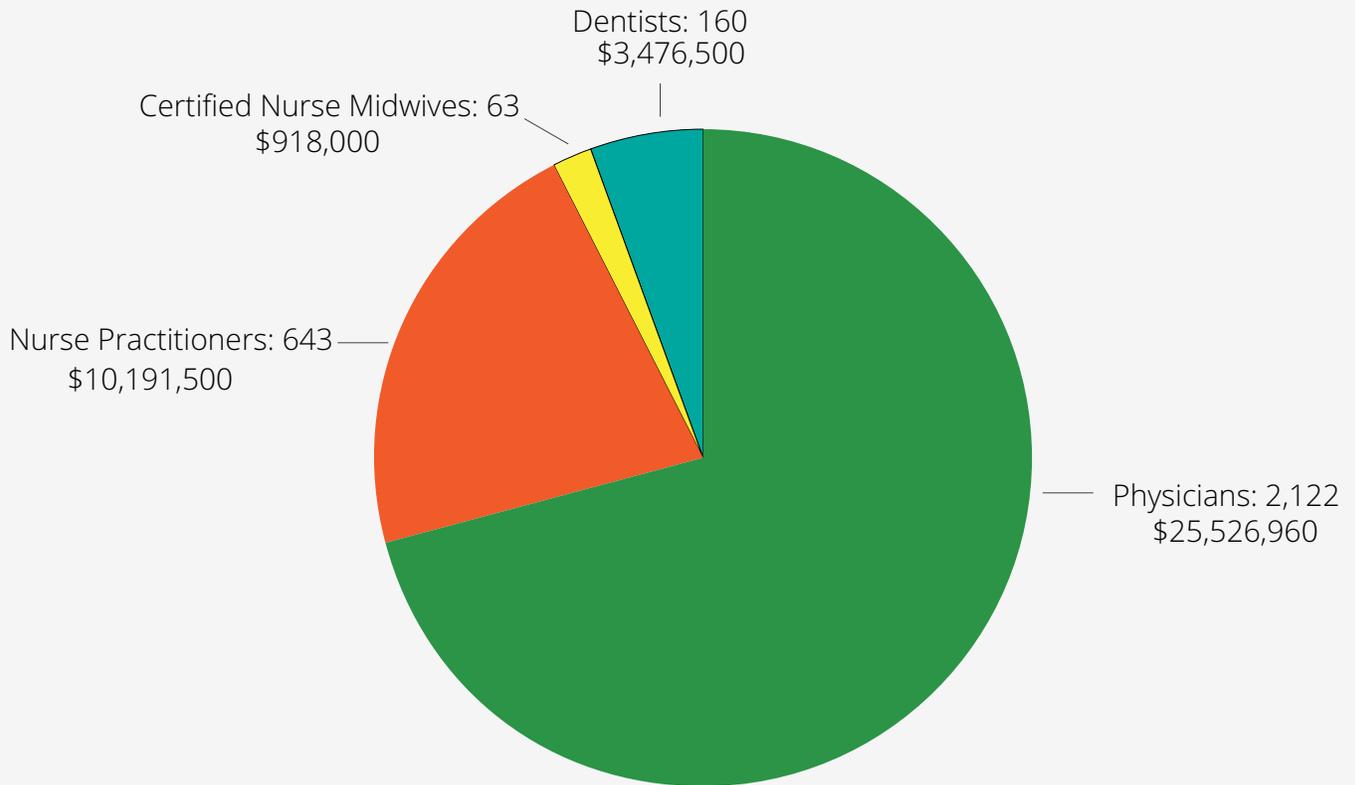
Ohio Medicaid is encouraging doctors, hospitals and other health care providers to convert their paper-based medical records to electronic formats. The transition to an electronic standard will allow for the more seamless sharing of information between patients, insurers and other health care providers. In fact, Ohio Medicaid has become a national leader in its assistance to medical professionals transferring to electronic health records.

In addition to payments to specific provider types, ODM made approximately **\$52.6 million dollars** in MPIP payments to qualifying hospitals.

Despite a growing need to migrate paper-based records to electronic platforms, conversions such as these remain expensive and time-consuming for providers. In order to meet demand and foster modernization, Ohio Medicaid has been aggressive in getting Ohio's share of federal Medicaid Provider Incentive Program (MPIP) grants to help health care providers make a successful transition.

Since the program began in 2011, Ohio Medicaid ranks fifth in the nation for the total number of Medicaid incentive payments (8,669) distributed to providers and sixth in the nation for total amount paid by the Medicaid Incentive Program (more than \$311 million). In SFY 14, Ohio Medicaid distributed 3,172 payments totalling nearly \$93 million.

**Figure 2.5: 2014 MPIP Payments by Provider Type**  
(Excludes Hospital payments.)



Total Provider Payments SYF 2014: \$40,122,960

# 2

## POLICY

### ICD-10

The Ohio Department of Medicaid entered 2013 well on track to fully implement the advanced and detailed ICD-10 coding system in October 2014 as required by federal law. The ICD-10 (International Classification of Diseases, 10th Clinical Modification) coding system aims to achieve greater precision and transparency in billing by diagnoses.

However, in April 2014 federal legislation was passed delaying the start date for ICD-10 implementation one full year, until October 2015. The Congressional delay was successfully sought to ensure adequate preparation time to replace the old system of codes (ICD-9) with the new vastly more detailed codes. The system now in use has a menu of 14,000 codes to describe treatment. ICD-10 features 72,000 codes to detail provided treatment.

When the new system is implemented, every claim submitted to Ohio Medicaid by health care providers will have to be in the language of ICD-10 as will the claims submitted to Ohio Medicaid sister agencies who deliver services on behalf of Medicaid.

The Ohio Department of Medicaid remains on track for a successful implementation now scheduled for October 2015.

Figure 2.6: ICD-9 vs. ICD-10 Change Graph

Diagnosis <i>[non-institutional // inpatient // outpatient]</i>	ICD-9 CM	vs.	ICD-10 CM
<b># of Alphanumeric Characters</b>	<b>3 - 5</b>		<b>3 - 7</b>
<b># of Codes</b>	<b>14k</b>		<b>69k</b>
Procedure <i>[inpatient only]</i>	ICD-9 PCS	vs.	ICD-10 PCS
<b># of Numeric Characters</b> <i>[ICD-10 PCS = Alphanumeric Characters]</i>	<b>3 - 4</b>		<b>7</b>
<b># of Codes</b>	<b>4k</b>		<b>72k</b>



# 3

## LONG TERM CARE SERVICES & SUPPORT

*The Ohio Department of Medicaid continued to undergo rapid change in state fiscal year 2014 and the pace of change may have been most significant in the agency's services to seniors and individuals living with disabilities. The work has been noted nationally. The Kaiser Commission on Medicaid and the Uninsured called out Ohio as a leader in transitioning people from institutional to home care.<sup>1</sup>*

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<sup>1</sup>The Kaiser Commission on Medicaid and the Uninsured, Money Follows the Person, the Henry J. Kaiser Family Foundation, A 2013 Survey of Transitions, Services and Costs, April 2014.

# 3

## LONG TERM CARE SERVICES & SUPPORTS

*The Kaiser Commission, part of the Henry J. Kaiser Foundation, reported that Ohio:*

- » *transitioned the largest number of participants with behavioral health needs;*
- » *was one of three states (with Texas and Washington) that accounted for 40 percent of the total national number of people moved from institutions to home care; and*
- » *was one of a handful of states to continue to add services to the program after they were transitioned.*

*A separate ranking by Mathematica Policy Research had previously singled out Ohio's achievements on behalf of transitioning individuals out of institutions, such as nursing facilities, and back into community-based settings.*

*Further progress was made in terms of funding for long-term care services. In SFY 14, Ohio drew within a percentage point of its goal to direct 50 percent of all funding for long-term care to home and community-based initiatives. These benchmarks come as the agency worked to streamline collaboration with its sister state agencies who administer services and programs paid for through Ohio Medicaid. The following elements of the report on long-term care services and support will help illuminate how the agency was able to accomplish such rapid and often innovative growth.*

## MEDICAID WAIVERS

Medicaid waivers are programs designed to provide different benefits to groups of individuals according to their needs. Each new or innovative program must have approval from the Center for Medicare and Medicaid Services (CMS). Ohio has nine such waiver programs that are paid through Medicaid. Two of those programs are administered by ODM, while four are administered by the Ohio Department of Developmental Disabilities (DODD) and three by the Ohio Department of Aging (ODA).

### Harmony

ODM's goal is to provide a streamlined process to meet the needs of people who meet a nursing facility level of care. This will not only improve access to a broader, consistent array of services, but will also offer flexibility over how individuals choose to receive services. Efforts are underway to streamline existing regulatory and administrative processes with the Ohio Department of Aging. In March 2014, the PASSPORT Waiver will offer the self-directed service option and, effective July 1, 2014, will be extended to include the Ohio Home Care Waiver services.

The successful administration of several Medicaid waivers relies on Ohio Medicaid's interagency partnerships with its sister agencies. Such successful collaboration can be seen on an ongoing basis between Medicaid and the Departments of Aging and Developmental Disabilities. SFY 14 highlights of such cooperation can be seen in the programs in this section.

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## LONG TERM CARE SERVICES & SUPPORTS

### Transitions Carve-Out Waiver to PASSPORT

As a part of the effort to provide a waiver for people who meet a nursing facility level of care, individuals enrolled in the Transitions Carve-Out Waiver will be offered the opportunity to enroll in the PASSPORT Waiver. In June 2014, CMS approved the project and phase-out plan for the Transitions Carve-Out Waiver. The phase-out plan is to be completed by June 30, 2015.

### Individual Options Home and Community Based Services 1915 (c) Waiver

In SFY 14, CMS approved the State of Ohio's 1915(c) home and community-based services Individual Options waiver renewal application.

Effective July 1, 2014, the renewal will permit individuals with intellectual and developmental disabilities to continue to be served through the waiver in lieu of institutionalization. The waiver, which was approved for a period of five years through June 30, 2019, will be administered by the Ohio Department of Developmental Disabilities, in conjunction with Ohio Medicaid. Up to 21,700 individuals are expected to be served through the waiver.

### Transitions Developmental Disabilities Home and Community Based Services 1915 (c) Waiver

CMS also approved the State of Ohio's 1915(c) home and community-based services Transitions Developmental Disabilities waiver amendment, effective July 1, 2014.

The amendment was needed to enhance the provider pool to allow greater access for individuals enrolled. Additionally, modifications were made to provider qualifications and overall service requirements. Specifically, the amendment:

- » allows additional agencies to be providers of personal care aide services;
- » aligns requirements for criminal history/background checks for independent providers of personal care aide services with Section 5123.081 of the Ohio Revised Code; and
- » establishes an annual limitation on out-of-home respite services to 90 calendar days per year.

### Waiver Quality Reviews

ODM must comply with six federal waiver program assurances to maintain approval from CMS to operate the waiver programs. Currently, the agency uses several methods to assure the compliance and ongoing improvement of the waivers, including:

- » conducting interviews with randomly selected waiver participants;
- » reviewing care plans for randomly selected waiver participants;

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## LONG TERM CARE SERVICES & SUPPORTS

- » assuring resolution of case-specific problems;
- » generating, compiling, and analyzing data;
- » producing performance reports;
- » convening quality briefings with each waiver-operating agency semi-annually;
- » convening a quarterly multi-agency quality steering committee; and
- » conducting audits and fiscal reviews.

Every year, ODM conducts interviews with approximately 150 participants on each waiver. During SFY 14, it completed reviews on Assisted Living (April 2014), Transitions Aging Carve-Out (December 2013), Ohio Home Care (October 2013), PASSPORT and Choices (February 2013) waivers.

At least twice each year, ODM also convenes a Quality Assurance meeting with each agency that operates Medicaid waivers. In these meetings, ODM and the operating agency review performance data, identify trends and patterns, and collaborate to develop quality improvement plans. During SFY 14, quality briefings were held in October 2013 and May 2014 with the ODA, and December 2013 and June 2014 with DODD.

Lastly, ODM leads an interagency HCBS Waiver Quality Steering Committee (QSC) that meets quarterly. The QSC is a forum in which representatives from the Departments of Medicaid, Aging, and Developmental Disabilities can examine performance data across waiver systems, provide updates on quality assurance activities, and share information about best practices. Quarterly meetings were held throughout the fiscal year.

## BALANCING INCENTIVE PROGRAM

In March 2013, the State of Ohio furthered its commitment to serving more individuals in home and community-based settings by applying for participation in the Balancing Incentive Program (BIP). Three months later, it was announced that Ohio would be on the receiving end of \$169 million in additional federal medical assistance percentage (FMAP) under BIP. The award came as a result of the state's success in improving its long-term care system and directing half of all Medicaid long-term care funding to home and community-based services by 2015.

Throughout SFY 14, Ohio Medicaid convened regular meetings with stakeholders through its BIP implementation and advisory committees. This work coincided with the state beginning to draw down the enhanced federal match funding.

Under the leadership of the department, two assessment tools were developed and tested to assist in the execution of BIP-related activities. One assessment method was designed for children seeking entry into nursing facility level of care programs and included a set of age-appropriate

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## LONG TERM CARE SERVICES & SUPPORTS

questions, while the other was developed for adults with similar nursing facility level of care needs. Both assessment tools utilize a BIP core data set.

By the state fiscal year's conclusion, Ohio was well within reach of its ultimate funding goals as long-term care funding balance achieved 49.45 percent (community) to 50.55 percent (institutional).

### HOME CHOICE PROGRAM

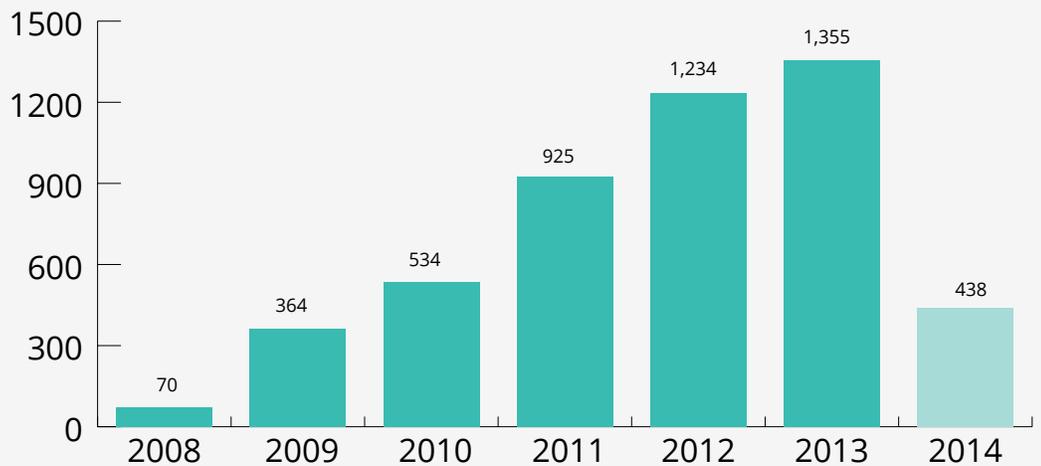
HOME Choice, Ohio's iteration of the federal Money Follows the Person (MFP) program, continued its highly successful run of transitioning Ohioans out of institutional settings (such as nursing facilities) and into community-based settings.

In the second half of 2013, HOME Choice earned national recognition by ranking first among MFP states in transitioning individuals living with mental illness and second overall in total transitions completed.

Launched in 2008 with the goal of transitioning 2,000 individuals, HOME Choice finished the year just shy of completing its 5,000th transition in SFY 14 – far exceeding its original charge.

Ohio HOME Choice also achieved CMS approval for major revisions to the program's operational protocol in order to improve outcomes for individuals. These changes included the addition of pre-transition case management services and a fourth deliverable to transition coordination, which allows for the transition coordinator to follow an individual after discharge from the facility into the community.

Figure 3.1: HOME Choice Transitions 2008 - 2014<sup>1</sup>

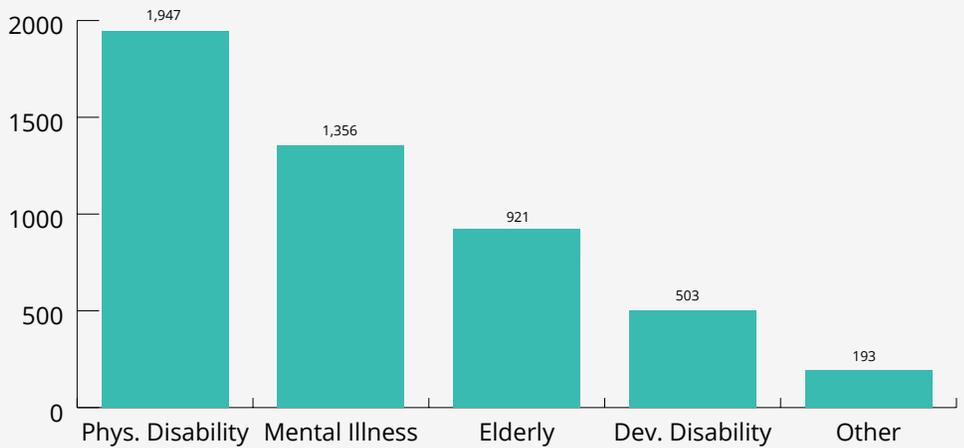


<sup>1</sup>Totals for Figure 3.1 - HOME Choice Transitions for calendar years 2008 - 2014 are accurate as of May 31, 2014.

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Figure 3.2: Total HOME Choice Transitions by Service Population<sup>2</sup>



## HOME CARE OPERATIONS

In 2012, Ohio Medicaid commenced work on a plan to modernize its home and community-based waivers by bringing more choice to individuals served through the program. ODM explored options to give Ohioans a choice of case management agencies to serve their needs.

The first half of SFY 14 saw the Department of Medicaid enter into contractual agreements with three case management agencies to serve individuals on Medicaid waivers. The three entities tasked with case management for Ohio's Medicaid waivers are CareSource, CareStar, and the Council on Aging.

Together, the three case management agencies served 12,617 Ohio residents receiving waiver services in SFY 14.

### New Case Management System

Ohio Medicaid has initiated work on developing a streamlined, single-point assessment and case management system. A request for proposals (RFP) was developed and posted in SFY 14 with procurement and development expected to occur in the next state fiscal year.

The new system is expected to improve case management capacity, reporting and data collection, while also implementing a single statewide assessment tool for long-term care services. Preliminary plans are for the system to interface with the Medicaid Information Technology System (MITS) and Ohio Benefits. Compatibility with these systems will improve ODM's ability to monitor eligibility status and test for authorization before paying providers for services rendered.

<sup>2</sup>Totals for Figure 3.2 - Transitions by Service Population for calendar years 2008 - 2014 are accurate as of May 31, 2014.

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## LONG TERM CARE SERVICES & SUPPORTS

### NURSING FACILITIES

Ohio Medicaid continued to work with various state partners to ensure that individuals in Ohio's nursing facilities received the high quality services that they require. In addition to ODM, this ongoing partnership includes the Ohio Departments of Health (ODH), Aging (ODA), Mental Health and Addiction Services (MHAS), Developmental Disabilities (DODD), and the Office of the State Long Term Care Ombudsman.

Pursuant to language proposed in the Executive Budget, ODM began participating with ODH, ODA and the Ombudsman in the review of selected ODH citations issued during the licensure and certification survey process. This collaborative review engages multiple perspectives and assists in improving the quality of services provided in Ohio's nursing homes over time.

House Bill 59, the biennial budget bill, included a series of provisions impacting nursing facilities across Ohio. Included in the changes was a modification to the peer groups used annually to calculate Medicaid rates for nursing facilities. "Peer groups" are groupings of nursing facilities based on the county where the facility is located, and in some cases, the number of beds in the facility. Ohio Medicaid successfully implemented the peer group change for dates of service on or after October 1, 2013. As a result of this change, nursing facilities in Stark and Mahoning counties received an increase in the rate paid by the Ohio Department of Medicaid.

The payment rate calculated for each nursing facility includes a quality incentive payment based on the facility's performance on 20 measures. In 2013, ODM worked to implement two significant changes to the quality incentive rate component that were proposed in the Executive budget approved by the General Assembly for rates effective July 1, 2014. The first change required a nursing facility to achieve the benchmark for at least one clinical measure in order to achieve the full quality incentive payment. The second change made the quality point related to a good certification survey unavailable to facilities identified as special focus facilities (facilities identified by CMS as having chronic quality issues over time) during calendar year 2013.

Also in SFY 14, ODM successfully implemented an increase in the personal needs allowance amount for individuals residing in nursing facilities. The allowance was increased to from \$40.00 per month to \$45.00 effective January 1, 2014. The personal needs allowance is the amount of income an individual receiving Medicaid funded nursing facility services keeps to cover personal expenses such as a newspaper subscription or clothing. The increase was proposed by Governor Kasich as part of his budget package and approved through the General Assembly.



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## MANAGED CARE

*The vast majority of individuals insured under Ohio Medicaid are covered through one of five private Medicaid managed care plans. The plans' contracts with the Ohio Department of Medicaid (ODM) require each to provide person-centered care focused on high quality and value to Ohio taxpayers. It is through such care management that ODM best addresses its mission of promoting personal responsibility and choice through coordinated quality health care.*

*At the start of state fiscal year 2014, 2.3 million Ohioans received health care coverage through the Medicaid program, of which, roughly 1.7 million individuals were insured through a managed care program. Among the 1.7 million managed care beneficiaries, almost 170,000 were eligible as Aged, Blind or Disabled adults, while the remaining 1.5 million individuals were included as part of the Covered Families and Children eligibility category.*

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*Over the course of the next 12 months, additional populations of Medicaid beneficiaries were provided the opportunity to access coordinated care through Ohio's Medicaid managed care system. Specifically, more than 37,000 children with special health care needs were transitioned to managed care in July 2013. Additionally, by the end of June 2014, 285,000 newly eligible Ohioans acquired Medicaid coverage, all of whom would be covered by one of the five managed care plans.*

*The final significant impact on the overall managed care population occurred in the final two months of the fiscal year with the start of MyCare Ohio enrollment for those individuals eligible for both Medicaid and Medicare. Once fully implemented, MyCare Ohio is expected to serve 114,000 residents in 29 Ohio counties.*

*SFY 14 closed with more than two million individuals covered by the Medicaid managed care program. The overall Medicaid population closed the fiscal year at greater than 2.6 million people.*

### NEW MANAGED CARE PROGRAM

Recent years have seen managed care become the cornerstone of Ohio's Medicaid program. As the state entered the new fiscal year, 70 percent of its Medicaid population received necessary health services through a private managed care plan. Just as significant, July 1, 2013, saw the launch of a new Medicaid managed care program aimed at limiting fragmentation and offering individuals more consistency in coverage.

Recognizing the need to revamp its system, the State of Ohio released a request for applications (RFA) in early 2012. After a sound and effective procurement process, five managed care plans were selected to be part of the new program.

Those plans are:

- » Buckeye Community Healthplan of Ohio;
- » CareSource;
- » Molina Healthcare of Ohio;
- » Paramount Advantage; and
- » United Healthcare Community Plan of Ohio

Under Ohio's previous managed care system, the state was divided into eight distinct regions with two to three plans serving each one. Too often, individuals or families moving from one Ohio region to another had no choice but to select a different plan to serve their health care needs.

Today, the new Medicaid managed care program is composed of just three regions, with all five healthcare plans available statewide.

The first batch of enrollment letters were sent to managed care beneficiaries during the first half of 2013. Individuals had until July 1, 2014 to pick a plan of their choosing for services to commence on that date. A successful launch

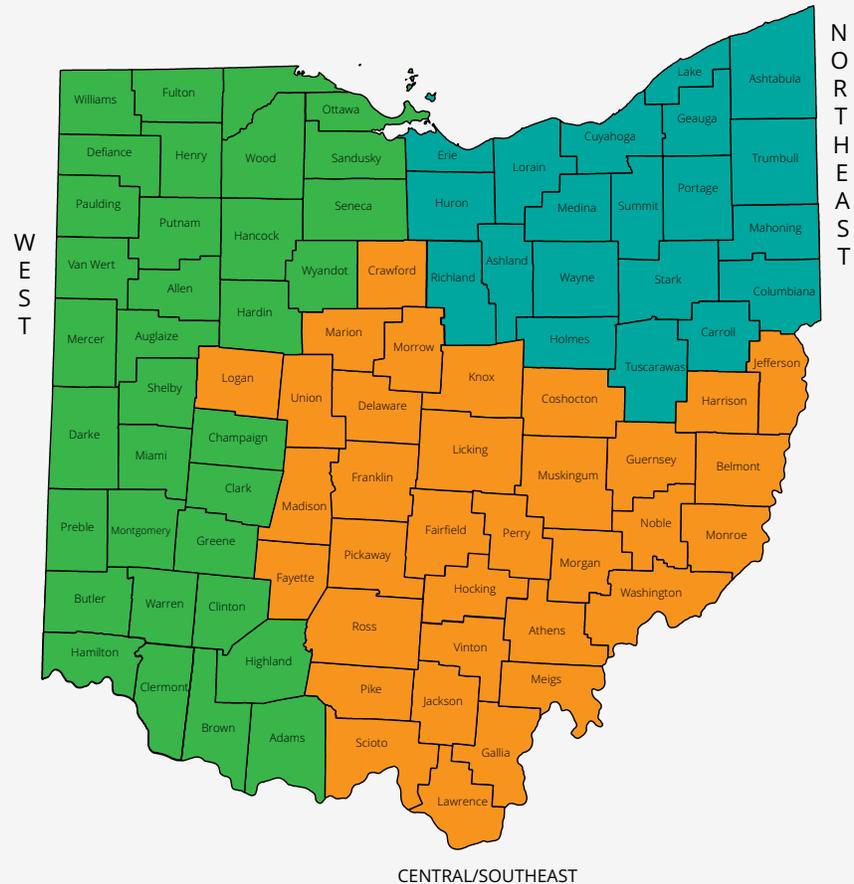
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was achieved, as Ohio Medicaid worked closely with stakeholders and plan representatives to achieve a smooth transition.

Additionally, as part of the new program, some 37,000 children with special health care needs were enrolled into managed care for the first time. Previously, this population had their health care needs addressed by the Medicaid fee-for-service (FFS) system. The transition to managed care allows for a greater coordination of care that addresses the diverse needs of individuals.

Figure 4.1: Managed Care Three Region Map



## CARE MANAGEMENT

Care management is a significant component of the Ohio Medicaid managed care delivery system. Care management is a set of activities tailored to meet an individual's health-related needs. Components of care management are culturally-competent, goal-oriented, outcomes focused and person-centered.

Key care management functions include:

- » the identification of individuals with complex needs;
- » assessment of needs;
- » assignment of a care manager;
- » development of an individualized care plan;
- » assistance with accessing needed medical, social, behavioral and other support services;

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- » implementing the care plan through coordination of services, information exchange, and conducting follow up;
- » monitoring the effectiveness and appropriateness of the care plan and updating when necessary; and
- » collaborating with providers and the members throughout all of steps of the care management process.

In 2012, Ohio Medicaid redesigned the care management program to place an emphasis on the most vulnerable, high-risk beneficiaries with a more hands-on approach to coordinated care. The program emphasized the use of a team of health professionals to manage care and the importance of managing clinical and non-clinical needs, boosted the staff-to-consumer ratio, and increased the consumer-care manager contact with in person visit contacts each quarter. This more intensive approach to care management must be extended to at least one percent of the MCP's overall membership. Results for 2013 were compiled and released in SFY 14.

Goals of care management are improved health outcomes, functional status, and quality of life; increased consumer satisfaction; cost savings; appropriate utilization of services; and increased patient engagement.

Figure 4.2: Care Management of High Risk Members

Managed Care Plan	Members in High Risk Care Management*
Buckeye Community Health Plan	9,783
CareSource	2,480
Molina Healthcare of Ohio	2,747
Paramount Advantage	1,486
UnitedHealthcare Community Plan of Ohio	1,610
<b>Total</b>	<b>18,106</b>

\*As of December 2013

## QUALITY MEASURES

ODM's quality goals are to promote better care, healthy people and communities, and best evidence medicine. The department's strategy to advance these goals is to develop and implement initiatives that make care safer, improve care coordination, promote evidence-based prevention and treatment practices, support family-centered care, and ensure effective and efficient administration. In order to achieve the biggest benefit, these initiatives are focused on the following high impact populations: high risk pregnancy/premature births, behavioral health, cardiovascular disease, diabetes, asthma, and upper respiratory infections.

One of ODM's quality initiatives is to measure Medicaid managed care plans' (MCP) performance and hold them accountable to standard levels

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In total, five managed care plans were awarded **\$29 million**, or **39%** of available award funds.

of performance. In 2013, MCPs were expected to meet set standards on specific performance measures linked to the clinical focus areas listed above. Performance measures placed in the contract with the MCPs were specific to prenatal and postpartum care, behavioral health, cholesterol management, comprehensive diabetes care, asthma medications, and preventive care measures. Currently contracted MCPs met the standard for 17 of 18 measures in SFY 14.

Although the MCPs performed well by meeting the performance standards, more improvement is needed. ODM will continue to challenge the MCPs to improve in these clinical focus areas by raising the standard in future contracts.

### PAY FOR PERFORMANCE

In order to serve Ohioans with their diverse and sometimes complex health care needs, ODM seeks partners who are able to think creatively and take new approaches that result in better health outcomes. That is why ODM demands innovation and constant improvement from Medicaid managed care plans. To incentivize Ohio Medicaid managed care plans to improve health outcomes, ODM implemented a Pay-for-Performance (P4P) program based on key clinical performance measures. These measures align with Medicaid's most critical clinical conditions such as high-risk pregnancy, behavioral health, cardiovascular disease, diabetes, asthma and upper respiratory infections.

The P4P program was designed to award more money for better results. The MCPs' results were compared to standards based on national data and were awarded more money for higher outcomes. In the first year of the program, MCPs were awarded \$29 million (39 percent) of a possible \$73 million (see chart below). Although Medicaid managed care plans improved in 4 of 5 measures, this analysis shows that more work lays ahead, and ODM challenged each Medicaid managed care plan to commit their organizations to initiatives aimed at sustained improvement.

Figure 4.3: 2013 Pay for Performance - Statewide Medicaid

Trend / Measure [Performance Rate]	Performance Levels	Bonus / Measure
↓ <i>Timelines of Prenatal Care [87.5%]</i>	NCQA 90th percentile	\$12.1 million
	NCQA 75th percentile	\$11 million
		\$9.9 million
		\$8.8 million
		\$7.7 million
↑ <i>Follow-up after MH Inpatient [44.1%]</i>	NCQA 50th percentile	\$6.6 million
		\$5.5 million
↑ <i>Diabetes: LDL Screening [71.2%]</i>		\$4.4 million
↑ <i>Control High Blood Pressure [51.6%]</i>	NCQA 25th percentile	\$3.3 million
		\$2.2 million
-- <i>Appropriate Use of Asthma Meds [81.9%]</i>		\$1.1 million
	NCQA 10th percentile	\$0

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### CONSUMER SATISFACTION SURVEY

ODM utilizes a variety of quality assessment and improvement activities to ensure that individuals in managed care have timely access to high quality health care services. These activities include annual surveys of member experience and satisfaction with health care. Survey results provide important feedback on the managed care plans (MCP) and program performance that informs efforts to achieve continuous quality improvement in member care.

ODM requires its contracting MCPs to administer Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Surveys to their Ohio Medicaid members on an annual basis using a National Committee for Quality Assurance (NCQA) Certified Survey Vendor and to submit their collected survey data to the state. Results for the adult and child populations are reported separately. Ohio Medicaid averages and NCQA National Medicaid benchmarks are used for comparative purposes.

Ohio Medicaid MCPs submitted 2013 CAHPS® Medicaid Health Plan Survey data to the state. The data was collected from February to May 2013 from adult members and the parents or caretakers of child members from each MCP using the CAHPS® 5.0H Adult Medicaid Health Plan Survey and the CAHPS® 5.0H Child Medicaid Health Plan Survey (with the children with chronic conditions measurement set), respectively. CAHPS® satisfaction measures are derived from individual questions that ask for a general (or global) rating, as well as groups of questions that form composite measures.

### 2013 Consumer Satisfaction Survey Results

- » *The Ohio Medicaid Managed Care Program had good to excellent performance (i.e., none of the program's means were below the 50th percentile) when compared to national Medicaid percentiles.*
- » *Compared with national Medicaid data, the program's mean for the child population was at or above the 75th percentile for all five composite measures and two of four global ratings. For the adult population, the program's mean was at or above the 75th percentile for two of four composite measures when compared to national Medicaid data.*
- » *Areas of excellent performance included Getting Needed Care (general child population), Getting Care Quickly (general child population), and Customer Service (both adult and general child populations). For these areas, the program mean was at or above the 90th percentile compared to national Medicaid percentiles.*
- » *The program mean scores for the general child population exceeded the national Medicaid averages for all five composite measures and were the same or higher than the national Medicaid averages for three of four global ratings.*
- » *The program means scores for the adult population exceeded the national Medicaid averages for three of five composite measures and one of four global ratings. For one of the remaining measures, the adult program mean equaled the national Medicaid result.*
- » *Ratings for the general child population tended to be higher than those for the adult population.*

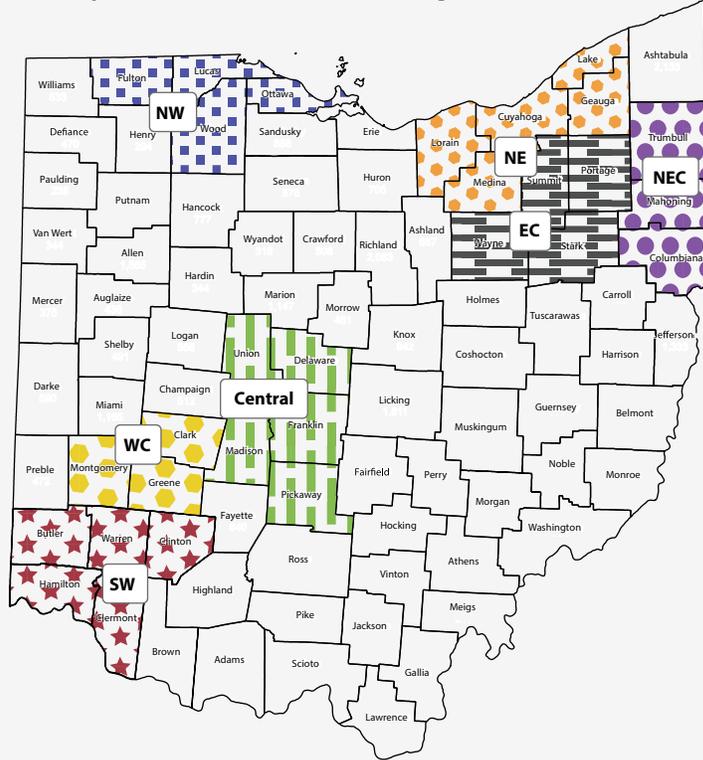
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### MYCARE OHIO

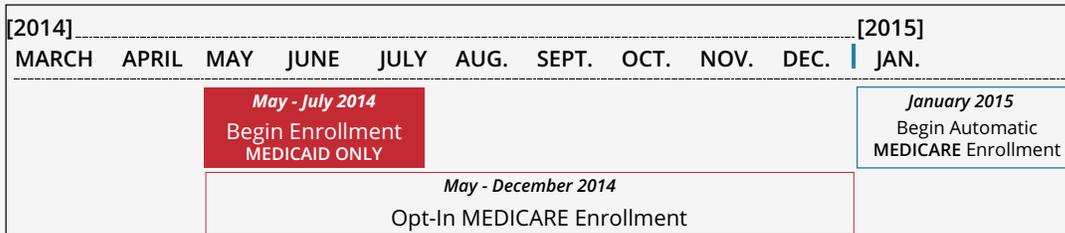
December 2012 saw Ohio become just the third state in the nation to receive federal approval for its plan to coordinate the benefits for individuals receiving both Medicare and Medicaid benefits. This relatively small population, often times referred to as “dual eligible,” makes up only 14 percent of the total Medicaid population but accounts for roughly 34 percent of all costs.

Figure 4.4 MyCare Ohio Demonstration Regions



Implementation efforts for the three-year MyCare Ohio demonstration unfolded throughout FY14. Ongoing negotiations with managed care plans and the Centers for Medicare and Medicaid Services (CMS) were held simultaneously with regular stakeholder meetings in order to ensure a seamless and efficient launch.

Figure 4.5 MyCare Ohio Implementation Timeline



MyCare Ohio went live for just Medicaid benefits, on May 1, 2014 with the enrollment of individuals in the Northeast Region, consisting of Cuyahoga, Medina, Lorain, Geauga and Lake Counties. Beneficiaries

were provided 60 days to choose a MyCare Ohio managed care plan. Individuals failing to select a plan at the end of 60 days had a plan selected for them. MyCare Ohio beneficiaries will have until the close of Calendar Year 2014 to choose a MyCare Ohio plan for their Medicare benefits.

The additional six MyCare Ohio regions went live on June 1 and July 1 of 2014. Of the roughly 182,000 Ohioans covered by both Medicare and Medicaid, as many 106,000 were enrolled in MyCare Ohio.



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## PROVIDERS

*As the largest health care payer in Ohio, the Ohio Department of Medicaid (ODM) has direct relationships with thousands of diverse health care providers across the state. Ensuring an efficient and reliable exchange of information regarding both billing and policy is central to maintaining a strong relationship with the provider community. The department has put an emphasis on creating and improving a channel of communication with providers that better suits the pace of modern communication.*

*ODM also has a fundamental responsibility to Ohio taxpayers to ensure that they are receiving value for the money spent and the services provided. To this end, the department operates one of the most effective program integrity efforts to track the money being spent and is a leader in identifying fraud, waste, and abuse..*

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### PROVIDER ENROLLMENT AND MANAGEMENT

The past year has seen ODM strengthen its provider relationships and enrich its proven auditing systems to assure program integrity. In state fiscal year 2014, Ohio Medicaid’s network of physicians, dentists, nurses, physical therapists, personal care assistants, hospitals and nursing facilities totaled more than 93,000 providers located across the state. Many of those providers also work through the six private health plans that participate in the Medicaid managed care program and MyCare Ohio. A key tool in the improvements in provider management was expanding the uses of the Medicaid Information Technology System (MITS) to search out more information on potential providers and to communicate new initiatives and goals to existing providers.

### MEDICAID INFORMATION TECHNOLOGY SYSTEM (MITS)

ODM receives and screens approximately 1,200 applications from potential providers each month and now uses recent enhancements to the MITS system to increase efficiency and security around those applications. Interfaces were built between MITS and federal and state exclusion databases that enable the system to verify the eligibility of providers to enroll in Medicaid. This automated “verification” allows for greater staff efficiency by limiting the amount of searches that were previously conducted manually. In addition, the system enhancement allows applicants to track their application online. The MITS system has also aided in the implementation of a five-year limit on provider agreements and the revalidation process that is tied to that limit. Revalidation is the process of rescreening, updating information and re-enrolling existing providers every five years. The notification process has been automated using the MITS system to generate notices and reminders to providers as well as automatically end the provider agreement if proper response is not received. This automation, in turn, frees staff to give comprehensive assistance to providers who are in compliance and engaged in the revalidation process.

New implementation for MITS continued to be applied by ODM in SFY 14 including proactive collaboration on systems issues from ODM managed care staff to the managed care organizations under contract to the agency. As a result, the implementation of big projects has gone smoother and new system releases have gone live with fewer defects or immediate needs for modification.

This strategy of robust collaboration had three main features:

- » ODM regularly engaged the managed care plans to share the State’s vision and provide updates on large initiatives.
- » the Department implemented a more comprehensive testing strategy

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## PROVIDERS

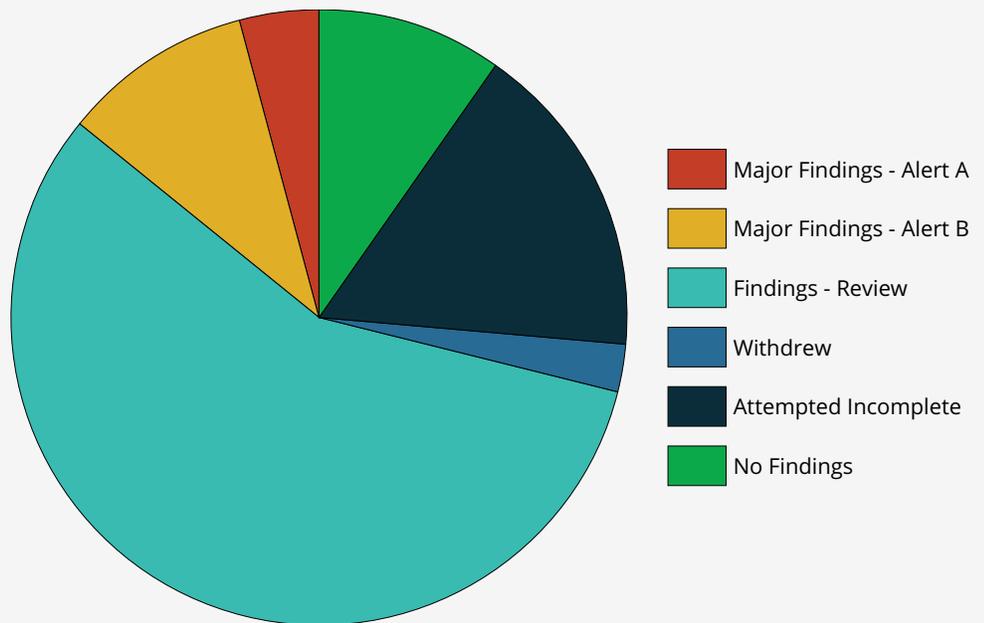
to assure effective exchange with managed care plans and other vendors such as the Medicaid Hotline.

- » the Department made it routine for systems staff from all sides to convene on a daily basis as new systems implementation came on line.

### SITE VISITS

In the second half of SFY 14, Ohio Medicaid contracted with Public Consulting Group (PCG) to execute unannounced site visits as part of heightened focus on specific types of providers identified by the federal government as provider types at high risk for Medicaid fraud. Wheelchair van providers, durable medical equipment providers and non-Medicare certified home health agencies were all cited as provider types being at high risk for potential fraud and abuse. By the end of the fiscal year, PCG had completed 302 unannounced inspections on behalf of ODM. Based on the results of the site visits, further action may include provider sanctioning, corrective action, or referral to the Ohio Attorney General’s Office in cases of suspected fraud. In SFY 14, there were 303 site visits with 13 cases referred to the Attorney General. The chart below illustrates the relative weight of the site visit findings.

Figure 5.1 PCG Onsite Screening Results



### PROGRAM INTEGRITY GROUP

The Ohio Medicaid Program Integrity Group (PIG) brings together representatives from ODM; the Auditor of State; and the Ohio Attorney General which each operate complementary Medicaid integrity sections. The combined forces craft data mining algorithms designed to identify fraudulent Medicaid providers and plan coordinated response to these findings. This coordinated approach to program integrity was one of the programs recognized as a “Bright Idea” for 2012 by the Ash Center for

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Democratic Governance and Innovation at Harvard University's John F. Kennedy School of Government. It continued to work and refine its efforts in SFY 14.

An outgrowth of this effort in practice and in law is to couple the PIG's work with the findings of additional audit programs within ODM. If the results of any review give ODM reason to believe that an incident of fraud has occurred in the Medicaid program, ODM refers the case to the Medicaid Fraud Control Unit of the Ohio Attorney General's office. As needed, ODM supports the Attorney General by providing supporting documentation and resources, while protecting the privacy rights of Medicaid beneficiaries. ODM also accepts referrals from the Attorney General to initiate action to recover improper payments made to providers. Representatives of the federal Centers for Medicare and Medicaid Services (CMS) also join the communication to discuss procedures, potential areas of risk and other relevant investigatory information.

In SFY 14, the Medicaid Fraud Control Unit of the Attorney General recorded:

- » 143 indictments,
- » 126 convictions; and,
- » \$71 million in recovery.

## SURVEILLANCE AND UTILIZATION REVIEW

The ODM Surveillance and Utilization Review Section (SURS) is the foundation for the agency's efforts to detect Medicaid fraud, waste and abuse. The majority of Medicaid audit resources for state fiscal year 2014 were used for the SURS monitoring of Medicaid providers and for monitoring of nursing facilities and intermediate care facilities for the developmentally disabled. During SFY 14, ODM issued 422 final adjudication orders to nursing and intermediate care facilities for overpayments due the state. These orders resulted in identified recoveries of \$9.35 million due to the state. In addition to the final adjudication orders, SURS staff conducted 349 provider reviews that identified overpayments of \$2.48 million.

In addition to these agency investigations, Medicaid providers also conduct reviews of their own billing and at times discover instances of overpayment by the Medicaid program. When such discoveries occur, providers contact the agency with the overpayment information and remit payment. During SFY 14, providers conducted 83 self-reviews, for total overpayments of \$2.43 million.

## INPATIENT HOSPITAL REVIEW CONTRACT

Permedion is an ODM contractor that performs retrospective reviews primarily focused on inpatient hospital care. The reviews are for the purpose

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of determining whether the care provided to a beneficiary meets medical necessity and quality care standards. The hospitals that are the subject of a review may appeal findings to Permedion; if the finding is upheld at that level, the provider may request a Surveillance and Utilization Review. In SFY 14, Permedion reviewed 16,240 inpatient cases that resulted in denials and/or adjustments to 5,736 claims for a savings of \$39.1 million. Permedion also completed 1,760 outpatient reviews that resulted in 2,648 cases being denied for using incorrect coding for a savings of \$10 million.

Permedion also performs pre-certifications for certain inpatient medical procedures. Pre-certification is an approval a hospital must obtain for procedures to be performed in an inpatient hospital setting that are normally performed in an outpatient setting. Permedion receives about 131 pre-certification requests per month. In SFY 14, Permedion completed 1,576 reviews that resulted in four denials and a cost savings of \$34,800.

In addition, Permedion performs special reviews to determine the medical necessity of services that are not covered and scholarly studies that support efforts toward ensuring higher standards of health care, quality and access to Medicaid consumers.

### THIRD PARTY LIABILITY

Ohio Medicaid's approach to program integrity in SFY 14 included enhanced efforts at tracking dollars paid to providers.

Under law, health care providers are prohibited from charging the state Medicaid agency for services if other sources are responsible for payment. Those other sources for payment may include private insurance companies, Medicare, or court-ordered coverage. Such sources are known as "third parties," and Medicaid staff aggressively tracks their responsibility to pay their clients' claims or "liabilities."

Due to the work of ODM's Third Party Liability and Recoveries staff, the State of Ohio avoided more than \$800 million in billed charges for health care during SFY 14.

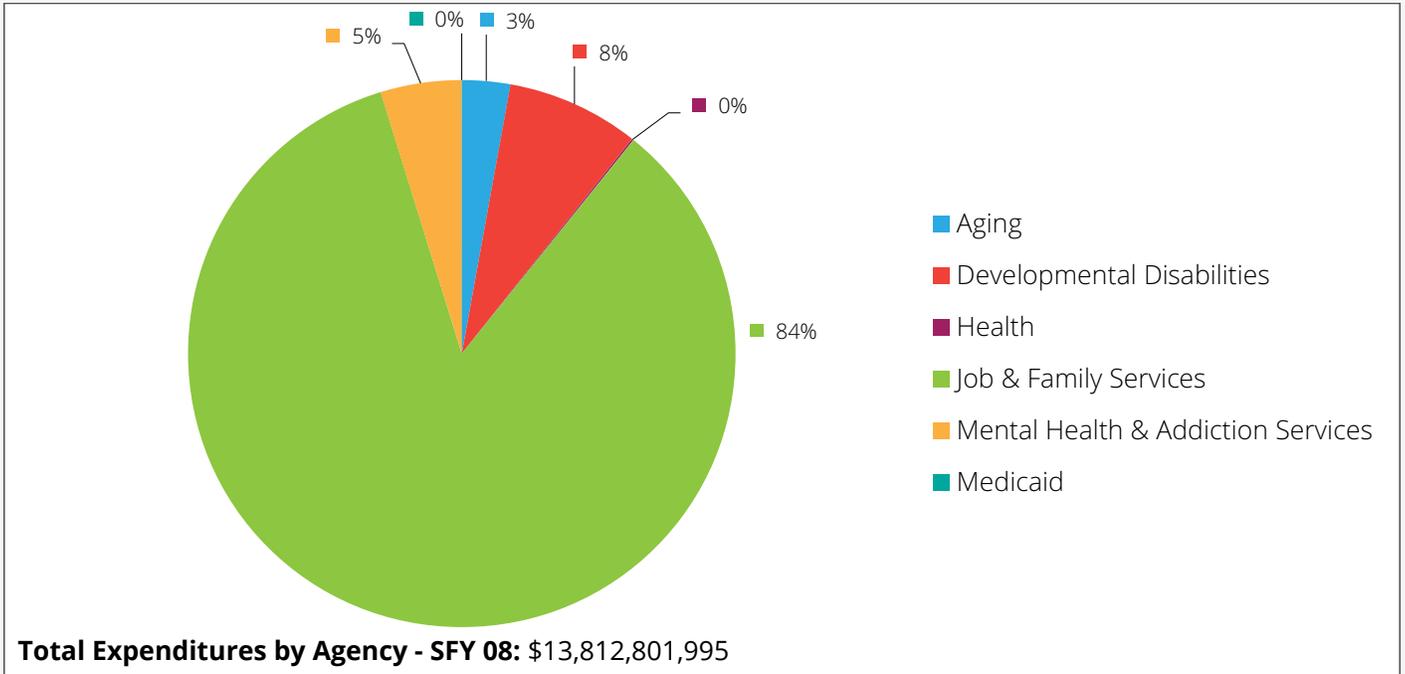
Despite this effort, daily changes in insurance circumstances or events can impact the payment responsibility even after a claim has been sent to Ohio Medicaid and is paid by the agency. In these cases, Ohio Medicaid will still learn that Medicaid is not responsible for the claim. Armed with the new information, the department authorizes collection activities to recover the Medicaid's payment. In SFY 2014, these activities resulted in \$78 million being returned to Ohio Medicaid.



# 6

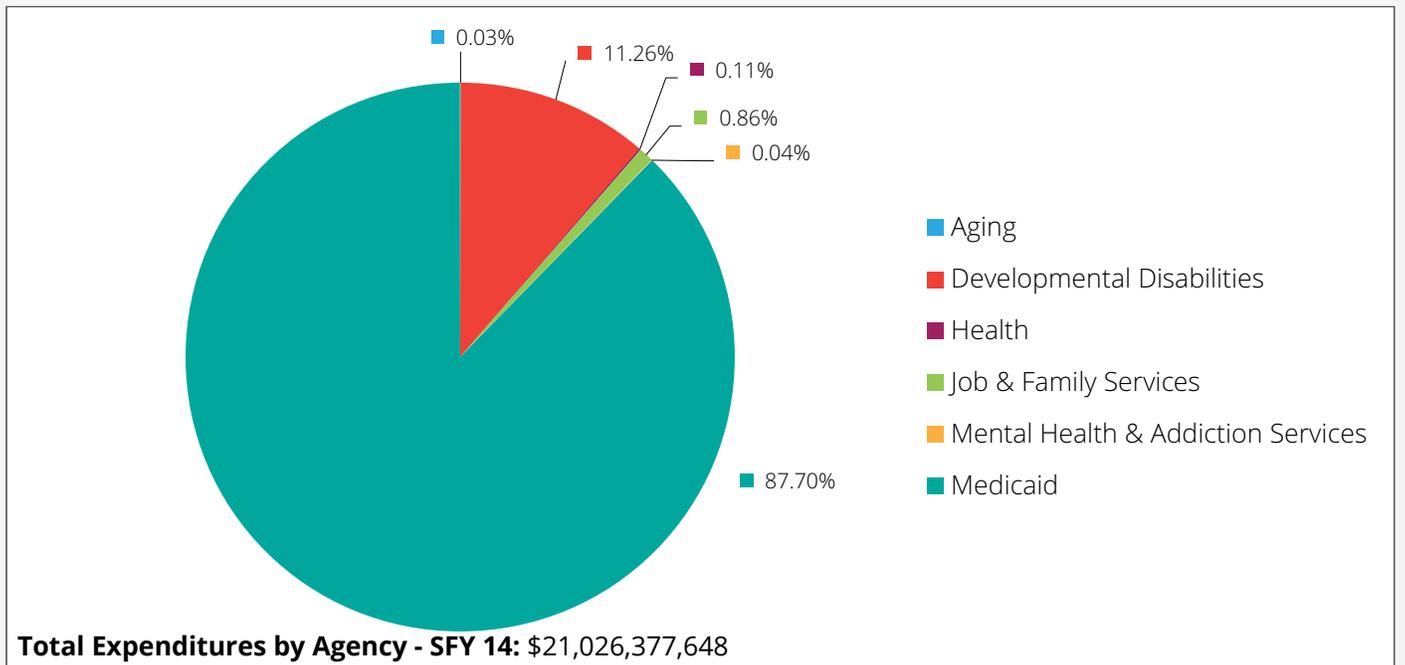
## APPENDIX

# 1. MEDICAID EXPENDITURES BY AGENCY - SFY 08



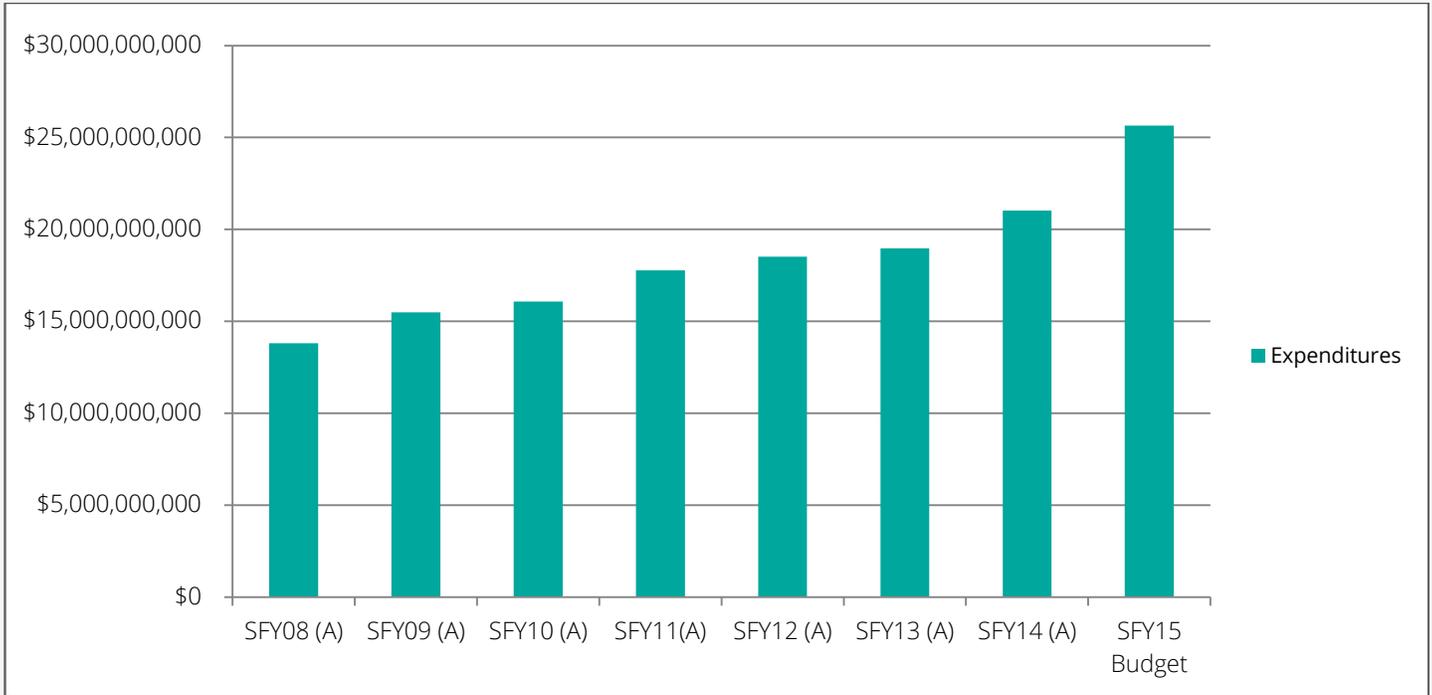
A historic capsule of Medicaid expenditures when organized under the Ohio Department of Job and Family Services. Note that Medicaid spending was spread across four agencies.

# 2. MEDICAID EXPENDITURES BY AGENCY - SFY 14



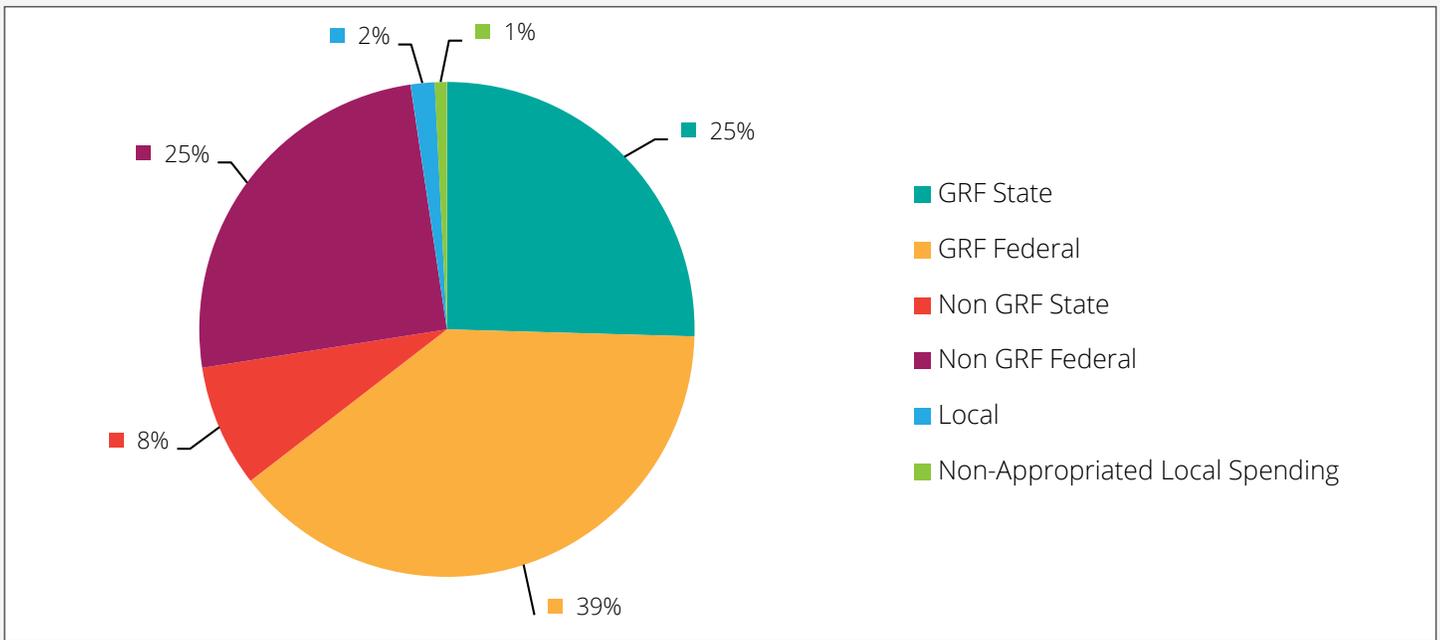
Current Medicaid expenditures as organized under the Ohio Department of Medicaid. Now, 99 percent of the program is housed within Medicaid and the Department of Developmental Disabilities.

### 3. ALL AGENCY MEDICAID EXPENDITURES ACTUAL / BUDGET SFY 08 - SFY 15



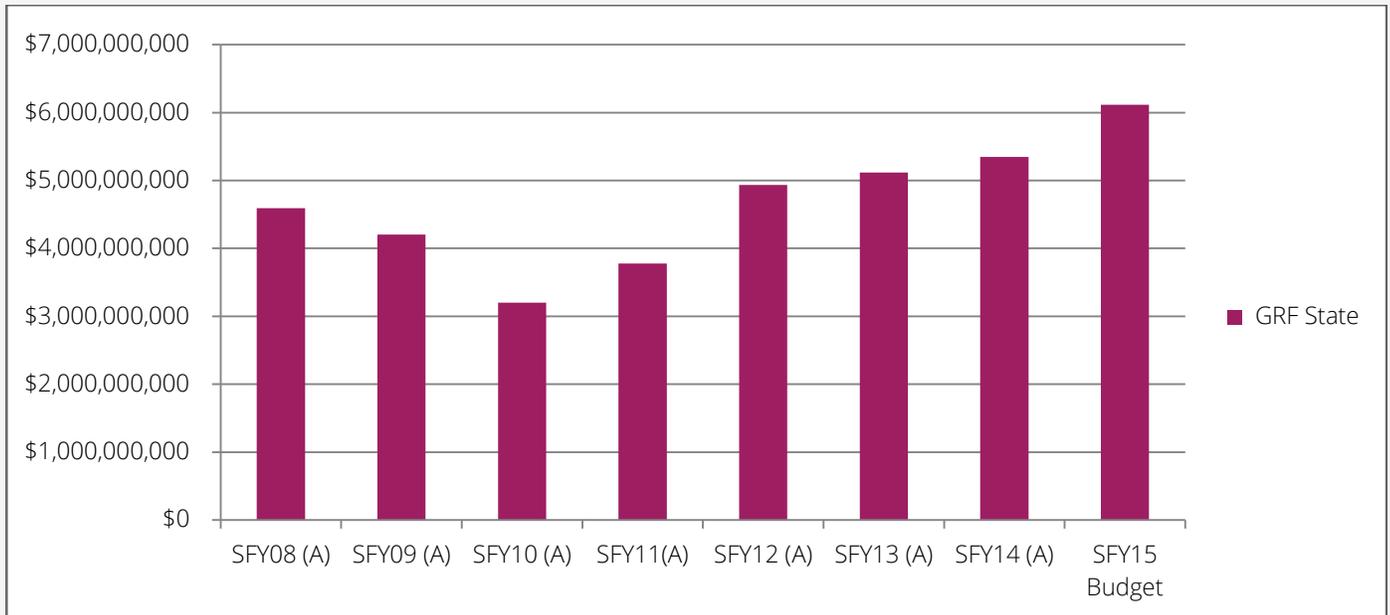
Historic view of total Ohio Medicaid expenditures for SFY 08 - 14 and planned budget for SFY 15.

### 4. ALL AGENCY MEDICAID SPENDING BY FUNDING SOURCE SFY 14



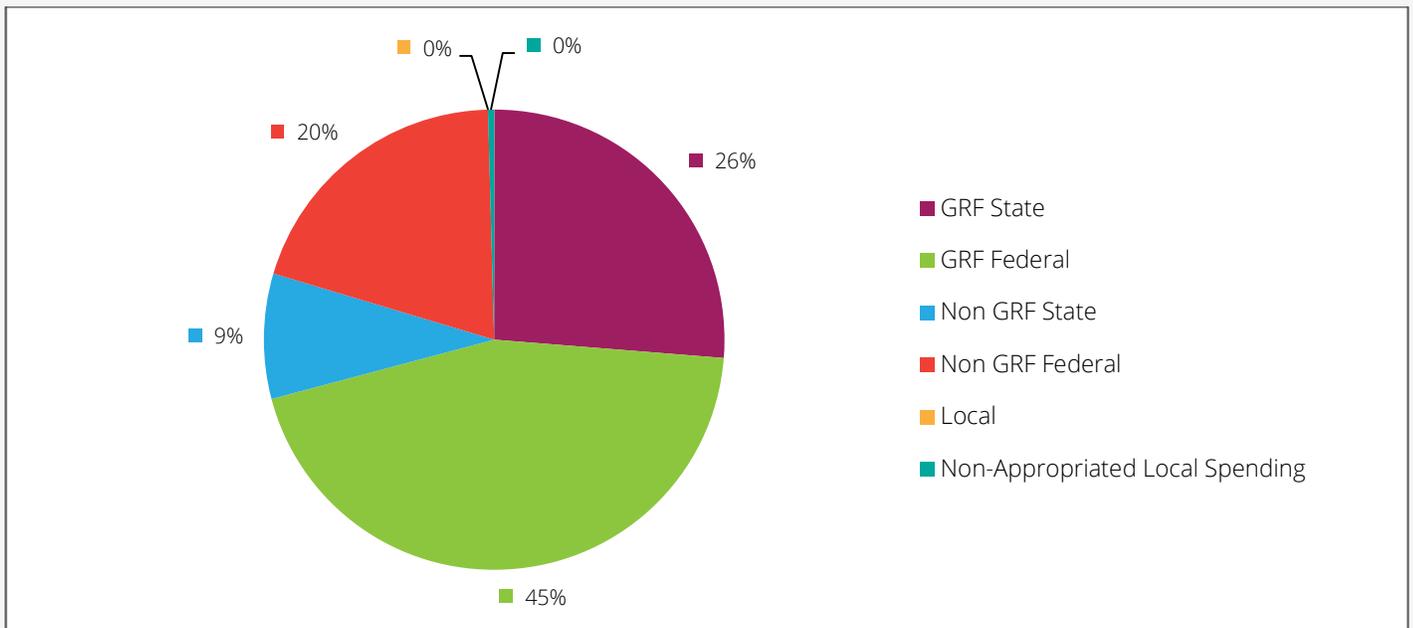
Sources include the state and federal General Revenue Funds, special dedicated state and federal revenues, and local contributions including locally raised health and human service levies.

## 5. ALL AGENCY MEDICAID GRF STATE SHARE



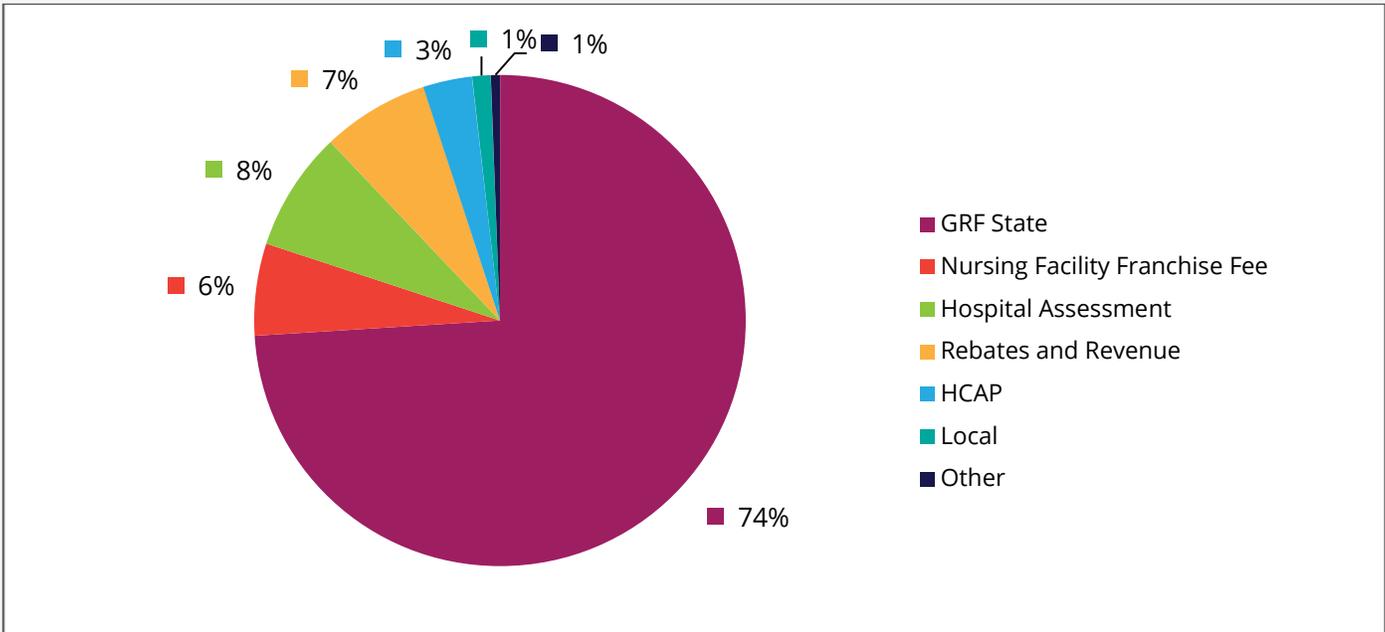
A historic view of Ohio general revenue fund spending and planned budget for SFY 15.

## 6. ODM MEDICAID SPENDING BY FUNDING SOURCE SFY 14



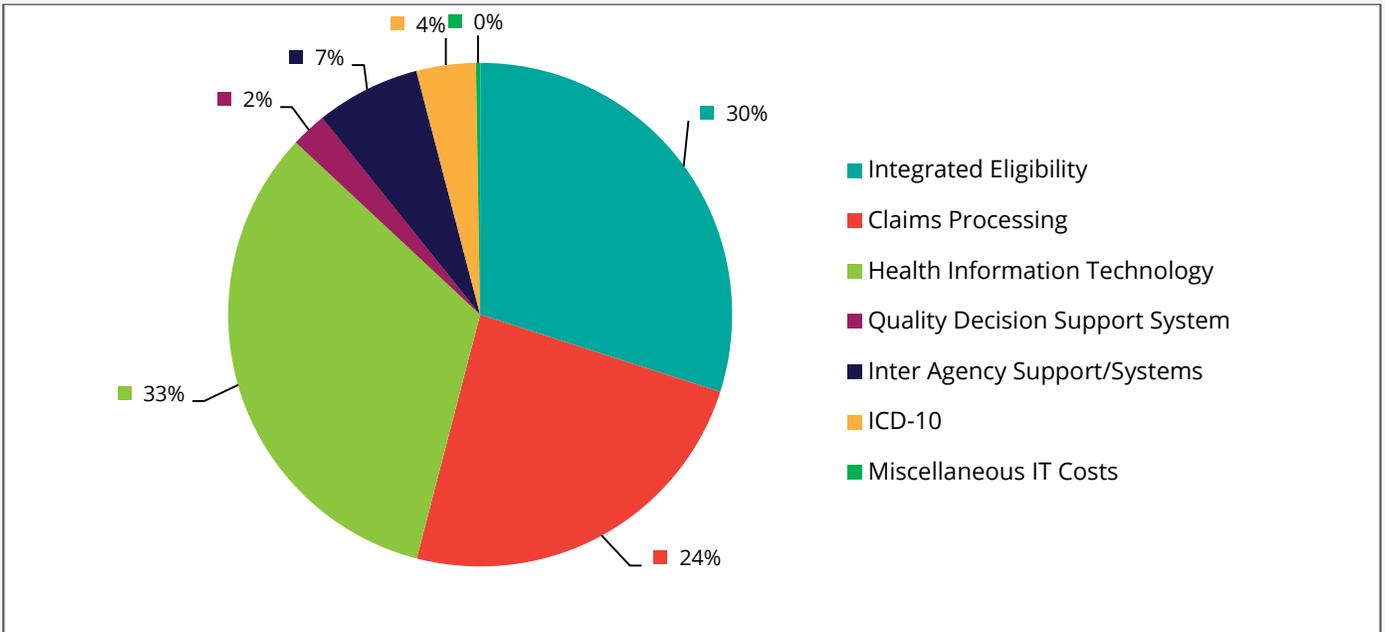
Recent Ohio Medicaid funding by source of those funds. for Medicaid payments based on origination.

## 7. ODM MEDICAID STATE MATCH BY FUNDING SOURCE SFY 14



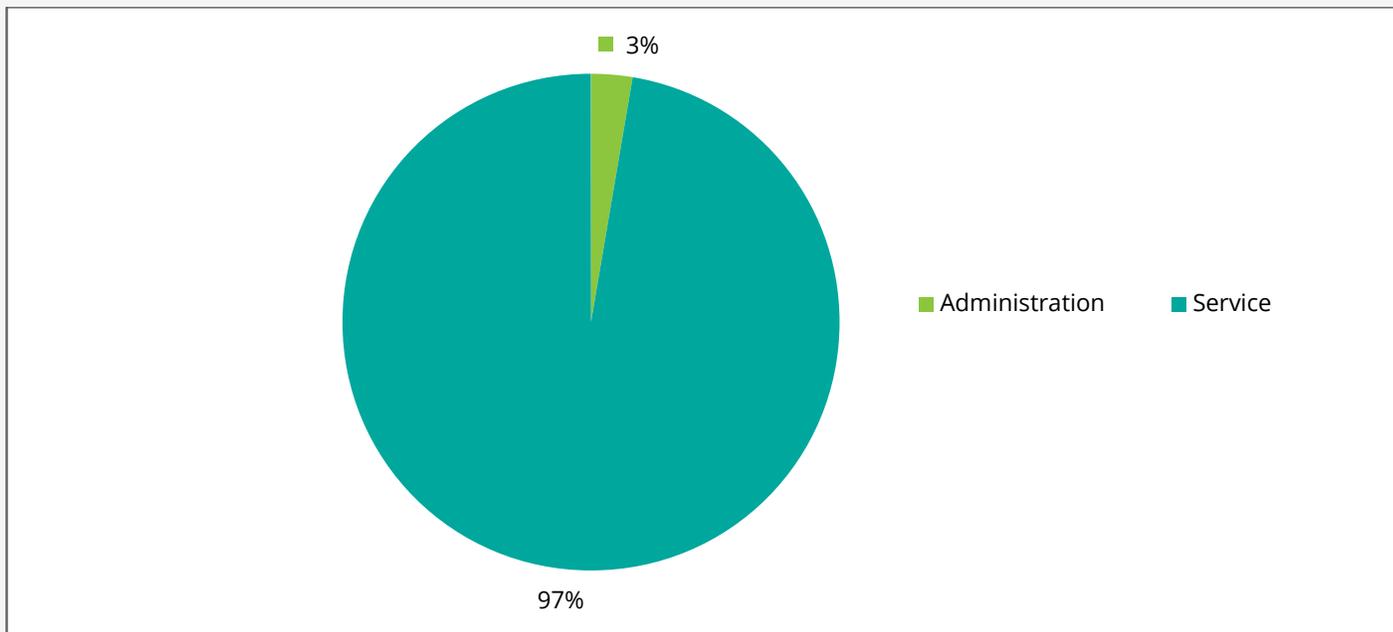
Sources of state contribution for Medicaid payments based on origination.

## 8. ODM IT EXPENDITURES SFY 14



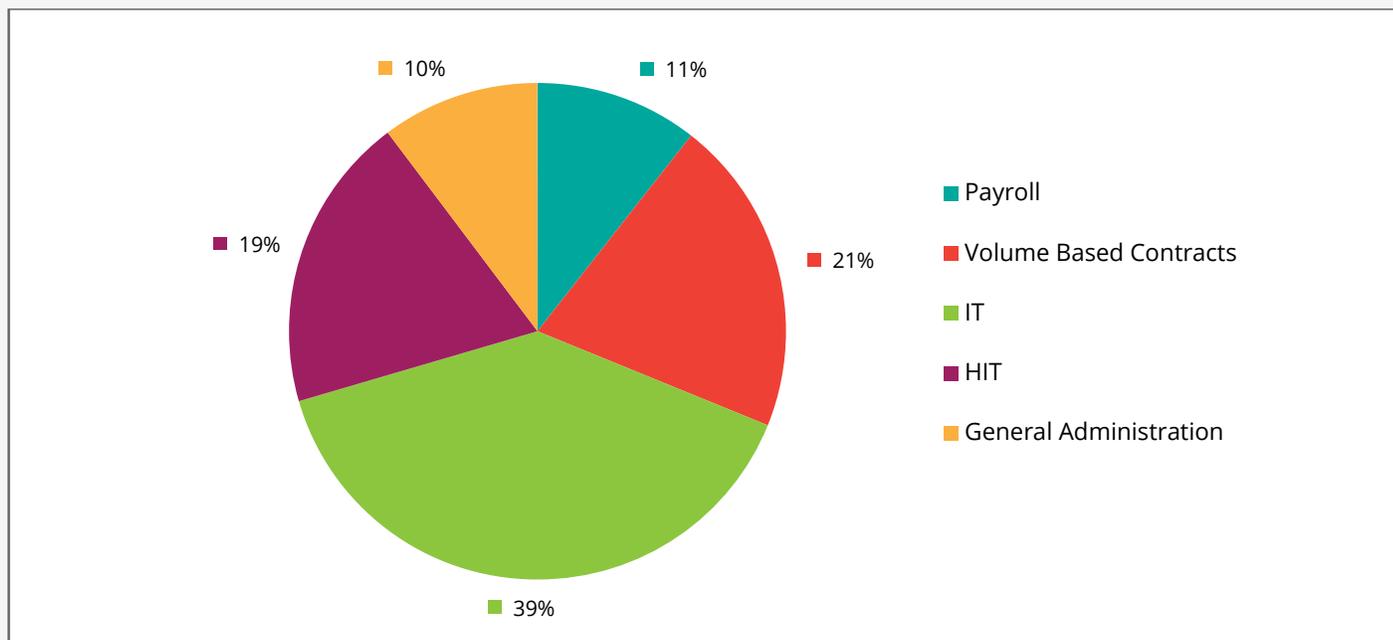
Ohio initiated several technology programs to make Medicaid operations more efficient, accessible and accountable while meeting new levels of federal requirements.

## 9. ODM ADMINISTRATION vs SERVICES SFY 14



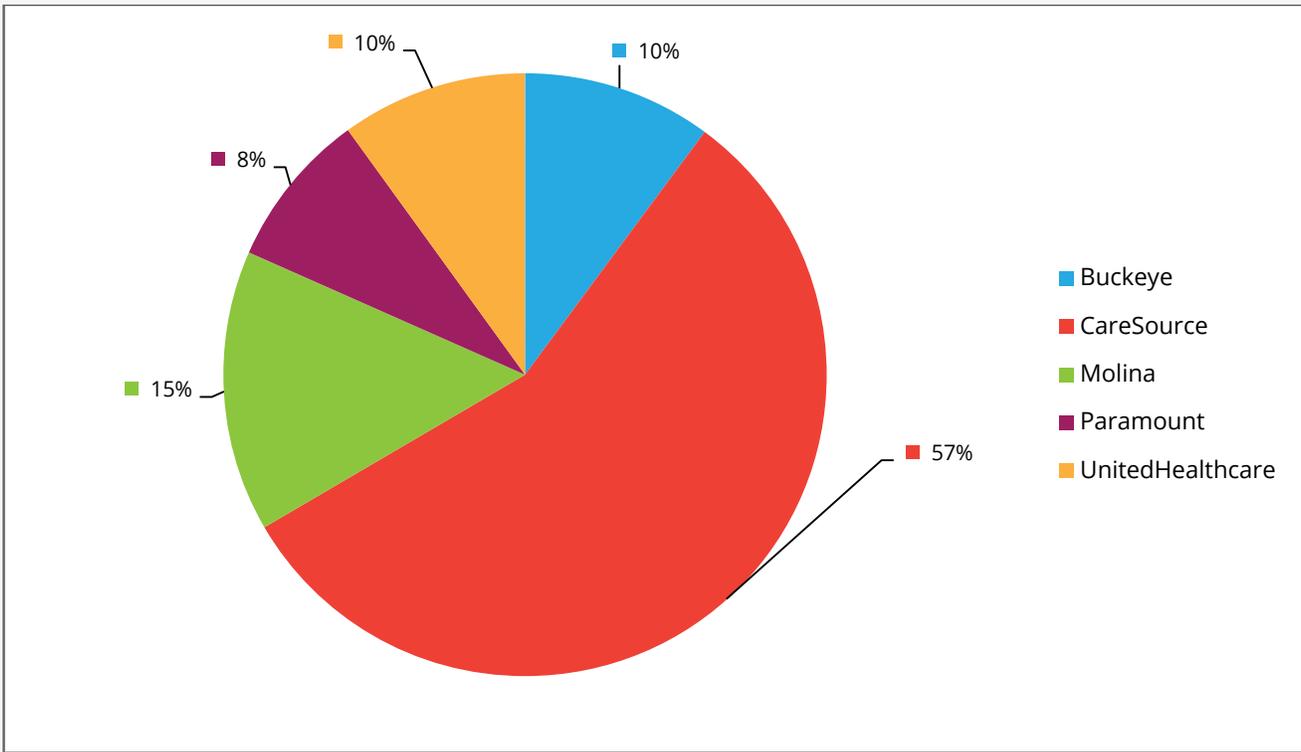
The vast majority of Medicaid funds are spent on services rather than administrative needs.

## 10. ODM ADMINISTRATION BY TYPE SFY 14



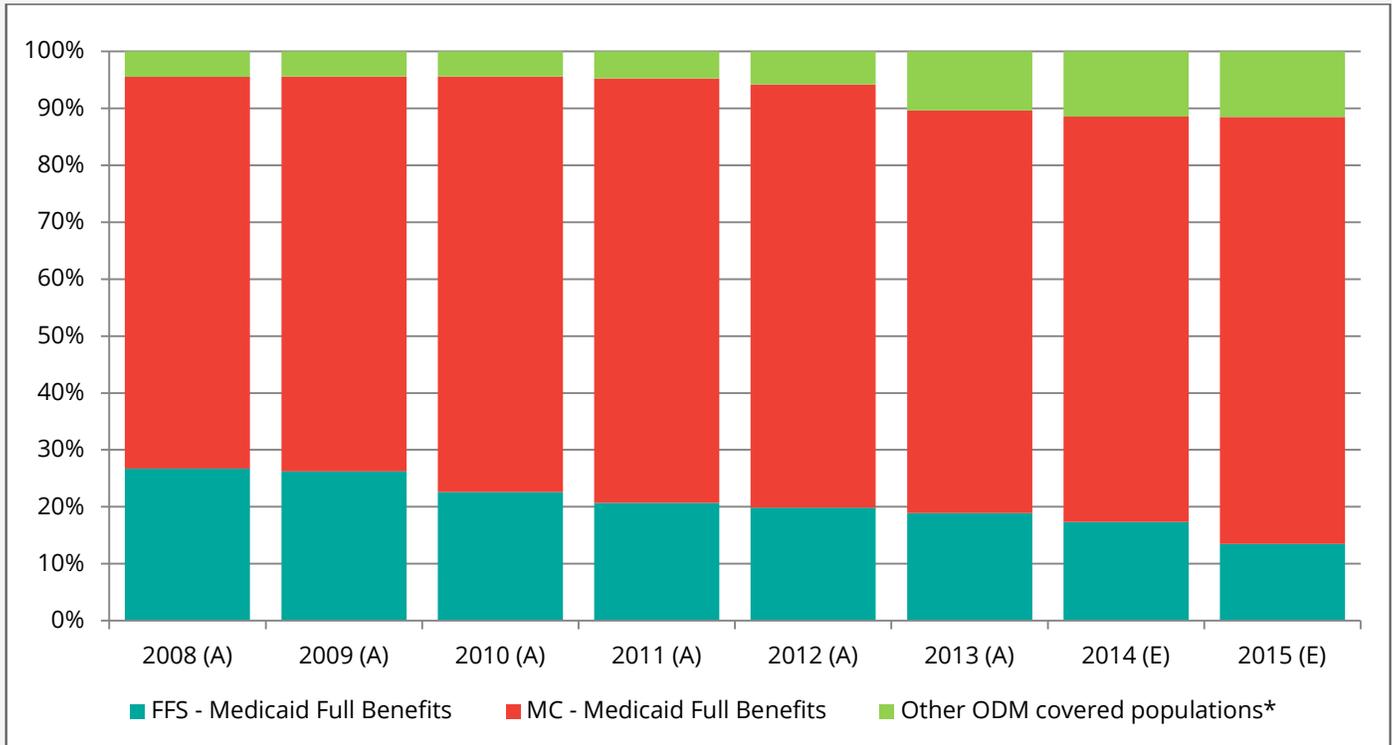
This illustrates how the administrative budget was spent in SFY 14.

# 11. MEDICAID MANAGED CARE ENROLLMENT BY PLAN



Seventy percent of all Ohio Medicaid beneficiaries are enrolled in managed care plans under contract with ODM.

# 12. AVERAGE MONTHLY MEDICAID ENROLLMENT ACTUAL / BUDGET SFY 08 - SFY 15



\* includes Medicare Premium Assistance, Refugee Medical Assistance, and Family Planning

Historical Managed Care (MC) versus Fee-for-Service (FFS) enrollment breakdown since 2008.



